Suspend the Rules and Pass the Bill, H.R. 5210, with an Amendment

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

114TH CONGRESS
2D SESSION

H. R. 5210

To improve access to durable medical equipment for Medicare beneficiaries under the Medicare program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 12, 2016

Mr. TOM PRICE of Georgia (for himself, Mr. LOEBSACK, Mrs. MCMORRIS RODGERS, Mr. WELCH, Mr. COLLINS of New York, Mr. CRAMER, Mr. FLORES, Mr. HARPER, Mr. LUETKEMEYER, Mr. ROE of Tennessee, Mr. THOMPSON of Pennsylvania, Mr. TIPTON, Ms. DUCKWORTH, Mr. DUNCAN of Tennessee, Mr. JOYCE, Mr. ZINKE, Mr. KELLY of Pennsylvania, Mr. BLUM, Mrs. ELLMERS of North Carolina, Mr. GOHMERT, Mr. LONG, Mr. HARRIS, Mr. RENACCI, Mr. TIBERI, Mr. PETERSON, Mr. MURPHY of Pennsylvania, Mrs. NOEM, Mr. GIBBS, Mr. AUSTIN SCOTT of Georgia, Mr. GUTHRIE, Mr. DESJARLAIS, Ms. JENKINS of Kansas, Mr. DAVID SCOTT of Georgia, Mrs. BLACK, Mrs. BLACKBURN, Mr. SMITH of Missouri, Mr. MULLIN, Mr. POMPEO, Mr. BYRNE, Mrs. WAGNER, and Mr. BOUSTANY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, 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

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A BILL

To improve access to durable medical equipment for Medicare beneficiaries under the Medicare program, 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.

This Act may be cited as the ''Patient Access to Durable Medical Equipment Act of 2016'' or the ''PADME Act''.

SEC. 2. INCREASING OVERSIGHT OF TERMINATION OF MEDICAID PROVIDERS.

(a) INCREASED OVERSIGHT AND REPORTING.—

(1) STATE REPORTING REQUIREMENTS.—Section 1902(kk) of the Social Security Act (42 U.S.C. 1396a(kk)) is amended—

(A) by redesignating paragraph (8) as paragraph (9); and

(B) by inserting after paragraph (7) the following new paragraph:

''(8) PROVIDER TERMINATIONS.—

''(A) IN GENERAL.—Beginning on July 1, 2018, in the case of a notification under subsection (a)(41) with respect to a termination for a reason specified in section 455.101 of title 42, Code of Federal Regulations (as in effect on November 1, 2015) or for any other reason specified by the Secretary, of the participation of a provider of services or any other person

under the State plan (or under a waiver of the plan), the State, not later than 21 business days after the effective date of such termination, submits to the Secretary with respect to any such provider or person, as appropriate—

''(i) the name of such provider or person;

''(ii) the provider type of such provider or person;

''(iii) the specialty of such provider's or person's practice;

''(iv) the date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of such provider or person;

''(v) the reason for the termination;

''(vi) a copy of the notice of termination sent to the provider or person;

''(vii) the date on which such termination is effective, as specified in the notice; and

''(viii) any other information required by the Secretary.

''(B) EFFECTIVE DATE DEFINED.—For purposes of this paragraph, the term 'effective date' means, with respect to a termination described in subparagraph (A), the later of—

''(i) the date on which such termination is effective, as specified in the notice of such termination; or

''(ii) the date on which all appeal rights applicable to such termination have been exhausted or the timeline for any such appeal has expired.''.

(2) CONTRACT REQUIREMENT FOR MANAGED CARE ENTITIES.—Section 1932(d) of the Social Security Act (42 U.S.C. 1396u–2(d)) is amended by adding at the end the following new paragraph:

''(5) CONTRACT REQUIREMENT FOR MANAGED CARE ENTITIES.—With respect to any contract with a managed care entity under section 1903(m) or 1905(t)(3) (as applicable), no later than July 1, 2018, such contract shall include a provision that providers of services or persons terminated (as described in section 1902(kk)(8)) from participation under this title, title XVIII, or title XXI be terminated from participating under this title as a provider in any network of such entity that serves indi-

viduals eligible to receive medical assistance under this title.''.

