

given the risks of racial or ethnic profiling and the lack of science to back TSA's claim of this security effectiveness.

I am pleased that Chairman KATKO was receptive to repurposing this position, at the Federal Security Director's discretion, to any alternate position within TSA's checkpoint screening functions.

I, once again, urge Members to support H.R. 5340, the FASTER Act, as it will ensure that TSA receives funding it needs to acquire and maintain staff and resources to efficiently carry out its mission without compromising security effectiveness.

I yield back the balance of my time. Mr. KATKO. Mr. Speaker, I yield myself the balance of my time to close.

The threats facing our Nation's aviation system are constantly changing and adapting. For this reason, TSA's mission is not only difficult, but critical to the national security of the United States and the safety of traveling Americans.

I, again, wish to thank all of the bipartisan cosponsors of this legislation, and I urge my colleagues to support this bill.

I yield back the balance of my time.

Mr. MCCAUL. Mr. Speaker, the traveling public is suffering from staggeringly long airport wait times. As the busy summer travel season has begun, I am consistently hearing reports of missed flights, delays, and two-hour plus wait times at TSA security checkpoints. This bipartisan legislation includes meaningful reforms that the Homeland Security Committee has identified to address wait times, while making sure that the traveling public remains safe. I also want to encourage the Senate to act on other House-passed bills that would help alleviate checkpoint wait times.

TSA's Admiral Neffenger testified before my committee that the provisions outlined in H.R. 5338 would help optimize checkpoints and reduce the burden on TSA and passengers. Our bill has also received overwhelming support from transportation stakeholders, such as the airport and airline community.

The Checkpoint Optimization and Efficiency Act redeploys TSA personnel to enhance staffing and increase operational capability, allowing more screening lanes to be open. The bill ushers in a new era of transparency and accountability between TSA and its airport and airline stakeholders, while pushing continued expansion of TSA's PreCheck program, which the House has already sought to expand with the passage of the TSA PreCheck Expansion Act.

Mr. Speaker, the President's recent budget requests have failed to predict the resources that were needed to mitigate this problem before it started. In fact, last year, TSA gave \$100 million back to the U.S. Treasury. Now, Secretary Johnson has had to ask Congress for reprogramming requests to alleviate the burden placed on TSA operations. While these reprogramming requests were necessary, I am pleased that this legislation will go a step further by reallocating existing assets in a much more effective manner.

I wish to thank Chairman KATKO for his leadership on this important issue, as well as each of the cosponsors of the bill. In par-

ticular, I wish to thank Ranking Member RICE and Representative KEATING for lending their support to the bill and for their engagement and work on enhancing transportation security. I urge my colleagues to support this critical legislation.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mr. KATKO) that the House suspend the rules and pass the bill, H.R. 5338, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

HELPING HOSPITALS IMPROVE PATIENT CARE ACT OF 2016

Mr. TIBERI. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 5273) to amend title XVIII of the Social Security Act to provide for regulatory relief under the Medicare program for certain providers of services and suppliers and increased transparency in hospital coding and enrollment data, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 5273

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Helping Hospitals Improve Patient Care Act of 2016".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—PROVISIONS RELATING TO MEDICARE PART A

Sec. 101. Development of Medicare study for HCPCS version of MS-DRG codes for similar hospital services.

Sec. 102. Establishing beneficiary equity in the Medicare hospital readmission program.

Sec. 103. Five-year extension of the rural community hospital demonstration program.

Sec. 104. Regulatory relief for LTCHs.

Sec. 105. Savings from IPPS MACRA pay-for-through not applying documentation and coding adjustments.

TITLE II—PROVISIONS RELATING TO MEDICARE PART B

Sec. 201. Continuing Medicare payment under HOPD prospective payment system for services furnished by mid-build off-campus outpatient departments of providers.

Sec. 202. Treatment of cancer hospitals in off-campus outpatient department of a provider policy.

Sec. 203. Treatment of eligible professionals in ambulatory surgical centers for meaningful use and MIPS.

TITLE III—OTHER MEDICARE PROVISIONS

Sec. 301. Delay in authority to terminate contracts for Medicare Advantage plans failing to achieve minimum quality ratings.

Sec. 302. Requirement for enrollment data reporting for Medicare.

Sec. 303. Updating the Welcome to Medicare package.

TITLE I—PROVISIONS RELATING TO MEDICARE PART A

SEC. 101. DEVELOPMENT OF MEDICARE STUDY FOR HCPCS VERSION OF MS-DRG CODES FOR SIMILAR HOSPITAL SERVICES.

Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

“(t) RELATING SIMILAR INPATIENT AND OUTPATIENT HOSPITAL SERVICES.—

“(1) DEVELOPMENT OF HCPCS VERSION OF MS-DRG CODES.—

“(A) IN GENERAL.—Not later than January 1, 2018, the Secretary shall develop HCPCS versions for MS-DRGs that is similar to the ICD-10-PCS for such MS-DRGs such that, to the extent possible, the MS-DRG assignment shall be similar for a claim coded with the HCPCS version as an identical claim coded with a ICD-10-PCS code.

“(B) COVERAGE OF SURGICAL MS-DRGS.—In carrying out subparagraph (A), the Secretary shall develop HCPCS versions of MS-DRG codes for not fewer than 10 surgical MS-DRGs.

“(C) PUBLICATION AND DISSEMINATION OF THE HCPCS VERSIONS OF MS-DRGS.—

“(i) IN GENERAL.—The Secretary shall develop a HCPCS MS-DRG definitions manual and software that is similar to the definitions manual and software for ICD-10-PCS codes for such MS-DRGs. The Secretary shall post the HCPCS MS-DRG definitions manual and software on the Internet website of the Centers for Medicare & Medicaid Services. The HCPCS MS-DRG definitions manual and software shall be in the public domain and available for use and redistribution without charge.

