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(Original Signature of Member)

114TH CONGRESS
2D SESSION

H. R.

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

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

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 OMMENDATIONS 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.