

[DISCUSSION DRAFT]

113TH CONGRESS
2^D SESSION

H. R. _____

To amend title XVIII of the Social Security Act to include revisions to hospital payment and quality under the Medicare program, hospital priorities of Members of the Committee on Ways and Means for the 113th Congress, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. BRADY of Texas introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title XVIII of the Social Security Act to include revisions to hospital payment and quality under the Medicare program, hospital priorities of Members of the Committee on Ways and Means for the 113th Congress, 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 “Hospital Improvements for Payment Act of 2014”.

1 (b) TABLE OF CONTENTS.—The table of contents of
2 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—HOSPITAL PAYMENT AND QUALITY PROVISIONS

Subtitle A—Payment

- Sec. 101. Hospital Prospective Payment System.
- Sec. 102. Per diem payment rate for short lengths of stay.
- Sec. 103. Repeal of the two midnights payment reduction.

Subtitle B—Audits

- Sec. 104. Monitoring performance of the Recovery Audit Contractor (RAC) program.
- Sec. 105. Improvements to the RAC program.

Subtitle C—Appeals

- Sec. 106. Retrospective hospital solutions to address problems in the Medicare appeals process.
- Sec. 107. Retrospective non-hospital solutions to address problems in the Medicare appeals process.
- Sec. 108. Prospective solutions to address problems in the Medicare appeals process.

Subtitle D—Quality and Transparency

- Sec. 109. Hospital assessment data.
- Sec. 110. Cost information on hospital payments.

TITLE II—HOSPITAL PRIORITIES OF THE COMMITTEE ON WAYS
AND MEANS FOR THE 113TH CONGRESS (AS LISTED IN ORDER
OF MEMBER SENIORITY)

- Sec. 201. (Johnson) Repeal of ObamaCare moratorium on physician-owned hospitals.
- Sec. 202. H.R. 2053 – (Brady) To amend title XVIII of the Social Security Act to apply budget neutrality on a State-specific basis in the calculation of the Medicare hospital wage index floor for non-rural areas.
- Sec. 203. H.R. 4418 – (Ryan) Expanding the Availability of Medicare Data Act.
- Sec. 204. H.R. 2500 (Section 4) – (Nunes) Ambulatory Surgical Center Quality and Access Act of 2013.
- Sec. 205. H.R. 4187 – (Roskam) Developing an Innovative Strategy for Anti-microbial Resistant Microorganisms Act of 2014.
- Sec. 206. (Buchanan) Hand sanitation demonstration program.
- Sec. 207. H.R. 3769 – (Smith) Extension of nonenforcement instruction for the Medicare direct supervision requirement for therapeutic hospital outpatient services for critical access hospitals and rural hospitals; study of impact of failure to extend such instruction.
- Sec. 208. H.R. 3991 – (Smith) Critical Access Hospital Relief Act of 2014.

- Sec. 209. H.R. 5227 – (Schock) Making the Education of Nurses Dependable for Schools Act.
- Sec. 210. H.R. 1379 – (Schock) Puerto Rico Hospital HITECH Amendments Act of 2013.
- Sec. 211. H.R. 4781 – (Jenkins) Medicare Access to Rural Anesthesiology Act of 2014.
- Sec. 212. H.R. 4663 – (Black) Protect Patient Access and Promote Hospital Efficiency Act.
- Sec. 213. H.R. 3796 – (Black) Comprehensive Care Payment Innovation Act.
- Sec. 214. (Black) Tennessee DSH allotment for fiscal year 2015 and succeeding fiscal years.
- Sec. 215. H.R. 4857 – (Reed) Ensuring Equal Access to Treatments Act of 2014.
- Sec. 216. H.R. 5232 – (Young) NOTICE Act.
- Sec. 217. H.R. 4188 – (Renacci) Establishing Beneficiary Equity in the Hospital Readmission Program Act.
- Sec. 218. (Camp) Cancer Exemption for Certain Qualifying Hospitals.
- Sec. 219. (Camp) Retrospective payment adjustments during a contractor change.

1 **TITLE I—HOSPITAL PAYMENT**
2 **AND QUALITY PROVISIONS**
3 **Subtitle A—Payment**

4 **SEC. 101. HOSPITAL PROSPECTIVE PAYMENT SYSTEM.**

5 (a) FINDINGS ON MEDICARE REIMBURSEMENT FOR
6 HOSPITALS.—Congress finds the following:

7 (1) On an annual basis, the Centers for Medi-
8 care & Medicaid Services (CMS) updates Medicare
9 reimbursement for hospitals through two distinct
10 regulatory proposals—the inpatient prospective pay-
11 ment system (IPPS) and the outpatient prospective
12 payment system (OPPS). The IPPS and the OPPS
13 reimburse Medicare services in very different ways.