“(ii) USE OF PREVIOUS ANALYSIS DONE BY MEDPAC.—In developing the HCPCS MS-DRG definitions manual and software under clause (i), the Secretary shall consult with the Medicare Payment Advisory Commission and shall consider the analysis done by such Commission in translating outpatient surgical claims into inpatient surgical MS-DRGs in preparing chapter 7 (relating to hospital short-stay policy issues) of its 'Medicare and the Health Care Delivery System' report submitted to Congress in June 2015.

“(D) DEFINITION AND REFERENCE.—In this paragraph:

“(i) HCPCS.—The term 'HCPCS' means, with respect to hospital items and services, the code under the Healthcare Common Procedure Coding System (HCPCS) (or a successor code) for such items and services.

“(ii) ICD-10-PCS.—The term 'ICD-10-PCS' means the International Classification of Diseases, 10th Revision, Procedure Coding System, and includes a subsequent revision of such International Classification of Diseases, Procedure Coding System.”.

SEC. 102. ESTABLISHING BENEFICIARY EQUITY IN THE MEDICARE HOSPITAL READMISSION PROGRAM.

(a) TRANSITIONAL ADJUSTMENT FOR DUAL ELIGIBLE POPULATION.—Section 1886(q)(3) of the Social Security Act (42 U.S.C. 1395ww(q)(3)) is amended—

(1) in subparagraph (A), by inserting “subject to subparagraph (D),” after “purposes of paragraph (1),”; and

(2) by adding at the end the following new subparagraph:

“(D) TRANSITIONAL ADJUSTMENT FOR DUAL ELIGIBLES.—

“(i) IN GENERAL.—In determining a hospital's adjustment factor under this paragraph for purposes of making payments for discharges occurring during and after fiscal

year 2019, and before the application of clause (i) of subparagraph (E), the Secretary shall assign hospitals to groups (as defined by the Secretary under clause (ii)) and apply the applicable provisions of this subsection using a methodology in a manner that allows for separate comparison of hospitals within each such group, as determined by the Secretary.

“(ii) DEFINING GROUPS.—For purposes of this subparagraph, the Secretary shall define groups of hospitals based on their overall proportion, of the inpatients who are entitled to, or enrolled for, benefits under part A, who are full-benefit dual eligible individuals (as defined in section 1935(c)(6)). In defining groups, the Secretary shall consult the Medicare Payment Advisory Commission and may consider the analysis done by such Commission in preparing the portion of its report submitted to Congress in June 2013 relating to readmissions.

“(iii) MINIMIZING REPORTING BURDEN ON HOSPITALS.—In carrying out this subparagraph, the Secretary shall not impose any additional reporting requirements on hospitals.

“(iv) BUDGET NEUTRAL DESIGN METHODOLOGY.—The Secretary shall design the methodology to implement this subparagraph so that the estimated total amount of reductions in payments under this subsection equals the estimated total amount of reductions in payments that would otherwise occur under this subsection if this subparagraph did not apply.”

(b) SUBSEQUENT ADJUSTMENTS BASED ON IMPACT REPORTS.—Section 1886(q)(3) of the Social Security Act (42 U.S.C. 1395ww(q)(3)), as amended by subsection (a), is further amended by adding at the end the following new subparagraph:

“(E) CHANGES IN RISK ADJUSTMENT.—

“(i) CONSIDERATION OF RECOMMENDATIONS IN IMPACT REPORTS.—The Secretary may take into account the studies conducted and the recommendations made by the Secretary under section 2(d)(1) of the IMPACT Act of 2014 (Public Law 113-185; 42 U.S.C. 1395l11 note) with respect to the application under this subsection of risk adjustment methodologies. Nothing in this clause shall be construed as precluding consideration of the use of groupings of hospitals.”

(c) MEDPAC STUDY ON READMISSIONS PROGRAM.—The Medicare Payment Advisory Commission shall conduct a study to review overall hospital readmissions described in section 1886(q)(5)(E) of the Social Security Act (42 U.S.C. 1395ww(q)(5)(E)) and whether such readmissions are related to any changes in outpatient and emergency services furnished. The Commission shall submit to Congress a report on such study in its report to Congress in June 2017.

(d) ADDRESSING ISSUE OF CERTAIN PATIENTS.—Subparagraph (E) of section 1886(q)(3) of the Social Security Act (42 U.S.C. 1395ww(q)(3)), as added by subsection (b), is further amended by adding at the end the following new clause:

“(ii) CONSIDERATION OF EXCLUSION OF PATIENT CASES BASED ON V OR OTHER APPROPRIATE CODES.—In promulgating regulations to carry out this subsection with respect to discharges occurring after fiscal year 2018, the Secretary may consider the use of V or other ICD-related codes for removal of a readmission. The Secretary may consider modifying measures under this subsection to incorporate V or other ICD-related codes at the same time as other changes are being made under this subparagraph.”

(e) REMOVAL OF CERTAIN READMISSIONS.—Subparagraph (E) of section 1886(q)(3) of the Social Security Act (42 U.S.C. 1395ww(q)(3)), as added by subsection (b) and amended by subsection (d), is further amended by adding at the end the following new clause:

“(iii) REMOVAL OF CERTAIN READMISSIONS.—In promulgating regulations to carry out this subsection, with respect to discharges occurring after fiscal year 2018, the Secretary may consider removal as a readmission of an admission that is classified within one or more of the following: transplants, end-stage renal disease, burns, trauma, psychosis, or substance abuse. The Secretary may consider modifying measures under this subsection to remove readmissions at the same time as other changes are being made under this subparagraph.”

