

114TH CONGRESS
2D SESSION

H. R. 5273

IN THE SENATE OF THE UNITED STATES

JUNE 8, 2016

Received; read twice and referred to the Committee on Finance

AN ACT

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.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

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

4 (b) TABLE OF CONTENTS.—The table of contents for
 5 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.

1 **TITLE I—PROVISIONS RELATING**
 2 **TO MEDICARE PART A**

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

6 Section 1886 of the Social Security Act (42 U.S.C.
 7 1395ww) is amended by adding at the end the following
 8 new subsection:

9 “(t) RELATING SIMILAR INPATIENT AND OUT-
 10 PATIENT HOSPITAL SERVICES.—

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

13 “(A) IN GENERAL.—Not later than Janu-
 14 ary 1, 2018, the Secretary shall develop
 15 HCPCS versions for MS-DRGs that is similar
 16 to the ICD-10-PCS for such MS-DRGs such
 17 that, to the extent possible, the MS-DRG as-
 18 signment shall be similar for a claim coded with
 19 the HCPCS version as an identical claim coded
 20 with a ICD-10-PCS code.

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

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

3 “(i) IN GENERAL.—The Secretary
4 shall develop a HCPCS MS-DRG defini-
5 tions manual and software that is similar
6 to the definitions manual and software for
7 ICD-10-PCS codes for such MS-DRGs.
8 The Secretary shall post the HCPCS MS-
9 DRG definitions manual and software on
10 the Internet website of the Centers for
11 Medicare & Medicaid Services. The
12 HCPCS MS-DRG definitions manual and
13 software shall be in the public domain and
14 available for use and redistribution without
15 charge.

16 “(ii) USE OF PREVIOUS ANALYSIS
17 DONE BY MEDPAC.—In developing the
18 HCPCS MS-DRG definitions manual and
19 software under clause (i), the Secretary
20 shall consult with the Medicare Payment
21 Advisory Commission and shall consider
22 the analysis done by such Commission in
23 translating outpatient surgical claims into
24 inpatient surgical MS-DRGs in preparing
25 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 PRO-
GRAM.**

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

4 (2) by adding at the end the following new sub-
5 paragraph:

6 “(D) TRANSITIONAL ADJUSTMENT FOR
7 DUAL ELIGIBLES.—

8 “(i) IN GENERAL.—In determining a
9 hospital’s adjustment factor under this
10 paragraph for purposes of making pay-
11 ments for discharges occurring during and
12 after fiscal year 2019, and before the ap-
13 plication of clause (i) of subparagraph (E),
14 the Secretary shall assign hospitals to
15 groups (as defined by the Secretary under
16 clause (ii)) and apply the applicable provi-
17 sions of this subsection using a method-
18 ology in a manner that allows for separate
19 comparison of hospitals within each such
20 group, as determined by the Secretary.

21 “(ii) DEFINING GROUPS.—For pur-
22 poses of this subparagraph, the Secretary
23 shall define groups of hospitals based on
24 their overall proportion, of the inpatients
25 who are entitled to, or enrolled for, bene-

fits 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.”.

1 (b) SUBSEQUENT ADJUSTMENTS BASED ON IM-
 2 PACT REPORTS.—Section 1886(q)(3) of the Social Secu-
 3 rity Act (42 U.S.C. 1395ww(q)(3)), as amended by sub-
 4 section (a), is further amended by adding at the end the
 5 following new subparagraph:

6 “(E) CHANGES IN RISK ADJUSTMENT.—

7 “(i) CONSIDERATION OF REC-
 8 OMMENDATIONS IN IMPACT REPORTS.—

9 The Secretary may take into account the
 10 studies conducted and the recommenda-
 11 tions made by the Secretary under section
 12 2(d)(1) of the IMPACT Act of 2014 (Pub-
 13 lic Law 113–185; 42 U.S.C. 1395lll note)
 14 with respect to the application under this
 15 subsection of risk adjustment methodolo-
 16 gies. Nothing in this clause shall be con-
 17 strued as precluding consideration of the
 18 use of groupings of hospitals.”.

