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(Original Signature of Member)

114<sup>TH</sup> CONGRESS  
2<sup>D</sup> 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.

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## IN THE HOUSE OF REPRESENTATIVES

Mr. TIBERI (for himself and Mr. McDERMOTT) introduced the following bill; which was referred to the Committee on \_\_\_\_\_

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## 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.

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

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

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

1 (b) TABLE OF CONTENTS.—The table of contents for  
2 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.

3 **TITLE I—PROVISIONS RELATING**  
4 **TO MEDICARE PART A**

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

8 Section 1886 of the Social Security Act (42 U.S.C.  
9 1395ww) is amended by adding at the end the following  
10 new subsection:

11 “(t) RELATING SIMILAR INPATIENT AND OUT-  
12 PATIENT HOSPITAL SERVICES.—

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

3           “(A) IN GENERAL.—Not later than Janu-  
4 ary 1, 2018, the Secretary shall develop  
5 HCPCS versions for MS-DRGs that is similar  
6 to the ICD-10-PCS for such MS-DRGs such  
7 that, to the extent possible, the MS-DRG as-  
8 signment shall be similar for a claim coded with  
9 the HCPCS version as an identical claim coded  
10 with a ICD-10-PCS code.

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

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

18           “(i) IN GENERAL.—The Secretary  
19 shall develop a HCPCS MS-DRG defini-  
20 tions manual and software that is similar  
21 to the definitions manual and software for  
22 ICD-10-PCS codes for such MS-DRGs.  
23 The Secretary shall post the HCPCS MS-  
24 DRG definitions manual and software on  
25 the Internet website of the Centers for

1 Medicare & Medicaid Services. The  
2 HCPCS MS-DRG definitions manual and  
3 software shall be in the public domain and  
4 available for use and redistribution without  
5 charge.

6 “(ii) USE OF PREVIOUS ANALYSIS  
7 DONE BY MEDPAC.—In developing the  
8 HCPCS MS-DRG definitions manual and  
9 software under clause (i), the Secretary  
10 shall consult with the Medicare Payment  
11 Advisory Commission and shall consider  
12 the analysis done by such Commission in  
13 translating outpatient surgical claims into  
14 inpatient surgical MS-DRGs in preparing  
15 chapter 7 (relating to hospital short-stay  
16 policy issues) of its ‘Medicare and the  
17 Health Care Delivery System’ report sub-  
18 mitted to Congress in June 2015.

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

21 “(i) HCPCS.—The term ‘HCPCS’  
22 means, with respect to hospital items and  
23 services, the code under the Healthcare  
24 Common Procedure Coding System

1 (HCPCS) (or a successor code) for such  
2 items and services.

3 “(ii) ICD–10–PCS.—The term ‘ICD–  
4 10–PCS’ means the International Classi-  
5 fication of Diseases, 10th Revision, Proce-  
6 dure Coding System, and includes a subse-  
7 quent revision of such International Classi-  
8 fication of Diseases, Procedure Coding  
9 System.”.

10 **SEC. 102. ESTABLISHING BENEFICIARY EQUITY IN THE**  
11 **MEDICARE HOSPITAL READMISSION PRO-**  
12 **GRAM.**

13 (a) TRANSITIONAL ADJUSTMENT FOR DUAL ELIGI-  
14 BLE POPULATION.—Section 1886(q)(3) of the Social Se-  
15 curity Act (42 U.S.C. 1395ww(q)(3)) is amended—

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

19 (2) by adding at the end the following new sub-  
20 paragraph:

21 “(D) TRANSITIONAL ADJUSTMENT FOR  
22 DUAL ELIGIBLES.—

23 “(i) IN GENERAL.—In determining a  
24 hospital’s adjustment factor under this  
25 paragraph for purposes of making pay-

1           ments for discharges occurring during and  
2           after fiscal year 2019, and before the ap-  
3           plication of clause (i) of subparagraph (E),  
4           the Secretary shall assign hospitals to  
5           groups (as defined by the Secretary under  
6           clause (ii)) and apply the applicable provi-  
7           sions of this subsection using a method-  
8           ology in a manner that allows for separate  
9           comparison of hospitals within each such  
10          group, as determined by the Secretary.