SEC. 103. FIVE-YEAR EXTENSION OF THE RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) EXTENSION.—Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; 42 U.S.C. 1395ww note), as amended by sections 3123 and 10313 of the Patient Protection and Affordable Care Act (Public Law 111-148), is amended—

(1) in subsection (a)(5), by striking “5-year extension period” and inserting “10-year extension period”; and

(2) in subsection (g)—
(A) in the subsection heading, by striking “FIVE-YEAR” and inserting “TEN-YEAR”;

(B) in paragraph (1), by striking “additional 5-year” and inserting “additional 10-year”;

(C) by striking “5-year extension period” and inserting “10-year extension period” each place it appears;

(D) in paragraph (4)(B)—
(i) in the matter preceding clause (i), by inserting “each 5-year period in” after “hospital during”; and

(ii) in clause (i), by inserting “each applicable 5-year period in” after “the first day of”; and

(E) by adding at the end the following new paragraphs:

“(5) OTHER HOSPITALS IN DEMONSTRATION PROGRAM.—During the second 5 years of the 10-year extension period, the Secretary shall apply the provisions of paragraph (4) to rural community hospitals that are not described in paragraph (4) but are participating in the demonstration program under this section as of December 30, 2014, in a similar manner as such provisions apply to rural community hospitals described in paragraph (4).

“(6) EXPANSION OF DEMONSTRATION PROGRAM TO RURAL AREAS IN ANY STATE.—

“(A) IN GENERAL.—The Secretary shall, notwithstanding subsection (a)(2) or paragraph (2) of this subsection, not later than 120 days after the date of the enactment of this paragraph, issue a solicitation for applications to select up to the maximum number of additional rural community hospitals located in any State to participate in the demonstration program under this section for the second 5 years of the 10-year extension period without exceeding the limitation under paragraph (3) of this subsection.

“(B) PRIORITY.—In determining which rural community hospitals that submitted an application pursuant to the solicitation under subparagraph (A) to select for participation in the demonstration program, the Secretary—

“(i) shall give priority to rural community hospitals located in one of the 20 States with the lowest population densities (as determined by the Secretary using the 2015 Statistical Abstract of the United States); and

“(ii) may consider—
(I) closures of hospitals located in rural areas in the State in which the rural community hospital is located during the 5-year period immediately preceding the date of the enactment of this paragraph; and

“(II) the population density of the State in which the rural community hospital is located.”

(b) CHANGE IN TIMING FOR REPORT.—Subsection (e) of such section 410A is amended—

(1) by striking “Not later than 6 months after the completion of the demonstration program under this section” and inserting “Not later than August 1, 2018”; and

(2) by striking “such program” and inserting “the demonstration program under this section”.

SEC. 104. REGULATORY RELIEF FOR LTCHS.

(a) TECHNICAL CHANGE TO THE MEDICARE LONG-TERM CARE HOSPITAL MORATORIUM EXCEPTION.—

(1) IN GENERAL.—Section 114(d)(7) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by sections 3106(b) and 10312(b) of Public Law 111-148, section 1206(b)(2) of the Pathway for SGR Reform Act of 2013 (division B of Public Law 113-67), and section 112 of the Protecting Access to Medicare Act of 2014, is amended by striking “The moratorium under paragraph (1)(A)” and inserting “Any moratorium under paragraph (1)”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of section 112 of the Protecting Access to Medicare Act of 2014.

(b) MODIFICATION TO MEDICARE LONG-TERM CARE HOSPITAL HIGH COST OUTLIER PAYMENTS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)) is amended by adding at the end the following new paragraph:

“(7) TREATMENT OF HIGH COST OUTLIER PAYMENTS.—

“(A) ADJUSTMENT TO THE STANDARD FEDERAL PAYMENT RATE FOR ESTIMATED HIGH COST OUTLIER PAYMENTS.—Under the system described in paragraph (1), for fiscal years beginning on or after October 1, 2017, the Secretary shall reduce the standard Federal payment rate as if the estimated aggregate amount of high cost outlier payments for standard Federal payment rate discharges for each such fiscal year would be equal to 8 percent of estimated aggregate payments for standard Federal payment rate discharges for each such fiscal year.

“(B) LIMITATION ON HIGH COST OUTLIER PAYMENT AMOUNTS.—Notwithstanding subparagraph (A), the Secretary shall set the fixed loss amount for high cost outlier payments such that the estimated aggregate amount of high cost outlier payments made for standard Federal payment rate discharges for fiscal years beginning on or after October 1, 2017, shall be equal to 99.6875 percent of 8 percent of estimated aggregate payments for standard Federal payment rate discharges for each such fiscal year.

“(C) WAIVER OF BUDGET NEUTRALITY.—Any reduction in payments resulting from the application of subparagraph (B) shall not be taken into account in applying any budget neutrality provision under such system.

“(D) NO EFFECT ON SITE NEUTRAL HIGH COST OUTLIER PAYMENT RATE.—This paragraph shall not apply with respect to the computation of the applicable site neutral payment rate under paragraph (6).”

SEC. 105. SAVINGS FROM IPPS MACRA PAY-FOR-THROUGH NOT APPLYING DOCUMENTATION AND CODING ADJUSTMENTS.

Section 7(b)(1)(B)(iii) of the TMA, Abstinence Education, and QI Programs Extension Act of 2007 (Public Law 110-90), as amended by section 631(b) of the American Taxpayer Relief Act of 2012 (Public Law 122-240) and section 414(l)(B)(iii) of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114-10), is amended by striking “an increase of 0.5 percentage points for discharges occurring during each of fiscal years 2018 through 2023” and inserting “an increase

of 0.4590 percentage points for discharges occurring during fiscal year 2018 and 0.5 percentage points for discharges occurring during each of fiscal years 2019 through 2023”.

TITLE II—PROVISIONS RELATING TO MEDICARE PART B

SEC. 201. CONTINUING MEDICARE PAYMENT UNDER HOPD PROSPECTIVE PAYMENT SYSTEM FOR SERVICES FURNISHED BY MID-BUILD OFF-CAMPUS OUTPATIENT DEPARTMENTS OF PROVIDERS.