14 (2) The IPPS is focused on the international
15 classification of disease (ICD) diagnosis code system
16 that CMS maps to discrete bundles of reimburse-

1 ment, referred to as diagnosis related groups or
2 DRGs. CMS maintains 751 DRGs for inpatient hos-
3 pital payment.

4 (3) The OPSS is focused on current procedural
5 terminology (CPT) codes that are maintained by the
6 American Medical Association (AMA) and HCPCS
7 maintained by CMS. The CPT and HCPCS codes
8 map to Ambulatory Payment Classifications (APCs)
9 for outpatient service reimbursement. CMS main-
10 tains 813 APCs for outpatient hospital payment.

11 (4) There is no one-to-one matching of DRGs
12 to APCs nor ICD codes to CPT and HCPCS codes.
13 Hospitals are responsible for knowing two different
14 coding systems and two different payment systems
15 for Medicare reimbursement. Yet, hospitals are held
16 to one set of Medicare conditions of participation
17 and therefore use the same medical staff and phys-
18 ical space when treating patients—whether that
19 service is ultimately billed inpatient or outpatient.

20 (5) Some elements of IPPS and OPSS reim-
21 bursement are the same, such as making an adjust-
22 ment for the Medicare wage index. However, there
23 are distinct differences between the two payment
24 systems, the most significant of which are the base
25 reimbursement rates, indirect medical education

1 (IME) funds and disproportionate share (DSH) pay-
2 ments. The base reimbursement rate for all IPPS
3 payments is approximately \$5,900 and each DRG is
4 adjusted (using relative weights) from that base rate
5 depending on the intensity of resources needed to
6 treat the beneficiary. However, there is no equivalent
7 base reimbursement rate in the OPPS. A different
8 price standard is set for each APC.

9 (6) Arguably, the biggest difference between in-
10 patient and outpatient reimbursement are the dis-
11 charge add-on payments for IME and DSH. IME
12 and DSH are included in all IPPS payments, where
13 applicable, but they are not included in any OPPS
14 payments. IME and DSH funds per discharge often
15 make up a significant portion of a hospital's Medi-
16 care revenue.

17 (7) There may be as much as a tenfold dif-
18 ference in comparing the base DRG, IME and DSH
19 payment to the sole APC payment.

20 (8) An April 2013 Government Accountability
21 Organization study found that approximately 91
22 percent of hospitals are subject to an IPPS payment
23 adjustment or are excluded from the IPPS entirely,
24 suggesting that Medicare may not be operating a

1 true prospective payment system that is based on a
2 system of averages.

3 (9) The vast discrepancy in reimbursement be-
4 tween the IPPS and OPPS payment systems for
5 “short stays” may incentivize hospitals to bill all
6 services on an inpatient basis, even if a procedure is
7 medically appropriate as an outpatient service. Be-
8 cause of these misaligned incentives in the Medicare
9 payment systems, CMS has recognized short inpa-
10 tient stays as “errors” when administering its an-
11 nual Comprehensive Error Rate Testing (CERT)
12 program. As part of the CERT program, CMS has
13 stated that “hospital errors are identified more fre-
14 quently for shorter lengths of stay.” CMS contracts
15 with several types of auditors and uses the CERT
16 program to target improper payments.

17 (10) Over the last several years, RACs have
18 been auditing and denying reimbursement for short
19 stays at considerably high rates. This direction came
20 from the belief by CMS that short stays were inap-
21 propriately billed as inpatient, as well as recognition
22 of the inappropriate billing recognized by the CERT
23 annual reports.

24 (11) In the fiscal year 2014 IPPS final rule,
25 CMS established a new two-midnights standard. If a

1 Medicare beneficiary is treated in a hospital for a
2 minimum of two-midnights, the hospital stay is
3 deemed “generally reasonable and necessary” as an
4 inpatient stay. However, if a beneficiary is treated
5 for less than two-midnights (short stays), it is not
6 assumed that the inpatient stay is reasonable and
7 necessary.