11           “(ii) DEFINING GROUPS.—For pur-  
12          poses of this subparagraph, the Secretary  
13          shall define groups of hospitals based on  
14          their overall proportion of inpatients who  
15          are full-benefit dual eligible individuals (as  
16          defined in section 1935(c)(6)). In defining  
17          groups, the Secretary shall consult the  
18          Medicare Payment Advisory Commission  
19          and may consider the analysis done by  
20          such Commission in preparing the portion  
21          of its report submitted to Congress in June  
22          2013 relating to readmissions.

23           “(iii) MINIMIZING REPORTING BUR-  
24          DEN ON HOSPITALS.—In carrying out this  
25          subparagraph, the Secretary shall not im-

1           pose any additional reporting requirements  
2           on hospitals.

3                   “(iv) BUDGET NEUTRAL DESIGN  
4           METHODOLOGY.—The Secretary shall de-  
5           sign the methodology to implement this  
6           subparagraph so that the estimated total  
7           amount of reductions in payments under  
8           this subsection equals the estimated total  
9           amount of reductions in payments that  
10          would otherwise occur under this sub-  
11          section if this subparagraph did not  
12          apply.”.

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

18                   “(E) CHANGES IN RISK ADJUSTMENT.—  
19                   “(i) CONSIDERATION OF REC-  
20           COMMENDATIONS IN IMPACT REPORTS.—  
21           The Secretary may take into account the  
22           studies conducted and the recommenda-  
23           tions made by the Secretary under section  
24           2(d)(1) of the IMPACT Act of 2014 (Pub-  
25           lic Law 113–185; 42 U.S.C. 1395lll note)

1 with respect to the application under this  
2 subsection of risk adjustment methodolo-  
3 gies. Nothing in this clause shall be con-  
4 strued as precluding consideration of the  
5 use of groupings of hospitals.”.

6 (c) MEDPAC STUDY ON READMISSIONS PROGRAM.—

7 The Medicare Payment Advisory Commission shall con-  
8 duct a study to review overall hospital readmissions de-  
9 scribed in section 1886(q)(5)(E) of the Social Security Act  
10 (42 U.S.C. 1395ww(q)(5)(E)) and whether such readmis-  
11 sions are related to any changes in outpatient and emer-  
12 gency services furnished. The Commission shall submit to  
13 Congress a report on such study in its report to Congress  
14 in June 2017.

15 (d) ADDRESSING ISSUE OF CERTAIN PATIENTS.—

16 Subparagraph (E) of section 1886(q)(3) of the Social Se-  
17 curity Act (42 U.S.C. 1395ww(q)(3)), as added by sub-  
18 section (b), is further amended by adding at the end the  
19 following new clause:

20 “(ii) CONSIDERATION OF EXCLUSION  
21 OF PATIENT CASES BASED ON V OR OTHER  
22 APPROPRIATE CODES.—In promulgating  
23 regulations to carry out this subsection  
24 with respect to discharges occurring after  
25 fiscal year 2018, the Secretary may con-

1           sider the use of V or other ICD-related  
2           codes for removal of a readmission. The  
3           Secretary may consider modifying meas-  
4           ures under this subsection to incorporate V  
5           or other ICD-related codes at the same  
6           time as other changes are being made  
7           under this subparagraph.”.

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

13                   “(iii) REMOVAL OF CERTAIN RE-  
14                   ADMISSIONS.—In promulgating regulations  
15                   to carry out this subsection, with respect  
16                   to discharges occurring after fiscal year  
17                   2018, the Secretary may consider removal  
18                   as a readmission of an admission that is  
19                   classified within one or more of the fol-  
20                   lowing: transplants, end-stage renal dis-  
21                   ease, burns, trauma, psychosis, or sub-  
22                   stance abuse. The Secretary may consider  
23                   modifying measures under this subsection  
24                   to remove readmissions at the same time

1 as other changes are being made under  
2 this subparagraph.”.