(a) IN GENERAL.—Section 1833(t)(21) of the Social Security Act (42 U.S.C. 1395l(t)(21)) is amended—

(1) in subparagraph (B)—

(A) in clause (i), by striking “clause (ii)” and inserting “the subsequent provisions of this subparagraph”; and

(B) by adding at the end the following new clauses:

“(iii) DEEMED TREATMENT FOR 2017.—For purposes of applying clause (i) with respect to applicable items and services furnished during 2017, a department of a provider (as so defined) not described in such clause is deemed to be billing under this subsection with respect to covered OPD services furnished prior to November 2, 2015, if the Secretary received from the provider prior to December 2, 2015, an attestation (pursuant to section 413.65(b)(3) of title 42 of the Code of Federal Regulations) that such department was a department of a provider (as so defined).

“(iv) ALTERNATIVE EXCEPTION BEGINNING WITH 2018.—For purposes of paragraph (1)(B)(v) and this paragraph with respect to applicable items and services furnished during 2018 or a subsequent year, the term ‘off-campus outpatient department of a provider’ also shall not include a department of a provider (as so defined) that is not described in clause (ii) if—

“(I) the Secretary receives from the provider an attestation (pursuant to such section 413.65(b)(3)) not later than December 31, 2016 (or, if later, 60 days after the date of the enactment of this clause), that such department met the requirements of a department of a provider specified in section 413.65 of title 42 of the Code of Federal Regulations;

“(II) the provider includes such department as part of the provider on its enrollment form in accordance with the enrollment process under section 1866(j); and

“(III) the department met the mid-build requirement of clause (v) and the Secretary receives, not later than 60 days after the date of the enactment of this clause, from the chief executive officer or chief operating officer of the provider a written certification that the department met such requirement.

“(v) MID-BUILD REQUIREMENT DESCRIBED.—The mid-build requirement of this clause is, with respect to a department of a provider, that before November 2, 2015, the provider had a binding written agreement with an outside unrelated party for the actual construction of such department.

“(vii) AUDIT.—Not later than December 31, 2018, the Secretary shall audit the compliance with requirements of clause (iv) with respect to each department of a provider to which such clause applies. If the Secretary finds as a result of an audit under this clause that the applicable requirements were not met with respect to such department, the department shall not be excluded from the term ‘off-campus outpatient department of a provider’ under such clause.

“(viii) IMPLEMENTATION.—For purposes of implementing clauses (iii) through (vii):

“(I) Notwithstanding any other provision of law, the Secretary may implement such clauses by program instruction or otherwise.

“(II) Subchapter I of chapter 35 of title 44, United States Code, shall not apply.

“(III) For purposes of carrying out this subparagraph with respect to clauses (iii) and (iv) (and clause (vii) insofar as it relates to clause (iv)), \$10,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1841, to remain available until December 31, 2018.”; and

(2) in subparagraph (E), by adding at the end the following new clause:

“(iv) The determination of an audit under subparagraph (B)(vii).”.

(b) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of section 603 of the Bipartisan Budget Act of 2015 (Public Law 114-74).

SEC. 202. TREATMENT OF CANCER HOSPITALS IN OFF-CAMPUS OUTPATIENT DEPARTMENT OF A PROVIDER POLICY.

(a) IN GENERAL.—Section 1833(t)(21)(B) of the Social Security Act (42 U.S.C. 1395l(t)(21)(B)), as amended by section 201(a), is amended—

(1) by inserting after clause (v) the following new clause:

“(vi) EXCLUSION FOR CERTAIN CANCER HOSPITALS.—For purposes of paragraph (1)(B)(v) and this paragraph with respect to applicable items and services furnished during 2017 or a subsequent year, the term ‘off-campus outpatient department of a provider’ also shall not include a department of a provider (as so defined) that is not described in clause (ii) if the provider is a hospital described in section 1886(d)(1)(B)(v) and—

“(I) in the case of a department that met the requirements of section 413.65 of title 42 of the Code of Federal Regulations after November 1, 2015, and before the date of the enactment of this clause, the Secretary receives from the provider an attestation that such department met such requirements not later than 60 days after such date of enactment; or

“(II) in the case of a department that meets such requirements after such date of enactment, the Secretary receives from the provider an attestation that such department meets such requirements not later than 60 days after the date such requirements are first met with respect to such department.”;

(2) in clause (vii), by inserting after the first sentence the following: “Not later than 2 years after the date the Secretary receives an attestation under clause (vi) relating to compliance of a department of a provider with requirements referred to in such clause, the Secretary shall audit the compliance with such requirements with respect to the department.”; and

(3) in clause (viii)(III), by adding at the end the following: “For purposes of carrying out this subparagraph with respect to clause (vi) (and clause (vii) insofar as it relates to such clause), \$2,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1841, to remain available until expended.”.

(b) OFFSETTING SAVINGS.—Section 1833(t)(18) of the Social Security Act (42 U.S.C. 1395l(t)(18)) is amended—

(1) in subparagraph (B), by inserting “, subject to subparagraph (C),” after “shall”; and

(2) by adding at the end the following new subparagraph:

“(C) TARGET PCR ADJUSTMENT.—In applying section 419.43(i) of title 42 of the Code of Federal Regulations to implement the appropriate adjustment under this paragraph for services furnished on or after January 1, 2018, the Secretary shall use a target PCR that is 1.0 percentage points less than the target PCR that would otherwise apply. In addition to the percentage point reduction under the previous sentence, the Secretary may consider making an additional percentage point reduction to such target PCR that takes into

account payment rates for applicable items and services described in paragraph (21)(C) other than for services furnished by hospitals described in section 1886(d)(1)(B)(v). In making any budget neutrality adjustments under this subsection for 2018 or a subsequent year, the Secretary shall not take into account the reduced expenditures that result from the application of this subparagraph.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of section 603 of the Bipartisan Budget Act of 2015 (Public Law 114-74).

SEC. 203. TREATMENT OF ELIGIBLE PROFESSIONALS IN AMBULATORY SURGICAL CENTERS FOR MEANINGFUL USE AND MIPS.

