AMENDMENT TO H.R. 5273
OFFERED BY MR. BRADY OF TEXAS

Strike all after the enacting clause and insert the following:

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.

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.

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

1 policy issues) of its 'Medicare and the
2 Health Care Delivery System' report sub-
3 mitted to Congress in June 2015.
4 "(D) DEFINITION AND REFERENCE.—In
5 this paragraph:
6 "(i) HCPCS.—The term 'HCPCS'
7 means, with respect to hospital items and
8 services, the code under the Healthcare
9 Common Procedure Coding System
10 (HCPCS) (or a successor code) for such
11 items and services.
12 "(ii) ICD–10–PCS.—The term 'ICD–
13 10–PCS' means the International Classi-
14 fication of Diseases, 10th Revision, Proce-
15 dure Coding System, and includes a subse-
16 quent revision of such International Classi-
17 fication of Diseases, Procedure Coding
18 System.".
19 **SEC. 102. ESTABLISHING BENEFICIARY EQUITY IN THE**
20 **MEDICARE HOSPITAL READMISSION PRO-**
21 **GRAM.**
22 (a) TRANSITIONAL ADJUSTMENT FOR DUAL ELIGI-
23 BLE POPULATION.—Section 1886(q)(3) of the Social Se-
24 curity 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-

1 fits under part A, who are full-benefit dual
2 eligible individuals (as defined in section
3 1935(c)(6)). In defining groups, the Sec-
4 retary shall consult the Medicare Payment
5 Advisory Commission and may consider
6 the analysis done by such Commission in
7 preparing the portion of its report sub-
8 mitted to Congress in June 2013 relating
9 to readmissions.

10 "(iii) MINIMIZING REPORTING BUR-
11 DEN ON HOSPITALS.—In carrying out this
12 subparagraph, the Secretary shall not im-
13 pose any additional reporting requirements
14 on hospitals.

15 "(iv) BUDGET NEUTRAL DESIGN
16 METHODOLOGY.—The Secretary shall de-
17 sign the methodology to implement this
18 subparagraph so that the estimated total
19 amount of reductions in payments under
20 this subsection equals the estimated total
21 amount of reductions in payments that
22 would otherwise occur under this sub-
23 section if this subparagraph did not
24 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:

"(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

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

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

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".

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

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)), the
24 Secretary shall provide for the trans-
25 fer from the Supplementary Medical

1 Insurance Trust Fund under section
2 1841, of $10,000,000 to the Centers
3 for Medicare & Medicaid Services Pro-
4 gram Management Account to remain
5 available until December 31, 2018.'';
6 and
7 (2) in subparagraph (E), by adding at the end
8 the following new clause:
9 ''(iv) The determination of an audit
10 under subparagraph (B)(vii).''.
11 (b) EFFECTIVE DATE.—The amendments made by
12 this section shall be effective as if included in the enact-
13 ment of section 603 of the Bipartisan Budget Act of 2015
14 (Public Law 114–74).

15 **SEC. 202. TREATMENT OF CANCER HOSPITALS IN OFF-CAM-**
16 **PUS OUTPATIENT DEPARTMENT OF A PRO-**
17 **VIDER POLICY.**

18 (a) IN GENERAL.—Section 1833(t)(21)(B) of the So-
19 cial Security Act (42 U.S.C. 1395l(t)(21)(B)), as amended
20 by section 201(a), is amended—
21 (1) by inserting after clause (v) the following
22 new clause:
23 ''(vi) EXCLUSION FOR CERTAIN CAN-
24 CER HOSPITALS.—For purposes of para-
25 graph (1)(B)(v) and this paragraph with

1 respect to applicable items and services
2 furnished during 2017 or a subsequent
3 year, the term 'off-campus outpatient de-
4 partment of a provider' also shall not in-
5 clude a department of a provider (as so de-
6 fined) that is not described in clause (ii) if
7 the provider is a hospital described in sec-
8 tion 1886(d)(1)(B)(v) and—
9 "(I) in the case of a department
10 that met the requirements of section
11 413.65 of title 42 of the Code of Fed-
12 eral Regulations after November 1,
13 2015, and before the date of the en-
14 actment of this clause, the Secretary
15 receives from the provider an attesta-
16 tion that such department met such
17 requirements not later than 60 days
18 after such date of enactment; or
19 "(II) in the case of a department
20 that meets such requirements after
21 such date of enactment, the Secretary
22 receives from the provider an attesta-
23 tion that such department meets such
24 requirements not later than 60 days
25 after the date such requirements are

1 first met with respect to such depart-
2 ment.'';
3 (2) in clause (vii), by inserting after the first
4 sentence the following: ''Not later than 2 years after
5 the date the Secretary receives an attestation under
6 clause (vi) relating to compliance of a department of
7 a provider with requirements referred to in such
8 clause, the Secretary shall audit the compliance with
9 such requirements with respect to the department.'';
10 and
11 (3) in clause (viii)(III), by adding at the end
12 the following: ''For purposes of carrying out this
13 subparagraph with respect to clause (vi) (and clause
14 (vii) insofar as it relates to such clause), the Sec-
15 retary shall provide for the transfer from the Sup-
16 plementary Medical Insurance Trust Fund under
17 section 1841, of $2,000,000 to the Centers for Medi-
18 care & Medicaid Services Program Management Ac-
19 count to remain available until expended.'' ''.
20 (b) OFFSETTING SAVINGS.—Section 1833(t)(18) of
21 the Social Security Act (42 U.S.C. 1395l(t)(18)) is
22 amended—
23 (1) in subparagraph (B), by inserting '', subject
24 to subparagraph (C),'' after ''shall''; and

