Suspend the Rules and Pass the Bill, H.R. 5273, with An Amendment

(The amendment strikes all after the enacting clause and inserts a new text)

114TH CONGRESS
2D SESSION

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.

IN THE HOUSE OF REPRESENTATIVES

MAY 18, 2016

Mr. TIBERI (for himself and Mr. MCDERMOTT) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

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.

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, 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.''.

(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. 1395lll 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(1)(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 (ii) 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 de-

partment 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 appro-

priate 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 profes-

sional 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 subclauses (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 con-

tracts 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 enactment 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.