(a) IN GENERAL.—Section 1848(a)(7)(D) of the Social Security Act (42 U.S.C. 1395w-4(a)(7)(D)) is amended—

(1) by striking “HOSPITAL-BASED ELIGIBLE PROFESSIONALS” and all that follows through “No payment” and inserting the following: “HOSPITAL-BASED AND AMBULATORY SURGICAL CENTER-BASED ELIGIBLE PROFESSIONALS.—

“(i) HOSPITAL-BASED.—No payment”; and

(2) by adding at the end the following new clauses:

“(ii) AMBULATORY SURGICAL CENTER-BASED.—Subject to clause (iv), no payment adjustment may be made under subparagraph (A) for 2017 and 2018 in the case of an eligible professional with respect to whom substantially all of the covered professional services furnished by such professional are furnished in an ambulatory surgical center.

“(iii) DETERMINATION.—The determination of whether an eligible professional is an eligible professional described in clause (ii) may be made on the basis of—

“(I) the site of service (as defined by the Secretary); or

“(II) an attestation submitted by the eligible professional.

Determinations made under subclasses (I) and (II) shall be made without regard to any employment or billing arrangement between the eligible professional and any other supplier or provider of services.

“(iv) SUNSET.—Clause (ii) shall no longer apply as of the first year that begins more than 3 years after the date on which the Secretary determines, through notice and comment rulemaking, that certified EHR technology applicable to the ambulatory surgical center setting is available.”.

(b) CONTINUED APPLICATION OF CERTAIN PROVISIONS UNDER MIPS.—Section 1848(o)(2)(D) of the Social Security Act (42 U.S.C. 1395w-4(o)(2)(D)) is amended by adding at the end the following new sentence: “The provisions of subparagraphs (B) and (D) of subsection (a)(7), including the application of clause (iv) of such subparagraph (D), shall apply to assessments of MIPS eligible professionals under subsection (q) with respect to the performance category described in subsection (q)(2)(A)(iv) in a manner similar to the manner in which such provisions apply with respect to payment adjustments made under subsection (a)(7)(A).”.

TITLE III—OTHER MEDICARE PROVISIONS

SEC. 301. DELAY IN AUTHORITY TO TERMINATE CONTRACTS FOR MEDICARE ADVANTAGE PLANS FAILING TO ACHIEVE MINIMUM QUALITY RATINGS.

(a) FINDINGS.—Consistent with the studies provided under the IMPACT Act of 2014 (Public Law 113-185), it is the intent of Congress—

(1) to continue to study and request input on the effects of socioeconomic status and dual-eligible populations on the Medicare Advantage STARS rating system before reforming such system with the input of stakeholders; and

(2) pending the results of such studies and input, to provide for a temporary delay in

authority of the Centers for Medicare & Medicaid Services (CMS) to terminate Medicare Advantage plan contracts solely on the basis of performance of plans under the STARS rating system.

(b) DELAY IN MA CONTRACT TERMINATION AUTHORITY FOR PLANS FAILING TO ACHIEVE MINIMUM QUALITY RATINGS.—Section 1857(h) of the Social Security Act (42 U.S.C. 1395w-27(h)) is amended by adding at the end the following new paragraph:

“(3) DELAY IN CONTRACT TERMINATION AUTHORITY FOR PLANS FAILING TO ACHIEVE MINIMUM QUALITY RATING.—During the period beginning on the date of the enactment of this paragraph and through the end of plan year 2018, the Secretary may not terminate a contract under this section with respect to the offering of an MA plan by a Medicare Advantage organization solely because the MA plan has failed to achieve a minimum quality rating under the 5-star rating system under section 1853(o)(4).”

SEC. 302. REQUIREMENT FOR ENROLLMENT DATA REPORTING FOR MEDICARE.

Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

“(g) REQUIREMENT FOR ENROLLMENT DATA REPORTING.—

“(1) IN GENERAL.—Each year (beginning with 2016), the Secretary shall submit to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on Medicare enrollment data (and, in the case of part A, on data on individuals receiving benefits under such part) as of a date in such year specified by the Secretary. Such data shall be presented—

“(A) by Congressional district and State; and

“(B) in a manner that provides for such data based on—

“(i) fee-for-service enrollment (as defined in paragraph (2));

“(ii) enrollment under part C (including separate for aggregate enrollment in MA-PD plans and aggregate enrollment in MA plans that are not MA-PD plans); and

“(iii) enrollment under part D.

“(2) FEE-FOR-SERVICE ENROLLMENT DEFINED.—For purpose of paragraph (1)(B)(i), the term ‘fee-for-service enrollment’ means aggregate enrollment (including receipt of benefits other than through enrollment) under—

“(A) part A only;

“(B) part B only; and

“(C) both part A and part B.”

SEC. 303. UPDATING THE WELCOME TO MEDICARE PACKAGE.

(a) IN GENERAL.—Not later than 12 months after the last day of the period for the request of information described in subsection (b), the Secretary of Health and Human Services shall, taking into consideration information collected pursuant to subsection (b), update the information included in the Welcome to Medicare package to include information, presented in a clear and simple manner, about options for receiving benefits under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including through the original Medicare fee-for-service program under parts A and B of such title (42 U.S.C. 1395c et seq., 42 U.S.C. 1395j et seq.), Medicare Advantage plans under part C of such title (42 U.S.C. 1395w-21 et seq.), and prescription drug plans under part D of such title (42 U.S.C. 1395w-101 et seq.). The Secretary shall make subsequent updates to the information included in the Welcome to Medicare package as appropriate.

(b) REQUEST FOR INFORMATION.—Not later than six months after the date of the enact-

ment of this Act, the Secretary of Health and Human Services shall request information, including recommendations, from stakeholders (including patient advocates, issuers, and employers) on information included in the Welcome to Medicare package, including pertinent data and information regarding enrollment and coverage for Medicare eligible individuals.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Ohio (Mr. TIBERI) and the gentleman from Washington (Mr. MCDERMOTT) each will control 20 minutes.

The Chair recognizes the gentleman from Ohio.

GENERAL LEAVE

Mr. TIBERI. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 5273.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Ohio?

There was no objection.