1 (2) by adding at the end the following new sub-
2 paragraph:
3 "(C) TARGET PCR ADJUSTMENT.—In ap-
4 plying section 419.43(i) of title 42 of the Code
5 of Federal Regulations to implement the appro-
6 priate adjustment under this paragraph for
7 services furnished on or after January 1, 2018,
8 the Secretary shall use a target PCR that is 1.0
9 percentage points less than the target PCR that
10 would otherwise apply. In addition to the per-
11 centage point reduction under the previous sen-
12 tence, the Secretary may consider making an
13 additional percentage point reduction to such
14 target PCR that takes into account payment
15 rates for applicable items and services described
16 in paragraph (21)(C) other than for services
17 furnished by hospitals described in section
18 1886(d)(1)(B)(v). In making any budget neu-
19 trality adjustments under this subsection for
20 2018 or a subsequent year, the Secretary shall
21 not take into account the reduced expenditures
22 that result from the application of this subpara-
23 graph.".
24 (c) EFFECTIVE DATE.—The amendments made by
25 this section shall be effective as if included in the enact-

ment 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

1 such professional are furnished in an am-
2 bulatory surgical center.
3 "(iii) DETERMINATION.—The deter-
4 mination of whether an eligible profes-
5 sional is an eligible professional described
6 in clause (ii) may be made on the basis
7 of—
8 "(I) the site of service (as de-
9 fined by the Secretary); or
10 "(II) an attestation submitted by
11 the eligible professional.
12 Determinations made under subclauses (I)
13 and (II) shall be made without regard to
14 any employment or billing arrangement be-
15 tween the eligible professional and any
16 other supplier or provider of services.
17 "(iv) SUNSET.—Clause (ii) shall no
18 longer apply as of the first year that be-
19 gins more than 3 years after the date on
20 which the Secretary determines, through
21 notice and comment rulemaking, that cer-
22 tified EHR technology applicable to the
23 ambulatory surgical center setting is avail-
24 able.".

(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 rat-

1 ing system before reforming such system with the
2 input of stakeholders; and
3 (2) pending the results of such studies and
4 input, to provide for a temporary delay in authority
5 of the Centers for Medicare & Medicaid Services
6 (CMS) to terminate Medicare Advantage plan con-
7 tracts solely on the basis of performance of plans
8 under the STARS rating system.
9 (b) DELAY IN MA CONTRACT TERMINATION AU-
10 THORITY FOR PLANS FAILING TO ACHIEVE MINIMUM
11 QUALITY RATINGS.—Section 1857(h) of the Social Secu-
12 rity Act (42 U.S.C. 1395w–27(h)) is amended by adding
13 at the end the following new paragraph:
14 "(3) DELAY IN CONTRACT TERMINATION AU-
15 THORITY FOR PLANS FAILING TO ACHIEVE MINIMUM
16 QUALITY RATING.—During the period beginning on
17 the date of the enactment of this paragraph and
18 through the end of plan year 2018, the Secretary
19 may not terminate a contract under this section with
20 respect to the offering of an MA plan by a Medicare
21 Advantage organization solely because the MA plan
22 has failed to achieve a minimum quality rating
23 under the 5-star rating system under section
24 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

1 "(iii) enrollment under part D.
2 "(2) FEE-FOR-SERVICE ENROLLMENT DE-
3 FINED.—For purpose of paragraph (1)(B)(i), the
4 term 'fee-for-service enrollment' means aggregate en-
5 rollment (including receipt of benefits other than
6 through enrollment) under—
7 "(A) part A only;
8 "(B) part B only; and
9 "(C) both part A and part B.".

10 **SEC. 303. UPDATING THE WELCOME TO MEDICARE PACK-**
11 **AGE.**

12 (a) IN GENERAL.—Not later than 12 months after
13 the last day of the period for the request of information
14 described in subsection (b), the Secretary of Health and
15 Human Services shall, taking into consideration informa-
16 tion collected pursuant to subsection (b), update the infor-
17 mation included in the Welcome to Medicare package to
18 include information, presented in a clear and simple man-
19 ner, about options for receiving benefits under the Medi-
20 care program under title XVIII of the Social Security Act
21 (42 U.S.C. 1395 et seq.), including through the original
22 medicare fee-for-service program under parts A and B of
23 such title (42 U.S.C. 1395c et seq., 42 U.S.C. 1395j et
24 seq.), Medicare Advantage plans under part C of such title
25 (42 U.S.C. 1395w–21 et seq.), and prescription drug plans

1 under part D of such title (42 U.S.C. 1395w–101 et
2 seq.)). The Secretary shall make subsequent updates to
3 the information included in the Welcome to Medicare
4 package as appropriate.
5 (b) REQUEST FOR INFORMATION.—Not later than six
6 months after the date of the enactment of this Act, the
7 Secretary of Health and Human Services shall request in-
8 formation, including recommendations, from stakeholders
9 (including patient advocates, issuers, and employers) on
10 information included in the Welcome to Medicare package,
11 including pertinent data and information regarding enroll-
12 ment and coverage for Medicare eligible individuals.