(3) TERMINATION NOTIFICATION DATABASE.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

''(ll) TERMINATION NOTIFICATION DATABASE.—In the case of a provider of services or any other person whose participation under this title, title XVIII, or title XXI is terminated (as described in subsection (kk)(8)), the Secretary shall, not later than 21 business days after the date on which the Secretary terminates such participation under title XVIII or is notified of such termination under subsection (a)(41) (as applicable), review such termination and, if the Secretary determines appropriate, include such termination in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 1395cc note; Public Law 111–148).''.

(4) NO FEDERAL FUNDS FOR ITEMS AND SERVICES FURNISHED BY TERMINATED PROVIDERS.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(A) in subsection (i)(2)—

(i) in subparagraph (A), by striking the comma at the end and inserting a semicolon;

(ii) in subparagraph (B), by striking ''or'' at the end; and

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

''(D) beginning not later than July 1, 2018, under the plan by any provider of services or person whose participation in the State plan is terminated (as described in section 1902(kk)(8)) after the date that is 60 days after the date on which such termination is included in the database or other system under section 1902(ll); or''; and

(B) in subsection (m), by inserting after paragraph (2) the following new paragraph:

''(3) No payment shall be made under this title to a State with respect to expenditures incurred by the State for payment for services provided by a managed care entity (as defined under section 1932(a)(1)) under the State plan under this title (or under a waiver of the plan) unless the State—

''(A) beginning on July 1, 2018, has a contract with such entity that complies with the requirement specified in section 1932(d)(5); and

''(B) beginning on January 1, 2018, complies with the requirement specified in section 1932(d)(6)(A).''.

(5) DEVELOPMENT OF UNIFORM TERMINOLOGY FOR REASONS FOR PROVIDER TERMINATION.—Not later than July 1, 2017, the Secretary of Health and Human Services shall, in consultation with the heads of State agencies administering State Medicaid plans (or waivers of such plans), issue regulations establishing uniform terminology to be used with respect to specifying reasons under subparagraph (A)(v) of paragraph (8) of section 1902(kk) of the Social Security Act (42 U.S.C. 1396a(kk)), as amended by paragraph (1), for the termination (as described in such paragraph) of the participation of certain providers in the Medicaid program under title XIX of such Act or the Children's Health Insurance Program under title XXI of such Act.

(6) CONFORMING AMENDMENT.—Section 1902(a)(41) of the Social Security Act (42 U.S.C. 1396a(a)(41)) is amended by striking ''provide that whenever'' and inserting ''provide, in accordance

with subsection (kk)(8) (as applicable), that whenever''.

(b) INCREASING AVAILABILITY OF MEDICAID PROVIDER INFORMATION.—

(1) FFS PROVIDER ENROLLMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting after paragraph (77) the following new paragraph:

''(78) provide that, not later than January 1, 2017, in the case of a State plan (or a waiver of the plan) that provides medical assistance on a fee-for-service basis, the State shall require each provider furnishing items and services to individuals eligible to receive medical assistance under such plan to enroll with the State agency and provide to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider;''.

(2) MANAGED CARE PROVIDER ENROLLMENT.—Section 1932(d) of the Social Security Act (42 U.S.C. 1396u–2(d)), as amended by subsection (a)(2), is amended by adding at the end the following new paragraph:

''(6) ENROLLMENT OF PARTICIPATING PROVIDERS.—

''(A) IN GENERAL.—Beginning not later than January 1, 2018, a State shall require that, in order to participate as a provider in the network of a managed care entity that provides services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for medical assistance under the State plan under this title (or under a waiver of the plan) and who are enrolled with the entity, the provider is enrolled with the State agency administering the State plan under this title (or waiver of the plan). Such enrollment shall include providing to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider.

''(B) RULE OF CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as requiring a provider described in such subparagraph to provide services to individuals who are

not enrolled with a managed care entity under this title.''.

(c) COORDINATION WITH CHIP.—

(1) IN GENERAL.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (B), (C), (D), (E), (F), (G), (H), (I), (J), (K), (L), (M), (N), and (O) as subparagraphs (D), (E), (F), (G), (H), (I), (J), (K), (M), (N), (O), (P), (Q), and (R), respectively;

(B) by inserting after subparagraph (A) the following new subparagraphs:

''(B) Section 1902(a)(39) (relating to termination of participation of certain providers).