Mr. TIBERI. Mr. Speaker, I yield myself such time as I may consume.

Today I rise in support of H.R. 5273, the Helping Hospitals Improve Patient Care Act, or “HIP-C” Act. This bill truly represents a bipartisan effort, and I want to thank the distinguished gentleman from Washington State (Mr. MCDERMOTT) for working with me on this bill. The bill also fully represents what the Speaker has often called true regular order.

Prior to introducing H.R. 5273, the Ways and Means Committee held three hearings on topics included in the bill during the 114th Congress, and the committee recently marked up the bill in a unanimous way.

H.R. 5273 strikes the right balance of preserving site-neutral payment policy, which I support, and providing essential relief for hospitals that were caught up in this policy change from last year’s budget deal. Specifically, this bill helps many hospitals around the country and in my State of Ohio, including a facility by OhioHealth and Nationwide Children’s Hospital that was started a year ago, last summer, and will benefit from full outpatient payments under the bill, as they had planned to when they dug the hole for their facility.

Further, the James Cancer Hospital, part of my alma mater at Ohio State University, will have their cancer designation protected under the bill, along with other designated cancer centers.

The bill also touches on three very important themes in the Medicare program: One, giving providers regulatory relief; two, ensuring access in rural areas; and three, protecting Medicare beneficiaries’ access to that important service that people like my mom and dad count on.

Under the topic of regulatory relief, we have included three Ways and Means member priorities:

Representative DIANE BLACK’s bill that provides physicians who primarily practice medicine in ambulatory sur-

gical centers relief in the electronic health records program; Representative VERN BUCHANAN’s bill, ensuring full access to Medicare advantage plans; and finally, Representative MIKE KELLY’s bill requiring fair and transparent reporting by congressional district on the enrollment of beneficiaries in both the traditional fee-for-service Medicare and Medicare Advantage programs. All of these priorities have previously passed the House during the 114th Session.

Under the topic of access in rural areas, the bill allows for continuation and expansion of participation in the Rural Community Hospital Demonstration Program. Championed by my colleagues, Senator GRASSLEY in the Senate and Chairman DON YOUNG in the House, this policy is a continuation from the Medicare Modernization Act of 2003.

Under the topic of beneficiary access in Medicare, the bill requires the Secretary to revise the pre-Medicare eligibility notification, adding greater transparency for beneficiaries, which was led by my colleagues, Dr. MCDERMOTT and Representative PAT MEEHAN.

Finally, the bill includes two important Member priorities that advance important Medicare hospital issues. The first requires the Secretary to ensure there is proper adjustment for socioeconomic factors. The gentleman from Ohio (Mr. RENACCI) has championed this issue for some time. Representative JIM RENACCI’s policy ensures that the hospital readmissions program provides an apples-to-apples comparison based on the specific patient population a hospital treats.

The second priority, led by our Speaker, PAUL RYAN, is the establishment of a crosswalk of hospital codes. Back when Speaker RYAN was the chairman of the Ways and Means Committee, he actively pursued Medicare hospital issues. His crosswalk is an important building block of a future system that promises to streamline the operation of hospital services.

I encourage my colleagues to pass this legislation, send it to the Senate, and let’s get this to the President’s desk.

Mr. Speaker, I reserve the balance of my time.

Mr. MCDERMOTT. Mr. Speaker, I yield myself such time as I may consume.

I rise today in support of the Helping Hospitals Improve Patient Care Act. This bill makes important changes that will help hospitals continue to provide high-quality care to patients as they implement the recent payment reforms. This is bipartisan legislation unique in itself that I am happy to have introduced with the gentleman from Ohio (Mr. TIBERI).

I thank the chairman for his willingness to collaborate on this bill. I also thank the staff of the Ways and Means Committee for their hard work in helping us come to an agreement on language that Members of both parties

can fully support. This final bill isn't perfect, but it is truly a bipartisan product that reflects the spirit of compromise.

Whenever we head back to our districts, we all hear from our hospitals about the effects that our policies are having back home. Although we made a smart change to hospital payments when we passed the Bipartisan Budget Act last year, we are beginning to recognize the unintended consequences of the legislation. We did not really expect everything that is happening.

Many hospitals that were in the process of constructing outpatient departments will be hit with unexpected payment cuts due to the BBA. In addition, many cancer hospitals would be harmed by the new payment rules. This bill fixes these problems in a narrowly tailored way that doesn't undermine the goals of the BBA.

Moving forward, hospitals will no longer be encouraged to consolidate by buying up physician practices for the purpose of billing Medicare at an inflated rate. This is a good policy that is consistent with the recommendations of a GAO report that was released last year. But facilities that were under development when we passed the BBA, as well as cancer hospitals, will be protected from these changes. This isn't a giveaway to hospitals. The industry will pay the full cost.

In addition, this bill makes refinements to the readmissions reduction program. To ensure that hospitals that serve a large number of low-income patients are not unfairly penalized, the bill will require CMS to make apples-to-apples comparisons between similar facilities. As we await additional data that will soon be available thanks to the IMPACT Act, this will ensure that the hospitals are not hit with undeserved penalties due to a flawed methodology.

Finally, I am happy that we are also able to come to an agreement on a bipartisan improvement to the beneficiary enrollment process. Each year, thousands of people enroll in Medicare; and thanks to this bill, seniors will have more information about their benefit options when they become eligible for Medicare. Providing complete and easy-to-understand information is critical. The decisions that beneficiaries make when they enroll in Medicare have serious, long-term implications, including a potential lifetime penalty if they fail to sign up for part B. This bill will also help beneficiaries make informed decisions by improving the Welcome to Medicare package.

I, again, thank my colleagues on both sides of the aisle for working together on this bill. I am pleased we were able to craft a bipartisan compromise, and I look forward to continuing to work together on these and other important issues in the weeks ahead.

I reserve the balance of my time.

Mr. TIBERI. Mr. Speaker, I yield 2 minutes to the gentleman from Alaska (Mr. YOUNG).