8 (12) On October 1, 2013, CMS placed a mora-
9 torium on RAC audits on most hospital shorts stays
10 related to medical necessity. With the passage of
11 Public Law 113–93, the Protecting Access to Medi-
12 care Act of 2014, Congress further codified the RAC
13 audit moratorium through March 31, 2015, in order
14 to provide more time to find a solution to these
15 issues.

16 (13) The Medicare Payment Advisory Commis-
17 sion (MedPAC) has found that observation cases
18 (those with a combination of inpatient status and
19 observation status) increased nearly 60 percent from
20 2009 to 2012—the period just prior to the imple-
21 mentation by CMS of the two-midnights standard.
22 Some policy experts have connected the increase in
23 observation stays to the unintended consequence of
24 hospitals attempting to avert RAC audits.

1 (14) To address all of these complex issues,
2 Representative Jim Gerlach introduced H.R. 3698 in
3 the 113th Congress.

4 (b) ESTABLISHMENT OF NEW HOSPITAL PROSPECTIVE
5 PAYMENT SYSTEM (HPPS).—Section 1886 of the
6 Social Security Act (42 U.S.C. 1395ww) is amended by
7 adding at the end the following new subsection:

8 “(t) ESTABLISHMENT OF SITE NEUTRAL HOSPITAL
9 PROSPECTIVE PAYMENT SYSTEM (HPPS).—

10 “(1) IN GENERAL.—The Secretary shall estab-
11 lish under this subsection a new hospital payment
12 system (in this subsection referred to as the ‘HPPS
13 system’) for payment for hospital short-term stays
14 for discharges (as defined in paragraph (10)) occur-
15 ring on or after October 1, 2019. Such system shall
16 be in place of the payment methods under subsection
17 (d) and section 1833(t) for such discharges from
18 subsection (d) hospitals. ’

19 “(2) ESTABLISHMENT OF BASE RATE.—

20 “(A) IN GENERAL.—In implementing the
21 HPPS system for discharges in fiscal year
22 2020, the Secretary shall establish by rule a
23 base payment rate (in this subsection referred
24 to as the ‘base payment rate’) for hospital

1 short-term stays, including payments for such
2 stays in subsection (d) Puerto Rico hospitals.

3 “(B) BLEND.—

4 “(i) IN GENERAL.—In computing the
5 base payment rate, the Secretary shall uti-
6 lize the payment rates established under
7 subsection (u)(2)(B), which reflect—

8 “(I) a blend of the base operating
9 DRG payment amount used in sub-
10 section (o)(7)(D) and an equivalent
11 base operating APC payment amount
12 that would apply under section
13 1833(t) with respect to overnight hos-
14 pital outpatient services; and

15 “(II) the data collected under
16 subsection (u)(4)(A).

17 “(ii) PROPORTIONALITY FOR BLEND-
18 ED PAYMENT AMOUNTS.—In implementing
19 clause (i), the Secretary shall apply an ap-
20 propriate proportionality for the payment
21 amounts described in such clause.

22 “(C) TREATMENT OF IME AND DSH.—

23 “(i) INCLUSION OF IME AND DSH IN
24 AGGREGATE.—In computing the base pay-
25 ment rate the Secretary shall take into ac-

1 count, in an aggregate manner and using
2 the most recent data available, the aggregate
3 payment adjustments under subparagraphs
4 (B) and (F) of subsection (d)(5)
5 that are attributable to inpatient short-
6 term hospital stays (and, with respect to
7 such subparagraph (F), paid directly with
8 respect to individual discharges).

9 “(ii) NO SEPARATE PAYMENT ADJUST-
10 MENT.—The Secretary shall not adjust or
11 vary the payment rate for short-term hos-
12 pital stays based on indirect medical teach-
13 ing expenses or disproportionate share hos-
14 pital payment adjustments (of the type
15 provided under subparagraphs (B) and (F)
16 of subsection (d)(5)).

17 “(D) EXCLUSION OF HOSPITAL SPECIFIC
18 RATES.—In computing the base payment rate
19 the Secretary shall not include any hospital spe-
20 cific rates nor any rates paid for subsection (d)
21 Puerto Rico hospitals under subsection (d)(9).
22 Such base rate shall supersede the payment
23 rates otherwise established under paragraphs
24 (5)(D) and (9) of subsection (d) for sole com-
25 munity hospitals, small rural hospitals, and

1 subsection (d) Puerto Rico hospitals, as well as
2 any payment rate otherwise established for sub-
3 section (d) hospitals which are medicare-de-
4 pendent, small rural hospitals as defined in
5 clause (iv) of subsection (d)(5)(G) (such as the
6 payment rate described in such subsection, even
7 if otherwise applicable).