''(C) Section 1902(a)(78) (relating to enrollment of providers participating in State plans providing medical assistance on a fee-for-service basis).'';

(C) by inserting after subparagraph (K) (as redesignated by subparagraph (A)) the following new subparagraph:

''(L) Section 1903(m)(3) (relating to limitation on payment with respect to managed care).''; and

(D) in subparagraph (P) (as redesignated by subparagraph (A)), by striking ''(a)(2)(C) and (h)'' and inserting ''(a)(2)(C) (relating to Indian enrollment), (d)(5) (relating to contract requirement for managed care entities), (d)(6) (relating to enrollment of providers participating with a managed care entity), and (h) (relating to special rules with respect to Indian enrollees, Indian health care providers, and Indian managed care entities)''.

(2) EXCLUDING FROM MEDICAID PROVIDERS EXCLUDED FROM CHIP.—Section 1902(a)(39) of the Social Security Act (42 U.S.C. 1396a(a)(39)) is amended by striking ''title XVIII or any other State plan under this title'' and inserting ''title XVIII, any other State plan under this title (or waiver of the plan), or any State child health plan under title XXI (or waiver of the plan)''.

(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as changing or limiting the appeal rights of providers or the process for appeals of States under the Social Security Act.

(e) OIG REPORT.—Not later than March 31, 2020, the Inspector General of the Department of Health and Human Services shall submit to Congress a report on the

implementation of the amendments made by this section. Such report shall include the following:

(1) An assessment of the extent to which providers who are included under subsection (ll) of section 1902 of the Social Security Act (42 U.S.C. 1396a) (as added by subsection (a)(3)) in the database or similar system referred to in such subsection are terminated (as described in subsection (kk)(8) of such section, as added by subsection (a)(1)) from participation in all State plans under title XIX of such Act (or waivers of such plans).

(2) Information on the amount of Federal financial participation paid to States under section 1903 of such Act in violation of the limitation on such payment specified in subsections (i)(2)(D) and (m)(3) of such section, as added by subsection (a)(4) of this section.

(3) An assessment of the extent to which contracts with managed care entities under title XIX of such Act comply with the requirement specified in section 1932(d)(5) of such Act, as added by subsection (a)(2) of this section.

(4) An assessment of the extent to which providers have been enrolled under section 1902(a)(78) or 1932(d)(6)(A) of such Act (42 U.S.C.

1396a(a)(78), 1396u–2(d)(6)(A)) with State agencies administering State plans under title XIX of such Act (or waivers of such plans).

SEC. 3. REQUIRING PUBLICATION OF FEE-FOR-SERVICE PROVIDER DIRECTORY.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (80), by striking ''and'' at the end;

(2) in paragraph (81), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (81) the following new paragraph:

''(82) provide that, not later than January 1, 2017, in the case of a State plan (or waiver of the plan) that provides medical assistance on a fee-for-service basis or through a primary care case-management system described in section 1915(b)(1) (other than a primary care case management entity (as defined by the Secretary)), the State shall publish (and update on at least an annual basis) on the public Website of the State agency administering the State plan, a directory of the physicians described in subsection (mm) and, at State option, other providers described in such subsection that—

''(A) includes—

''(i) with respect to each such physician or provider—

''(I) the name of the physician or provider;

''(II) the specialty of the physician or provider;

''(III) the address at which the physician or provider provides services; and

''(IV) the telephone number of the physician or provider; and

''(ii) with respect to any such physician or provider participating in such a primary care case-management system, information regarding—

''(I) whether the physician or provider is accepting as new patients individuals who receive medical assistance under this title; and

''(II) the physician's or provider's cultural and linguistic capabilities, including the languages spoken by the physician or provider or by the skilled medical interpreter providing interpre-

tation services at the physician's or provider's office; and

"(B) may include, at State option, with respect to each such physician or provider—

"(i) the Internet website of such physician or provider; or

"(ii) whether the physician or provider is accepting as new patients individuals who receive medical assistance under this title.".