(Mr. YOUNG of Alaska asked and was given permission to revise and extend his remarks.)

Mr. YOUNG of Alaska. Mr. Speaker, first I want to thank Chairman TIBERI for his kind work. We will miss the gentleman from Washington (Mr. McDERMOTT), and I thank him for this bipartisan effort because this is a good bill and I strongly support it.

This measure includes many important provisions as you have spoken about. But especially important to Alaska is section 103 language from legislation, H.R. 672, a 5-year extension of the Rural Community Hospital Demonstration Program. This demonstration program has worked well and has come to the aid of seniors in Alaska and healthcare providers across rural America.

Congress created the program to provide increased Medicare reimbursements for hospitals across the Nation that are too large to be considered Critical Access Hospitals, but too small to be supported by traditional low Medicare margins on inpatient services.

□ 1615

This program has helped three hospitals in Alaska: Central Peninsula of Soldotna, the Bartlett Regional Hospital in Juneau, and Mt. Edgecumbe in Sitka. These hospitals serve a wide variety of patients all across those vast areas.

I do believe this is one of the better bipartisan efforts. Go back to the old days when we accomplished things together by talking with one another. It is vital we pass this bipartisan legislation and that the Senate act on it. I would suggest, respectfully, to both my chairman and ranking member, let's talk to the Senate and see if we can't get something done. Four hundred bills over there is wrong. This is one that shouldn't be hung up.

I urge all my colleagues to support the passage of this legislation.

Mr. McDERMOTT. Mr. Speaker, I yield 3 minutes to the gentleman from Illinois (Mr. DANNY K. DAVIS).

Mr. DANNY K. DAVIS of Illinois. Mr. Speaker, I want to commend and congratulate Chairman TIBERI and Ranking Member McDERMOTT for having put together an outstanding piece of legislation. While we applaud it for being bipartisan, I applaud it because it is good. It actually helps to meet needs that exist. It protects hospitals and gives them the opportunity to provide a better level of patient care.

I attended, just last week, the opening of an outpatient center that St. Bernard Hospital in the Englewood community of Chicago had put together. Of course, everybody in the community was there because everybody recognized that inner-city hospitals, disproportionate share hospitals, and medical centers that are

complex need all of the protection that they can get, and we need to have a better understanding of readmission policies and practices and why some are different than others.

These gentlemen have put together a piece of legislation that all of us can be proud of. I strongly support it and thank them for their diligence, for their cooperation, and for their tremendous efforts to do a good bill.

Mr. TIBERI. Mr. Speaker, I yield 3 minutes to the gentleman from northeastern Ohio (Mr. RENACCI), a good friend, an important member of the Committee on Ways and Means, and a leader on the readmission policy dealing with hospitalization.

Mr. RENACCI. Mr. Speaker, I rise in support of H.R. 5273, the Helping Hospitals Improve Patient Care Act of 2016. I want to thank Chairman BRADY and my good friend and colleague, Subcommittee Chairman TIBERI, for all their great work to advance this bill, which addresses many concerns in payments to hospitals, and especially outpatient departments.

I heard from many of the hospitals in northeast Ohio, including MetroHealth, about the impact this payment policy had on their new facility. I am happy we are able to correct these issues for those facilities already under construction.

I also want to thank my colleague from Ohio for including my bill, H.R. 1343—the Establishing Beneficiary Equity in Hospital Readmission Program—in the underlying legislation. The Hospital Readmission Program was created due to concerns that too few resources were being spent on reducing acute care hospital readmissions.

While we do want to make sure hospitals are reducing acute care readmissions, we also want to make sure we are not disproportionately penalizing those who see a large number of our most vulnerable patient populations, especially those teaching hospitals who see a large number of dual-eligible beneficiaries, low-income seniors, or young people with disabilities who are eligible for both Medicare and Medicaid who would have been unintentionally hurt under the current program.

Again, I want to thank the chairman for working with me on this readmission component of this bill, but also all of the other important provisions included in this legislation. These are commonsense, bipartisan reforms to improve our healthcare system.

I urge all Members to support the Helping Hospitals Improve Patient Care Act of 2016.

Mr. McDERMOTT. Mr. Speaker, I reserve the balance of my time.

Mr. TIBERI. Mr. Speaker, I yield myself such time as I may consume to tell you a little bit about some of the hospital networks in my State of Ohio. Mr. RENACCI talked about some in northeastern Ohio that support this legislation. Let me just name a few hospitals in my State of Ohio that are

supportive of this legislation: Aultman, headquartered in his district in Canton; the Cleveland Clinic, Kettering Health Network in the Dayton area; Mercy Canton Sisters of Charity; MetroHealth System in Cleveland; OhioHealth, headquartered in Columbus; Ohio State University Wexner Medical Center in Columbus; the University of Cincinnati Health System in Cincinnati; and University Hospitals, headquartered in Cleveland. As was mentioned, this legislation passed the Committee on Ways and Means in a bipartisan manner.

Mr. Speaker, I reserve the balance of my time.

Mr. McDERMOTT. Mr. Speaker, occasionally we have an extra minute on the floor, and it makes sense to acknowledge some people that we trust and rely upon and we don't ever mention, so I would like to just say thank you to the Democratic staff: Sarah Levin, Melanie Egorin, Daniel Foster, JC Cannon, and Daniel Jackson; on the Republican side: Emily Murry, Lisa Grabert, Nick Uehlecke, Taylor Trott; to the staff at the CMS who helped put this bill together: Ira Burney, Anne Scott, Lisa Yen. And to the staff at legislative counsel: Ed Grossman—Ed has been there for as long as I have been here, so any bill that gets out of here without Ed looking at it is a pretty rare bill—and Jessica Shapiro is his assistant.

The Congressional Budget Office gets in on these deals as well: Tom Bradley, Lori Housman, Kevin McNellis, and Jamease Kowalczyk. I am from Chicago. I should be able to pronounce a Polish name. We appreciate their hard work.