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

5 (a) EXTENSION.—Section 410A of the Medicare Pre-  
6 scription Drug, Improvement, and Modernization Act of  
7 2003 (Public Law 108–173; 42 U.S.C. 1395ww note), as  
8 amended by sections 3123 and 10313 of the Patient Pro-  
9 tection and Affordable Care Act (Public Law 111–148),  
10 is amended—

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

14 (2) in subsection (g)—

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

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

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

23 (D) in paragraph (4)(B)—

1 (i) in the matter preceding clause (i),  
2 by inserting “each 5-year period in” after  
3 “hospital during”; and

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

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

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

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

20 “(A) IN GENERAL.—The Secretary shall,  
21 notwithstanding subsection (a)(2) or paragraph  
22 (2) of this subsection, not later than 120 days  
23 after the date of the enactment of this para-  
24 graph, issue a solicitation for applications to se-  
25 lect up to the maximum number of additional

1 rural community hospitals located in any State  
2 to participate in the demonstration program  
3 under this section for the second 5 years of the  
4 10-year extension period without exceeding the  
5 limitation under paragraph (3) of this sub-  
6 section.

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

12 “(i) shall give priority to rural com-  
13 munity hospitals located in one of the 20  
14 States with the lowest population densities  
15 (as determined by the Secretary using the  
16 2015 Statistical Abstract of the United  
17 States); and

18 “(ii) may consider—

19 “(I) closures of hospitals located  
20 in rural areas in the State in which  
21 the rural community hospital is lo-  
22 cated during the 5-year period imme-  
23 diately preceding the date of the en-  
24 actment of this paragraph; and

1                   “(II) the population density of  
2                   the State in which the rural commu-  
3                   nity hospital is located.”.

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

6               (1) by striking “Not later than 6 months after  
7               the completion of the demonstration program under  
8               this section” and inserting “Not later than August  
9               1, 2018”; and

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

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

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

15               (1) IN GENERAL.—Section 114(d)(7) of the  
16               Medicare, Medicaid, and SCHIP Extension Act of  
17               2007 (42 U.S.C. 1395ww note), as amended by sec-  
18               tions 3106(b) and 10312(b) of Public Law 111–148,  
19               section 1206(b)(2) of the Pathway for SGR Reform  
20               Act of 2013 (division B of Public Law 113–67), and  
21               section 112 of the Protecting Access to Medicare Act  
22               of 2014, is amended by striking “The moratorium  
23               under paragraph (1)(A)” and inserting “Any mora-  
24               torium under paragraph (1)”.

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

5           (b) MODIFICATION TO MEDICARE LONG-TERM CARE  
6 HOSPITAL HIGH COST OUTLIER PAYMENTS.—Section  
7 1886(m) of the Social Security Act (42 U.S.C.  
8 1395ww(m)) is amended by adding at the end the fol-  
9           lowing new paragraph:

10           “(7) TREATMENT OF HIGH COST OUTLIER PAY-  
11           MENTS.—

12           “(A) ADJUSTMENT TO THE STANDARD  
13           FEDERAL PAYMENT RATE FOR ESTIMATED  
14           HIGH COST OUTLIER PAYMENTS.—Under the  
15           system described in paragraph (1), for fiscal  
16           years beginning on or after October 1, 2017,  
17           the Secretary shall reduce the standard Federal  
18           payment rate as if the estimated aggregate  
19           amount of high cost outlier payments for stand-  
20           ard Federal payment rate discharges for each  
21           such fiscal year would be equal to 8 percent of  
22           estimated aggregate payments for standard  
23           Federal payment rate discharges for each such  
24           fiscal year.

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

13          “(C) WAIVER OF BUDGET NEUTRALITY.—  
14          Any reduction in payments resulting from the  
15          application of subparagraph (B) shall not be  
16          taken into account in applying any budget neu-  
17          trality provision under such system.

18          “(D) NO EFFECT ON SITE NEUTRAL HIGH  
19          COST OUTLIER PAYMENT RATE.—This para-  
20          graph shall not apply with respect to the com-  
21          putation of the applicable site neutral payment  
22          rate under paragraph (6).”.

1 **SEC. 105. SAVINGS FROM IPPS MACRA PAY-FOR THROUGH**  
2 **NOT APPLYING DOCUMENTATION AND COD-**  
3 **ING ADJUSTMENTS.**

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

16 **TITLE II—PROVISIONS RELAT-**  
17 **ING TO MEDICARE PART B**

18 **SEC. 201. CONTINUING MEDICARE PAYMENT UNDER HOPD**  
19 **PROSPECTIVE PAYMENT SYSTEM FOR SERV-**  
20 **ICES FURNISHED BY MID-BUILD OFF-CAMPUS**  
21 **OUTPATIENT DEPARTMENTS OF PROVIDERS.**