19 (c) MEDPAC STUDY ON READMISSIONS PROGRAM.—

20 The Medicare Payment Advisory Commission shall con-
 21 duct a study to review overall hospital readmissions de-
 22 scribed in section 1886(q)(5)(E) of the Social Security Act
 23 (42 U.S.C. 1395ww(q)(5)(E)) and whether such readmis-
 24 sions are related to any changes in outpatient and emer-
 25 gency services furnished. The Commission shall submit to

1 Congress a report on such study in its report to Congress
2 in June 2017.

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

8 “(ii) CONSIDERATION OF EXCLUSION
9 OF PATIENT CASES BASED ON V OR OTHER
10 APPROPRIATE CODES.—In promulgating
11 regulations to carry out this subsection
12 with respect to discharges occurring after
13 fiscal year 2018, the Secretary may con-
14 sider the use of V or other ICD-related
15 codes for removal of a readmission. The
16 Secretary may consider modifying meas-
17 ures under this subsection to incorporate V
18 or other ICD-related codes at the same
19 time as other changes are being made
20 under this subparagraph.”.

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

1 “(iii) REMOVAL OF CERTAIN RE-
2 ADMISSIONS.—In promulgating regulations
3 to carry out this subsection, with respect
4 to discharges occurring after fiscal year
5 2018, the Secretary may consider removal
6 as a readmission of an admission that is
7 classified within one or more of the fol-
8 lowing: transplants, end-stage renal dis-
9 ease, burns, trauma, psychosis, or sub-
10 stance abuse. The Secretary may consider
11 modifying measures under this subsection
12 to remove readmissions at the same time
13 as other changes are being made under
14 this subparagraph.”.

15 **SEC. 103. FIVE-YEAR EXTENSION OF THE RURAL COMMU-**
16 **NITY HOSPITAL DEMONSTRATION PROGRAM.**

17 (a) EXTENSION.—Section 410A of the Medicare Pre-
18 scription Drug, Improvement, and Modernization Act of
19 2003 (Public Law 108–173; 42 U.S.C. 1395ww note), as
20 amended by sections 3123 and 10313 of the Patient Pro-
21 tection and Affordable Care Act (Public Law 111–148),
22 is amended—

23 (1) in subsection (a)(5), by striking “5-year ex-
24 tension period” and inserting “10-year extension pe-
25 riod”; and

1 (2) in subsection (g)—

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

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

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

10 (D) in paragraph (4)(B)—

11 (i) in the matter preceding clause (i),
12 by inserting “each 5-year period in” after
13 “hospital during”; and

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

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

19 “(5) OTHER HOSPITALS IN DEMONSTRATION
20 PROGRAM.—During the second 5 years of the 10-
21 year extension period, the Secretary shall apply the
22 provisions of paragraph (4) to rural community hos-
23 pitals that are not described in paragraph (4) but
24 are participating in the demonstration program
25 under this section as of December 30, 2014, in a

1 similar manner as such provisions apply to rural
2 community hospitals described in paragraph (4).

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

5 “(A) IN GENERAL.—The Secretary shall,
6 notwithstanding subsection (a)(2) or paragraph
7 (2) of this subsection, not later than 120 days
8 after the date of the enactment of this para-
9 graph, issue a solicitation for applications to se-
10 lect up to the maximum number of additional
11 rural community hospitals located in any State
12 to participate in the demonstration program
13 under this section for the second 5 years of the
14 10-year extension period without exceeding the
15 limitation under paragraph (3) of this sub-
16 section.

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

22 “(i) shall give priority to rural com-
23 munity hospitals located in one of the 20
24 States with the lowest population densities
25 (as determined by the Secretary using the

1 2015 Statistical Abstract of the United
2 States); and

3 “(ii) may consider—

4 “(I) closures of hospitals located
5 in rural areas in the State in which
6 the rural community hospital is lo-
7 cated during the 5-year period imme-
8 diately preceding the date of the en-
9 actment of this paragraph; and

10 “(II) the population density of
11 the State in which the rural commu-
12 nity hospital is located.”.