Mr. Speaker, I yield back the balance of my time.

Mr. TIBERI. Mr. Speaker, let me just close by saying thank you to Dr. McDERMOTT. It has been enjoyable to work with his team, led by Amy, and we appreciate the bipartisanship. You mentioned all those names—stole my thunder—Emily and her team, and my staff, Whitney Koch Daffner and Abigail Finn, too, for yeoman's work.

Mr. Speaker, I urge a unanimous vote.

I yield back the balance of my time.

Mr. BRADY of Texas. Mr. Speaker, I rise today in support of H.R. 5273, the Helping Hospitals Improve Patient Care Act of 2016.

First, I'd like to thank Chairman TIBERI and Ranking Member McDERMOTT for their leadership on this important legislation.

At the Ways and Means Committee, we are working to deliver health care solutions that will expand access, increase choices, and improve the quality of care for the American people.

The Helping Hospitals Improve Patient Care Act helps advance all three of those goals. And the bill does so in a fiscally responsible manner that helps strengthen and preserve Medicare for the long-term.

At its core, our bipartisan legislation is about supporting the delivery of high-quality, affordable care to families and seniors throughout the country. It will especially help people who live in low-income and rural communities.

Our bill includes straightforward solutions to help hospitals and health care providers transition to—and preserve—the new site-neutral payment policies. This will give providers the certainty they need to best serve their patients, now and into the future.

This bill is an excellent illustration of what we can accomplish through regular order. It's the product of many innovative solutions, proposed by many members on both sides of the aisle.

The solutions in this bill will make a real difference when it comes to the delivery of high-quality care for the people of our districts.

In fact, the University of Texas' MD Anderson Cancer Center located in Houston has already embraced this bill. MD Anderson officials said, "This ensures our ability to continue providing the highest quality and level of cancer care to patients in the communities we serve."

And MD Anderson is just one of many hospitals and cancer treatment centers throughout the country that we help with H.R. 5273.

This bill is particularly personal for me because it builds from the hospital discussion draft I released as Health Subcommittee Chairman back in November 2014.

In the Helping Hospitals Improve Patient Care Act, we push forward two critical building blocks of that discussion draft.

First, Speaker RYAN's crosswalk bill that better coordinates care between inpatient and outpatient settings.

Second, Congressman JIM RENACCI's readmission policy, which helps hospitals in low-income communities serve their patients.

There are still many policies from our hospital discussion draft that are worthy of debate. We'll continue to work with Members and stakeholders to pursue additional reforms that make our health care system work better for patients and providers in our communities.

I'm grateful to all the members—on and off our committee—who worked hard to craft and advance the Helping Hospitals Improve Patient Care Act.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Ohio (Mr. TIBERI) that the House suspend the rules and pass the bill, H.R. 5273, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

SUPPORTING GOAL OF ENSURING ALL HOLOCAUST VICTIMS LIVE WITH DIGNITY, COMFORT, AND SECURITY

Ms. ROS-LEHTINEN. Mr. Speaker, I move to suspend the rules and agree to the concurrent resolution (H. Con. Res 129), expressing support for the goal of ensuring that all Holocaust victims live with dignity, comfort, and security in their remaining years, and urging the Federal Republic of Germany to reaffirm its commitment to this goal through a financial commitment to comprehensively address the unique health and welfare needs of vulnerable Holocaust victims, including home care and other medically prescribed needs, as amended.

The Clerk read the title of the concurrent resolution.

The text of the concurrent resolution is as follows:

H. CON. RES. 129

Whereas the annihilation of 6,000,000 Jews during the Holocaust and the murder of millions of others by the Nazi German state constitutes one of the most tragic and heinous crimes in human history;

Whereas hundreds of thousands of Jews survived persecution by the Nazi regime despite being imprisoned, subjected to slave labor, moved into ghettos, forced to live in hiding or under false identity, forced to live under curfew, or required to wear the "yellow star";

Whereas in fear of the oncoming Nazi Einsatzgruppen ("Nazi Killing Squads") and the likelihood of extermination, hundreds of thousands of Jewish Nazi victims fled for their lives;

Whereas whatever type of persecution suffered by Jews during the Holocaust, the common thread that binds these Holocaust victims is that they were targeted for extermination and that they lived with a constant fear for their lives and the lives of their loved ones;

Whereas Holocaust victims immigrated to the United States from Europe, the Middle East and North Africa, and the former Soviet Union from 1933 to today;

Whereas it is estimated that there are at least 100,000 Holocaust victims living in the United States and approximately 500,000 living around the world today, including child survivors;

Whereas tens of thousands of Holocaust victims are in their 80s or 90s or are more than 100 years in age, and the number of Holocaust victims is diminishing;

Whereas at least 50 percent of Holocaust victims alive today will pass away within the next decade, and those alive are becoming frailer and have increasing health and welfare needs;

Whereas Holocaust victims throughout the world continue to suffer from permanent physical and psychological injuries and disabilities and live with the emotional scars of this systematic genocide against the Jewish people;

Whereas many of the emotional and psychological scars of Holocaust victims are exacerbated in their old age, the past haunts and overwhelms many aspects of their lives when their health fails them;

Whereas Holocaust victims suffer particular trauma when their emotional and physical circumstances force them to leave the security of their own home and enter institutional or other group living residential facilities;

Whereas tens of thousands of Holocaust victims live in poverty, cannot afford and do not receive sufficient medical care, home care, mental health care, medicine, food, transportation, and other vital life-sustaining services that allow them to live their final years with comfort and dignity;

Whereas Holocaust victims often lack family support networks and require social worker-supported case management in order to manage their daily lives and access government funded services;

Whereas in response to a letter sent by Members of Congress to Germany's Minister of Finance in December 2015 regarding increased funding for Holocaust victims, German officials acknowledged that "recent experience has shown that the care financed by the German Government to date is insufficient" and that "it is imperative to expand these assistance measures quickly given the advanced age of many of the affected persons";