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

24 (1) in subparagraph (B)—

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

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

6 “(iii) DEEMED TREATMENT FOR  
7 2017.—For purposes of applying clause (ii)  
8 with respect to applicable items and serv-  
9 ices furnished during 2017, a department  
10 of a provider (as so defined) not described  
11 in such clause is deemed to be billing  
12 under this subsection with respect to cov-  
13 ered OPD services furnished prior to No-  
14 vember 2, 2015, if the Secretary received  
15 from the provider prior to December 2,  
16 2015, an attestation (pursuant to section  
17 413.65(b)(3) of title 42 of the Code of  
18 Federal Regulations) that such department  
19 was a department of a provider (as so de-  
20 fined).

21 “(iv) ALTERNATIVE EXCEPTION BE-  
22 GINNING WITH 2018.—For purposes of  
23 paragraph (1)(B)(v) and this paragraph  
24 with respect to applicable items and serv-  
25 ices furnished during 2018 or a subsequent

1 year, the term ‘off-campus outpatient de-  
2 partment of a provider’ also shall not in-  
3 clude a department of a provider (as so de-  
4 fined) that is not described in clause (ii)  
5 if—

6 “(I) the Secretary receives from  
7 the provider an attestation (pursuant  
8 to such section 413.65(b)(3)) before  
9 July 1, 2016, that such department  
10 met the requirements of a department  
11 of a provider specified in section  
12 413.65 of title 42 of the Code of Fed-  
13 eral Regulations;

14 “(II) the provider includes such  
15 department as part of the provider on  
16 its enrollment form in accordance with  
17 the enrollment process under section  
18 1866(j); and

19 “(III) before July 1, 2016, the  
20 department met the mid-build require-  
21 ment of clause (v) and the Secretary  
22 receives from the chief executive offi-  
23 cer or chief operating officer of the  
24 provider a written certification that  
25 the department met such requirement.

1           “(v) MID-BUILD REQUIREMENT DE-  
2           SCRIBED.—The mid-build requirement of  
3           this clause is, with respect to a department  
4           of a provider, that before November 2,  
5           2015, the provider had a binding written  
6           agreement with an outside unrelated party  
7           for the actual construction of such depart-  
8           ment.

9           “(vii) AUDIT.—Not later than Decem-  
10          ber 31, 2018, the Secretary shall audit the  
11          compliance with requirements of clause (iv)  
12          with respect to a department of a provider  
13          for which an attestation is submitted under  
14          such clause. If the Secretary finds as a re-  
15          sult of an audit under this clause that the  
16          applicable requirements were not met with  
17          respect to such department, the depart-  
18          ment shall not be excluded from the term  
19          ‘off-campus outpatient department of a  
20          provider’ under the respective clause.

21          “(viii) IMPLEMENTATION.—For pur-  
22          poses of implementing clauses (iii) through  
23          (vii):

24                       “(I) Notwithstanding any other  
25                       provision of law, the Secretary may

1                   implement such clauses by program  
2                   instruction or otherwise.

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

6                   “(III) For purposes of carrying  
7                   out this subparagraph with respect to  
8                   clauses (iii) and (iv) (and clause (vii)  
9                   insofar as it relates to such clauses),  
10                  the Secretary shall provide for the  
11                  transfer from the Supplementary  
12                  Medical Insurance Trust Fund under  
13                  section 1841, of \$10,000,000 to the  
14                  Centers for Medicare & Medicaid  
15                  Services Program Management Ac-  
16                  count to remain available until De-  
17                  cember 31, 2018.”; and

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

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

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

1 **SEC. 202. TREATMENT OF CANCER HOSPITALS IN OFF-CAM-**  
2 **PUS OUTPATIENT DEPARTMENT OF A PRO-**  
3 **VIDER POLICY.**

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

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

9 “(vi) EXCLUSION FOR CERTAIN CAN-  
10 CER HOSPITALS.—For purposes of para-  
11 graph (1)(B)(v) and this paragraph with  
12 respect to applicable items and services  
13 furnished during 2017 or a subsequent  
14 year, the term ‘off-campus outpatient de-  
15 partment of a provider’ also shall not in-  
16 clude a department of a provider (as so de-  
17 fined) that is not described in clause (ii) if  
18 the provider is a hospital described in sec-  
19 tion 1886(d)(1)(B)(v) and—