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

15 (1) by striking “Not later than 6 months after
16 the completion of the demonstration program under
17 this section” and inserting “Not later than August
18 1, 2018”; and

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

21 **SEC. 104. REGULATORY RELIEF FOR LTCHS.**

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

24 (1) IN GENERAL.—Section 114(d)(7) of the
25 Medicare, Medicaid, and SCHIP Extension Act of

1 2007 (42 U.S.C. 1395ww note), as amended by sec-
2 tions 3106(b) and 10312(b) of Public Law 111–148,
3 section 1206(b)(2) of the Pathway for SGR Reform
4 Act of 2013 (division B of Public Law 113–67), and
5 section 112 of the Protecting Access to Medicare Act
6 of 2014, is amended by striking “The moratorium
7 under paragraph (1)(A)” and inserting “Any mora-
8 torium under paragraph (1)”.

9 (2) EFFECTIVE DATE.—The amendment made
10 by paragraph (1) shall take effect as if included in
11 the enactment of section 112 of the Protecting Ac-
12 cess to Medicare Act of 2014.

13 (b) MODIFICATION TO MEDICARE LONG-TERM CARE
14 HOSPITAL HIGH COST OUTLIER PAYMENTS.—Section
15 1886(m) of the Social Security Act (42 U.S.C.
16 1395ww(m)) is amended by adding at the end the fol-
17 lowing new paragraph:

18 “(7) TREATMENT OF HIGH COST OUTLIER PAY-
19 MENTS.—

20 “(A) ADJUSTMENT TO THE STANDARD
21 FEDERAL PAYMENT RATE FOR ESTIMATED
22 HIGH COST OUTLIER PAYMENTS.—Under the
23 system described in paragraph (1), for fiscal
24 years beginning on or after October 1, 2017,
25 the Secretary shall reduce the standard Federal

1 payment rate as if the estimated aggregate
2 amount of high cost outlier payments for stand-
3 ard Federal payment rate discharges for each
4 such fiscal year would be equal to 8 percent of
5 estimated aggregate payments for standard
6 Federal payment rate discharges for each such
7 fiscal year.

8 “(B) LIMITATION ON HIGH COST OUTLIER
9 PAYMENT AMOUNTS.—Notwithstanding sub-
10 paragraph (A), the Secretary shall set the fixed
11 loss amount for high cost outlier payments such
12 that the estimated aggregate amount of high
13 cost outlier payments made for standard Fed-
14 eral payment rate discharges for fiscal years be-
15 ginning on or after October 1, 2017, shall be
16 equal to 99.6875 percent of 8 percent of esti-
17 mated aggregate payments for standard Fed-
18 eral payment rate discharges for each such fis-
19 cal year.

20 “(C) WAIVER OF BUDGET NEUTRALITY.—
21 Any reduction in payments resulting from the
22 application of subparagraph (B) shall not be
23 taken into account in applying any budget neu-
24 trality provision under such system.

1 “(D) NO EFFECT ON SITE NEUTRAL HIGH
2 COST OUTLIER PAYMENT RATE.—This para-
3 graph shall not apply with respect to the com-
4 putation of the applicable site neutral payment
5 rate under paragraph (6).”.

6 **SEC. 105. SAVINGS FROM IPPS MACRA PAY-FOR THROUGH**
7 **NOT APPLYING DOCUMENTATION AND COD-**
8 **ING ADJUSTMENTS.**

9 Section 7(b)(1)(B)(iii) of the TMA, Abstinence Edu-
10 cation, and QI Programs Extension Act of 2007 (Public
11 Law 110–90), as amended by section 631(b) of the Amer-
12 ican Taxpayer Relief Act of 2012 (Public Law 122–240)
13 and section 414(1)(B)(iii) of the Medicare Access and
14 CHIP Reauthorization Act of 2015 (Public Law 114–10),
15 is amended by striking “an increase of 0.5 percentage
16 points for discharges occurring during each of fiscal years
17 2018 through 2023” and inserting “an increase of 0.4590
18 percentage points for discharges occurring during fiscal
19 year 2018 and 0.5 percentage points for discharges occur-
20 ring during each of fiscal years 2019 through 2023”.