8 “(E) NO SEPARATE LOW-VOLUME PAY-
9 MENT ADJUSTMENT.—The Secretary shall not
10 adjust or vary the payment rate for short-term
11 hospital stays based on low-volume hospital
12 payment adjustments (of the type provided
13 under subsection (d)(12)).

14 “(3) ESTABLISHMENT OF WEIGHT SYSTEM FOR
15 DIFFERENT SERVICES.—The Secretary shall estab-
16 lish for discharges for short-term hospital stays an
17 appropriate weight system which reflects the relative
18 hospital resources used with respect to discharges
19 classified within that group compared to discharges
20 classified within other groups and which may be
21 based upon the weight system established under sub-
22 section (d)(4). Such weighting factors shall be re-
23 viewed and revised on an annual or other periodic
24 basis as specified by the Secretary.

1 “(4) APPLICATION OF AREA WAGE ADJUST-
2 MENT.—

3 “(A) IN GENERAL.—The Secretary shall
4 apply a geographic area wage adjustment to
5 discharges for short-term hospital stays that
6 utilizes the area wage index described in sub-
7 paragraph (B).

8 “(B) GEOGRAPHIC AREA WAGE ADJUST-
9 MENT DESCRIBED.—

10 “(i) IN GENERAL.—Subject to clause
11 (ii), a hospital’s geographic area wage
12 index described in this subparagraph is a
13 wage index that is calculated based on the
14 surveys of pay localities for the Employ-
15 ment Cost Index (wages and salaries, pri-
16 vate industry workers) published quarterly
17 by the Bureau of Labor Statistics. In cal-
18 culating an index described in the pre-
19 ceding sentence, the Secretary may not
20 apply to a hospital any wage index floor.

21 “(ii) EXCEPTION.—In no case may a
22 geographic area wage index utilized under
23 this paragraph for a hospital for any one
24 fiscal year result in a change in the wage
25 index for such hospital in an amount that

1 is greater than 10 percent (as compared to
2 the wage index utilized under this para-
3 graph or under section 1886(d), as appli-
4 cable, for such hospital for the prior fiscal
5 year). For purposes of the preceding sen-
6 tence, the term ‘change in the wage index’
7 includes both increases and decreases in
8 such wage index.

9 “(C) PROHIBITION ON RECLASSIFICA-
10 TION.—In the case that a hospital is treated as
11 within a pay locality for purposes of the Em-
12 ployment Cost Index described in clause (i), the
13 Secretary may not treat the hospital as though
14 it were within a different pay locality for pur-
15 poses of this paragraph.

16 “(D) PUBLICATION.—Not later than Octo-
17 ber 1, 2018, the Secretary shall make publicly
18 available on the Internet website of the Centers
19 for Medicare & Medicaid Services an estimate
20 of the geographic area wage adjustment that
21 will apply in 2020 to each hospital to which the
22 new payment system under this subsection will
23 apply.

24 “(5) ANNUAL UPDATING BY A MARKET BASKET
25 INCREASE FACTOR.—

1 “(A) IN GENERAL.—The base payment
2 rate shall be updated for each fiscal year (be-
3 ginning in fiscal year 2021) by a market basket
4 increase factor specified by the Secretary
5 that—

6 “(i) is based on the market basket
7 percentage increase applicable under sub-
8 section (b)(3)(B)(iii), the OPD fee sched-
9 ule increase factor under section
10 1833(t)(3)(C)(iv), or otherwise; and

11 “(ii) takes into account the same ad-
12 justments that are applicable to such other
13 increase factors, such as those relating to
14 productivity adjustment.

15 “(B) HOSPITAL-SPECIFIC ADJUST-
16 MENTS.—Such increase factor shall also be sub-
17 ject to adjustment, for individual hospitals,
18 based on the same adjustments that are applied
19 to the market basket percentage increase appli-
20 cable under subsection (b)(3)(B)(iii) or section
21 1833(t)(3)(C), including—

22 “(i) the adjustment for hospital re-
23 porting under subsection (b)(3)(B)(viii),
24 subsection (j)(7), and section 1833(t); and

1 “(ii) the adjustment for meaningful
2 use of electronic health records under sub-
3 section (b)(3)(B)(ix).