20 “(I) in the case of a department  
21 that met the requirements of section  
22 413.65 of title 42 of the Code of Fed-  
23 eral Regulations after November 1,  
24 2015, and before the date of the en-  
25 actment of this clause, the Secretary  
26 receives from the provider an attesta-

1                   tion that such department met such  
2                   requirements not later than 60 days  
3                   after such date of enactment; or

4                   “(II) in the case of a department  
5                   that meets such requirements after  
6                   such date of enactment, the Secretary  
7                   receives from the provider an attesta-  
8                   tion that such department meets such  
9                   requirements not later than 60 days  
10                  after the date such requirements are  
11                  first met with respect to such depart-  
12                  ment.”;

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

21                (3) in clause (viii)(III), by adding at the end  
22                the following: “For purposes of carrying out this  
23                subparagraph with respect to clause (vi) (and clause  
24                (vii) insofar as it relates to such clause), the Sec-  
25                retary shall provide for the transfer from the Sup-

1       plementary Medical Insurance Trust Fund under  
2       section 1841, of \$2,000,000 to the Centers for Medi-  
3       care & Medicaid Services Program Management Ac-  
4       count to remain available until expended.””.

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

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

10              (2) by adding at the end the following new sub-  
11       paragraph:

12                       “(C) TARGET PCR ADJUSTMENT.—In ap-  
13       plying section 419.43(i) of title 42 of the Code  
14       of Federal Regulations to implement the appro-  
15       priate adjustment under this paragraph for  
16       services furnished on or after January 1, 2018,  
17       the Secretary shall use a target PCR that is 1.0  
18       percentage points less than the target PCR that  
19       would otherwise apply. In addition to the per-  
20       centage point reduction under the previous sen-  
21       tence, the Secretary may consider making an  
22       additional percentage point reduction to such  
23       target PCR that takes into account payment  
24       rates for applicable items and services described  
25       in paragraph (21)(C) other than for services

1 furnished by hospitals described in section  
2 1886(d)(1)(B)(v). In making any budget neu-  
3 trality adjustments under this subsection for  
4 2018 or a subsequent year, the Secretary shall  
5 not take into account the reduced expenditures  
6 that result from the application of this subpara-  
7 graph.”.

8 (c) 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. 203. TREATMENT OF ELIGIBLE PROFESSIONALS IN**  
13 **AMBULATORY SURGICAL CENTERS FOR**  
14 **MEANINGFUL USE AND MIPS.**

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

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

23 “(i) HOSPITAL-BASED.—No pay-  
24 ment”; and

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

3                   “(ii) AMBULATORY SURGICAL CEN-  
4                   TER-BASED.—Subject to clause (iv), no  
5                   payment adjustment may be made under  
6                   subparagraph (A) for 2017 and 2018 in  
7                   the case of an eligible professional with re-  
8                   spect to whom substantially all of the cov-  
9                   ered professional services furnished by  
10                  such professional are furnished in an am-  
11                  bulatory surgical center.

12                  “(iii) DETERMINATION.—The deter-  
13                  mination of whether an eligible profes-  
14                  sional is an eligible professional described  
15                  in clause (ii) may be made on the basis  
16                  of—

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

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

21                  Determinations made under subclauses (I)  
22                  and (II) shall be made without regard to  
23                  any employment or billing arrangement be-  
24                  tween the eligible professional and any  
25                  other supplier or provider of services.

1                   “(iv) SUNSET.—Clause (ii) shall no  
2                   longer apply as of the first year that be-  
3                   gins more than 3 years after the date on  
4                   which the Secretary determines, through  
5                   notice and comment rulemaking, that cer-  
6                   tified EHR technology applicable to the  
7                   ambulatory surgical center setting is avail-  
8                   able.”.

9           (b) CONTINUED APPLICATION OF CERTAIN PROVI-  
10          SIONS UNDER MIPS.—Section 1848(o)(2)(D) of the So-  
11          cial Security Act (42 U.S.C. 1395w-4(o)(2)(D)) is amend-  
12          ed by adding at the end the following new sentence: “The  
13          provisions of subparagraphs (B) and (D) of subsection  
14          (a)(7), including the application of clause (iv) of such sub-  
15          paragraph (D), shall apply to assessments of MIPS eligi-  
16          ble professionals under subsection (q) with respect to the  
17          performance category described in subsection (q)(2)(A)(iv)  
18          in a manner similar to the manner in which such provi-  
19          sions apply with respect to payment adjustments made  
20          under subsection (a)(7)(A).”.