(b) DIRECTORY PHYSICIAN OR PROVIDER DESCRIBED.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 2(a)(3), is further amended by adding at the end the following new subsection:

"(mm) DIRECTORY PHYSICIAN OR PROVIDER DESCRIBED.—A physician or provider described in this subsection is—

"(1) in the case of a physician or provider of a provider type for which the State agency, as a condition on receiving payment for items and services furnished by the physician or provider to individuals eligible to receive medical assistance under the State plan, requires the enrollment of the physician or pro-

vider with the State agency, a physician or a provider that—

''(A) is enrolled with the agency as of the date on which the directory is published or updated (as applicable) under subsection (a)(82); and

''(B) received payment under the State plan in the 12-month period preceding such date; and

''(2) in the case of a physician or provider of a provider type for which the State agency does not require such enrollment, a physician or provider that received payment under the State plan (or waiver of the plan) in the 12-month period preceding the date on which the directory is published or updated (as applicable) under subsection (a)(82).''.

(c) RULE OF CONSTRUCTION.—

(1) IN GENERAL.—The amendment made by subsection (a) shall not be construed to apply in the case of a State (as defined for purposes of title XIX of the Social Security Act) in which all the individuals enrolled in the State plan under such title (or under a waiver of such plan), other than individuals described in paragraph (2), are enrolled with a medicaid managed care organization (as defined in sec-

tion 1903(m)(1)(A) of such Act (42 U.S.C. 1396b(m)(1)(A))), including prepaid inpatient health plans and prepaid ambulatory health plans (as defined by the Secretary of Health and Human Services).

(2) INDIVIDUALS DESCRIBED.—An individual described in this paragraph is an individual who is an Indian (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) or an Alaska Native.

(d) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), which the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet one or more additional requirements imposed by amendments made by this section, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative

session, each year of the session shall be considered to be a separate regular session of the State legislature.

SEC. 4. EXTENSION OF THE TRANSITION TO NEW PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services shall extend the transition period described in clause (i) of section 414.210(g)(9) of title 42, Code of Federal Regulations, from June 30, 2016, to September 30, 2016 (with the full implementation described in clause (ii) of such section applying to items and services furnished with dates of service on or after October 1, 2016).

(b) STUDY AND REPORT.—

(1) STUDY.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study that examines the impact of applicable payment adjustments upon—

(i) the number of suppliers of durable medical equipment that, on a date that is not before January 1, 2016, and not later than September 1, 2016, ceased to conduct business as such suppliers; and

(ii) the availability of durable medical equipment, during the period beginning on January 1, 2016, and ending on September 1, 2016, to individuals entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or enrolled under part B of such title.

(B) DEFINITIONS.—For purposes of this subsection, the following definitions apply:

(i) SUPPLIER; DURABLE MEDICAL EQUIPMENT.—The terms ''supplier'' and ''durable medical equipment'' have the meanings given such terms by section 1861 of the Social Security Act (42 U.S.C. 1395x).

(ii) APPLICABLE PAYMENT ADJUSTMENT.—The term ''applicable payment adjustment'' means a payment adjustment described in section 414.210(g) of title 42, Code of Federal Regulations, that is phased in by paragraph (9)(i) of such section. For purposes of the preceding sentence, a payment adjustment that is phased in pursuant to the extension under subsection (a) shall be considered a pay-

ment adjustment that is phased in by such paragraph (9)(i).

(2) REPORT.—The Secretary of Health and Human Services shall, not later than September 10, 2016, submit to the Committees on Ways and Means and on Energy and Commerce of the House of Representatives, and to the Committee on Finance of the Senate, a report on the findings of the study conducted under paragraph (1).

SEC. 5. EXCLUSION OF PAYMENTS FROM STATE EUGENICS COMPENSATION PROGRAMS FROM CONSIDERATION IN DETERMINING ELIGIBILITY FOR, OR THE AMOUNT OF, FEDERAL PUBLIC BENEFITS.

(a) IN GENERAL.—Notwithstanding any other provision of law, payments made under a State eugenics compensation program shall not be considered as income or resources in determining eligibility for, or the amount of, any Federal public benefit.

(b) DEFINITIONS.—For purposes of this section:

(1) FEDERAL PUBLIC BENEFIT.—The term ''Federal public benefit'' means—

(A) any grant, contract, loan, professional license, or commercial license provided by an

agency of the United States or by appropriated funds of the United States; and

(B) any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of the United States or by appropriated funds of the United States.

(2) STATE EUGENICS COMPENSATION PROGRAM.—The term ''State eugenics compensation program'' means a program established by State law that is intended to compensate individuals who were sterilized under the authority of the State.

SEC. 6. DEPOSIT OF SAVINGS INTO MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395iii(b)(1)) is amended by striking ''$0'' and inserting ''$3,000,000''.