1 **TITLE II—PROVISIONS RELAT-**
 2 **ING TO MEDICARE PART B**

3 **SEC. 201. CONTINUING MEDICARE PAYMENT UNDER HOPD**
 4 **PROSPECTIVE PAYMENT SYSTEM FOR SERV-**
 5 **ICES FURNISHED BY MID-BUILD OFF-CAMPUS**
 6 **OUTPATIENT DEPARTMENTS OF PROVIDERS.**

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

9 (1) in subparagraph (B)—

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

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

15 “(iii) DEEMED TREATMENT FOR
 16 2017.—For purposes of applying clause (ii)
 17 with respect to applicable items and serv-
 18 ices furnished during 2017, a department
 19 of a provider (as so defined) not described
 20 in such clause is deemed to be billing
 21 under this subsection with respect to cov-
 22 ered OPD services furnished prior to No-
 23 vember 2, 2015, if the Secretary received
 24 from the provider prior to December 2,
 25 2015, an attestation (pursuant to section

1 413.65(b)(3) of title 42 of the Code of
2 Federal Regulations) that such department
3 was a department of a provider (as so de-
4 fined).

5 “(iv) ALTERNATIVE EXCEPTION BE-
6 GINNING WITH 2018.—For purposes of
7 paragraph (1)(B)(v) and this paragraph
8 with respect to applicable items and serv-
9 ices furnished during 2018 or a subsequent
10 year, the term ‘off-campus outpatient de-
11 partment of a provider’ also shall not in-
12 clude a department of a provider (as so de-
13 fined) that is not described in clause (ii)
14 if—

15 “(I) the Secretary receives from
16 the provider an attestation (pursuant
17 to such section 413.65(b)(3)) not later
18 than December 31, 2016 (or, if later,
19 60 days after the date of the enact-
20 ment of this clause), that such depart-
21 ment met the requirements of a de-
22 partment of a provider specified in
23 section 413.65 of title 42 of the Code
24 of Federal Regulations;

1 “(II) the provider includes such
2 department as part of the provider on
3 its enrollment form in accordance with
4 the enrollment process under section
5 1866(j); and

6 “(III) the department met the
7 mid-build requirement of clause (v)
8 and the Secretary receives, not later
9 than 60 days after the date of the en-
10 actment of this clause, from the chief
11 executive officer or chief operating of-
12 ficer of the provider a written certifi-
13 cation that the department met such
14 requirement.

15 “(v) MID-BUILD REQUIREMENT DE-
16 SCRIBED.—The mid-build requirement of
17 this clause is, with respect to a department
18 of a provider, that before November 2,
19 2015, the provider had a binding written
20 agreement with an outside unrelated party
21 for the actual construction of such depart-
22 ment.

23 “(vii) AUDIT.—Not later than Decem-
24 ber 31, 2018, the Secretary shall audit the
25 compliance with requirements of clause (iv)

1 with respect to each department of a pro-
2 vider to which such clause applies. If the
3 Secretary finds as a result of an audit
4 under this clause that the applicable re-
5 quirements were not met with respect to
6 such department, the department shall not
7 be excluded from the term ‘off-campus out-
8 patient department of a provider’ under
9 such clause.

10 “(viii) IMPLEMENTATION.—For pur-
11 poses of implementing clauses (iii) through
12 (vii):

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

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

20 “(III) For purposes of carrying
21 out this subparagraph with respect to
22 clauses (iii) and (iv) (and clause (vii)
23 insofar as it relates to clause (iv)),
24 \$10,000,000 shall be available from
25 the Federal Supplementary Medical

1 Insurance Trust Fund under section
2 1841, to remain available until De-
3 cember 31, 2018.”; and

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

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

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

12 **SEC. 202. TREATMENT OF CANCER HOSPITALS IN OFF-CAM-**
13 **PUS OUTPATIENT DEPARTMENT OF A PRO-**
14 **VIDER POLICY.**