1       **TITLE III—OTHER MEDICARE**  
2                                   **PROVISIONS**

3       **SEC. 301. DELAY IN AUTHORITY TO TERMINATE CON-**  
4                                   **TRACTS FOR MEDICARE ADVANTAGE PLANS**  
5                                   **FAILING TO ACHIEVE MINIMUM QUALITY**  
6                                   **RATINGS.**

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

10               (1) to continue to study and request input on  
11 the effects of socioeconomic status and dual-eligible  
12 populations on the Medicare Advantage STARS rat-  
13 ing system before reforming such system with the  
14 input of stakeholders; and

15               (2) pending the results of such studies and  
16 input, to provide for a temporary delay in authority  
17 of the Centers for Medicare & Medicaid Services  
18 (CMS) to terminate Medicare Advantage plan con-  
19 tracts solely on the basis of performance of plans  
20 under the STARS rating system.

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

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

11 **SEC. 302. REQUIREMENT FOR ENROLLMENT DATA REPORT-**  
12 **ING FOR MEDICARE.**

13          Section 1874 of the Social Security Act (42 U.S.C.  
14 1395kk) is amended by adding at the end the following  
15 new subsection:

16          “(g) REQUIREMENT FOR ENROLLMENT DATA RE-  
17 PORTING.—

18           “(1) IN GENERAL.—Each year (beginning with  
19           2016), the Secretary shall submit to the Committees  
20           on Ways and Means and Energy and Commerce of  
21           the House of Representatives and the Committee on  
22           Finance of the Senate a report on Medicare enroll-  
23           ment data (and, in the case of part A, on data on  
24           individuals receiving benefits under such part) as of

1 a date in such year specified by the Secretary. Such  
2 data shall be presented—

3 “(A) by Congressional district and State;  
4 and

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

7 “(i) fee-for-service enrollment (as de-  
8 fined in paragraph (2));

9 “(ii) enrollment under part C (includ-  
10 ing separate for aggregate enrollment in  
11 MA–PD plans and aggregate enrollment in  
12 MA plans that are not MA–PD plans); and

13 “(iii) enrollment under part D.

14 “(2) FEE-FOR-SERVICE ENROLLMENT DE-  
15 FINED.—For purpose of paragraph (1)(B)(i), the  
16 term ‘fee-for-service enrollment’ means aggregate en-  
17 rollment (including receipt of benefits other than  
18 through enrollment) under—

19 “(A) part A only;

20 “(B) part B only; and

21 “(C) both part A and part B.”.

22 **SEC. 303. UPDATING THE WELCOME TO MEDICARE PACK-**  
23 **AGE.**

24 (a) IN GENERAL.—Not later than 12 months after  
25 the last day of the period for the request of information

1 described in subsection (b), the Secretary of Health and  
2 Human Services shall, taking into consideration informa-  
3 tion collected pursuant to subsection (b), update the infor-  
4 mation included in the Welcome to Medicare package to  
5 include information, presented in a clear and simple man-  
6 ner, about options for receiving benefits under the Medi-  
7 care program under title XVIII of the Social Security Act  
8 (42 U.S.C. 1395 et seq.), including through the original  
9 medicare fee-for-service program under parts A and B of  
10 such title (42 U.S.C. 1395c et seq., 42 U.S.C. 1395j et  
11 seq.), Medicare Advantage plans under part C of such title  
12 (42 U.S.C. 1395w–21 et seq.), and prescription drug plans  
13 under part D of such title (42 U.S.C. 1395w–101 et  
14 seq.)). The Secretary shall make subsequent updates to  
15 the information included in the Welcome to Medicare  
16 package as appropriate.

17 (b) REQUEST FOR INFORMATION.—Not later than six  
18 months after the date of the enactment of this Act, the  
19 Secretary of Health and Human Services shall request in-  
20 formation, including recommendations, from stakeholders  
21 (including patient advocates, issuers, and employers) on  
22 information included in the Welcome to Medicare package,  
23 including pertinent data and information regarding enroll-  
24 ment and coverage for Medicare eligible individuals.