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

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

20 “(vi) EXCLUSION FOR CERTAIN CAN-
21 CER HOSPITALS.—For purposes of para-
22 graph (1)(B)(v) and this paragraph with
23 respect to applicable items and services
24 furnished during 2017 or a subsequent
25 year, the term ‘off-campus outpatient de-

1 partment of a provider’ also shall not in-
2 clude a department of a provider (as so de-
3 fined) that is not described in clause (ii) if
4 the provider is a hospital described in sec-
5 tion 1886(d)(1)(B)(v) and—

6 “(I) in the case of a department
7 that met the requirements of section
8 413.65 of title 42 of the Code of Fed-
9 eral Regulations after November 1,
10 2015, and before the date of the en-
11 actment of this clause, the Secretary
12 receives from the provider an attesta-
13 tion that such department met such
14 requirements not later than 60 days
15 after such date of enactment; or

16 “(II) in the case of a department
17 that meets such requirements after
18 such date of enactment, the Secretary
19 receives from the provider an attesta-
20 tion that such department meets such
21 requirements not later than 60 days
22 after the date such requirements are
23 first met with respect to such depart-
24 ment.”;

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

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

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

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

21 (2) by adding at the end the following new sub-
 22 paragraph:

23 “(C) TARGET PCR ADJUSTMENT.—In ap-
 24 plying section 419.43(i) of title 42 of the Code
 25 of Federal Regulations to implement the appro-

1 priate adjustment under this paragraph for
2 services furnished on or after January 1, 2018,
3 the Secretary shall use a target PCR that is 1.0
4 percentage points less than the target PCR that
5 would otherwise apply. In addition to the per-
6 centage point reduction under the previous sen-
7 tence, the Secretary may consider making an
8 additional percentage point reduction to such
9 target PCR that takes into account payment
10 rates for applicable items and services described
11 in paragraph (21)(C) other than for services
12 furnished by hospitals described in section
13 1886(d)(1)(B)(v). In making any budget neu-
14 trality adjustments under this subsection for
15 2018 or a subsequent year, the Secretary shall
16 not take into account the reduced expenditures
17 that result from the application of this subpara-
18 graph.”.

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

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

4 (a) IN GENERAL.—Section 1848(a)(7)(D) of the So-
5 cial Security Act (42 U.S.C. 1395w–4(a)(7)(D)) is amend-
6 ed—

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

12 “(i) HOSPITAL-BASED.—No pay-
13 ment”; and

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

16 “(ii) AMBULATORY SURGICAL CEN-
17 TER-BASED.—Subject to clause (iv), no
18 payment adjustment may be made under
19 subparagraph (A) for 2017 and 2018 in
20 the case of an eligible professional with re-
21 spect to whom substantially all of the cov-
22 ered professional services furnished by
23 such professional are furnished in an am-
24 bulatory surgical center.

25 “(iii) DETERMINATION.—The deter-
26 mination of whether an eligible profes-

1 sional is an eligible professional described
2 in clause (ii) may be made on the basis
3 of—

4 “(I) the site of service (as de-
5 fined by the Secretary); or

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

8 Determinations made under subclauses (I)
9 and (II) shall be made without regard to
10 any employment or billing arrangement be-
11 tween the eligible professional and any
12 other supplier or provider of services.

13 “(iv) SUNSET.—Clause (ii) shall no
14 longer apply as of the first year that be-
15 gins more than 3 years after the date on
16 which the Secretary determines, through
17 notice and comment rulemaking, that cer-
18 tified EHR technology applicable to the
19 ambulatory surgical center setting is avail-
20 able.”.

21 (b) CONTINUED APPLICATION OF CERTAIN PROVI-
22 SIONS UNDER MIPS.—Section 1848(o)(2)(D) of the So-
23 cial Security Act (42 U.S.C. 1395w-4(o)(2)(D)) is amend-
24 ed by adding at the end the following new sentence: “The
25 provisions of subparagraphs (B) and (D) of subsection

1 (a)(7), including the application of clause (iv) of such sub-
 2 paragraph (D), shall apply to assessments of MIPS eligi-
 3 ble professionals under subsection (q) with respect to the
 4 performance category described in subsection (q)(2)(A)(iv)
 5 in a manner similar to the manner in which such provi-
 6 sions apply with respect to payment adjustments made
 7 under subsection (a)(7)(A).”.

8 **TITLE III—OTHER MEDICARE** 9 **PROVISIONS**

10 **SEC. 301. DELAY IN AUTHORITY TO TERMINATE CON-** 11 **TRACTS FOR MEDICARE ADVANTAGE PLANS** 12 **FAILING TO ACHIEVE MINIMUM QUALITY** 13 **RATINGS.**

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

17 (1) to continue to study and request input on
 18 the effects of socioeconomic status and dual-eligible
 19 populations on the Medicare Advantage STARS rat-
 20 ing system before reforming such system with the
 21 input of stakeholders; and

22 (2) pending the results of such studies and
 23 input, to provide for a temporary delay in authority
 24 of the Centers for Medicare & Medicaid Services
 25 (CMS) to terminate Medicare Advantage plan con-

1 tracts solely on the basis of performance of plans
2 under the STARS rating system.

3 (b) DELAY IN MA CONTRACT TERMINATION AU-
4 THORITY FOR PLANS FAILING TO ACHIEVE MINIMUM
5 QUALITY RATINGS.—Section 1857(h) of the Social Secu-
6 rity Act (42 U.S.C. 1395w–27(h)) is amended by adding
7 at the end the following new paragraph:

8 “(3) DELAY IN CONTRACT TERMINATION AU-
9 THORITY FOR PLANS FAILING TO ACHIEVE MINIMUM
10 QUALITY RATING.—During the period beginning on
11 the date of the enactment of this paragraph and
12 through the end of plan year 2018, the Secretary
13 may not terminate a contract under this section with
14 respect to the offering of an MA plan by a Medicare
15 Advantage organization solely because the MA plan
16 has failed to achieve a minimum quality rating
17 under the 5-star rating system under section
18 1853(o)(4).”.

19 **SEC. 302. REQUIREMENT FOR ENROLLMENT DATA REPORT-**
20 **ING FOR MEDICARE.**

21 Section 1874 of the Social Security Act (42 U.S.C.
22 1395kk) is amended by adding at the end the following
23 new subsection:

24 “(g) REQUIREMENT FOR ENROLLMENT DATA RE-
25 PORTING.—

“(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—

1 “(A) part A only;

2 “(B) part B only; and

3 “(C) both part A and part B.”.

4 **SEC. 303. UPDATING THE WELCOME TO MEDICARE PACK-**
5 **AGE.**

6 (a) IN GENERAL.—Not later than 12 months after
7 the last day of the period for the request of information
8 described in subsection (b), the Secretary of Health and
9 Human Services shall, taking into consideration informa-
10 tion collected pursuant to subsection (b), update the infor-
11 mation included in the Welcome to Medicare package to
12 include information, presented in a clear and simple man-
13 ner, about options for receiving benefits under the Medi-
14 care program under title XVIII of the Social Security Act
15 (42 U.S.C. 1395 et seq.), including through the original
16 medicare fee-for-service program under parts A and B of
17 such title (42 U.S.C. 1395c et seq., 42 U.S.C. 1395j et
18 seq.), Medicare Advantage plans under part C of such title
19 (42 U.S.C. 1395w–21 et seq.), and prescription drug plans
20 under part D of such title (42 U.S.C. 1395w–101 et
21 seq.)). The Secretary shall make subsequent updates to
22 the information included in the Welcome to Medicare
23 package as appropriate.

24 (b) REQUEST FOR INFORMATION.—Not later than 6
25 months after the date of the enactment of this Act, the

1 Secretary of Health and Human Services shall request in-
2 formation, including recommendations, from stakeholders
3 (including patient advocates, issuers, and employers) on
4 information included in the Welcome to Medicare package,
5 including pertinent data and information regarding enroll-
6 ment and coverage for Medicare eligible individuals.

Passed the House of Representatives June 7, 2016.

Attest:

KAREN L. HAAS,

Clerk.