4 “(6) APPLICATION OF HOSPITAL-SPECIFIC PAY-
5 MENT ADJUSTMENTS.—

6 “(A) IN GENERAL.—The payment adjust-
7 ments described in subparagraph (B) shall
8 apply to payment for short-term hospital stays
9 under this subsection in the same manner as
10 they apply to payment under subsection (d).

11 “(B) PAYMENT ADJUSTMENTS DE-
12 SCRIBED.—The payment adjustments described
13 in this subparagraph are the following:

14 “(i) Payment adjustment under the
15 hospital value-based purchasing program
16 under subsection (o).

17 “(ii) Payment adjustment for hospital
18 acquired conditions under subsection (p).

19 “(iii) Payment adjustment under the
20 hospital readmission reduction program
21 under subsection (q).

22 “(iv) Such other hospital-specific pay-
23 ment adjustments as are made to payment
24 under subsection (d) and section 1833(t)
25 as the Secretary may specify.

1 “(7) OFFSETS.—

2 “(A) OFFSET FROM IPPS PAYMENTS.—For
3 fiscal year 2020, the Secretary shall reduce
4 each of the standardized amounts otherwise
5 computed under subsection (d)(3)(A) by such
6 percentage as represents the Secretary’s esti-
7 mate (represented as a percentage) of payments
8 under this subsection for short-term hospital
9 stays in that fiscal year to total payments
10 under subsection (d) for discharges in that fis-
11 cal year.

12 “(B) OFFSET FROM OPSS PAYMENTS.—
13 For 2020, the Secretary shall reduce each of
14 the standardized amounts otherwise computed
15 under section 1833(t) by such percentage as
16 represents the Secretary’s estimate (represented
17 as a percentage) of payments under this sub-
18 section for overnight outpatient observation
19 stays in that year to total payments under sec-
20 tion 1833(t) for discharges in that year.

21 “(8) TREATMENT OF OUTPATIENT OBSERVA-
22 TION STAYS AS INPATIENT HOSPITAL SERVICES
23 UNDER PART A.—

24 “(A) IN GENERAL.—Notwithstanding any
25 other provision of law, outpatient hospital de-

1 partment services for which payment is made
2 under this subsection shall be treated as the
3 provision of inpatient hospital services for pur-
4 poses of the following:

5 “(i) HI PAYMENT.—Payment from
6 the Federal Hospital Insurance Trust
7 Fund (under section 1817) instead of
8 under the Federal Supplementary Medical
9 Insurance Trust Fund (under section
10 1841), including for purposes of computing
11 premiums under sections 1818(d) and
12 1839.

13 “(ii) APPLICATION OF PART A DE-
14 DUCTIBLE AND COST-SHARING.—Applica-
15 tion of deductibles and coinsurance under
16 section 1813 instead of under section
17 1833, including with respect to medicare
18 supplemental policies under section 1882
19 and medicare cost-sharing under title XIX,
20 but not for purposes of applying a limita-
21 tion on days of coverage of inpatient hos-
22 pital services under section 1812.

23 “(iii) APPLICATION OF POST-HOS-
24 PITAL PROVISIONS.—Application of spell of
25 illness (under section 1861(a)) with respect

1 to post-hospital extended care services
2 (under section 1861(i)).

3 “(B) CONSTRUCTION FOR OTHER OUT-
4 PATIENT HOSPITAL SERVICES.—Nothing in
5 subparagraph (A) shall be construed to affect
6 the payment or treatment under this title of
7 hospital outpatient department services that are
8 not short-term hospital stays.

9 “(9) LIMITATION.—There shall be no adminis-
10 trative or judicial review under section 1878 or oth-
11 erwise of determinations in carrying out this sub-
12 section.

13 “(10) DEFINITIONS.—In this subsection and
14 subsection (u):

15 “(A) SHORT-TERM HOSPITAL STAY.—The
16 term ‘short-term hospital stay’ means—

17 “(i) an inpatient short-term hospital
18 discharge (as defined in subparagraph
19 (B)); or

20 “(ii) overnight hospital outpatient
21 services (as defined in subparagraph (C)).

22 “(B) INPATIENT SHORT-TERM HOSPITAL
23 DISCHARGE.—

24 “(i) IN GENERAL.—Subject to clauses
25 (iii) and (iv), the term ‘inpatient short-

1 term hospital discharge’ means a discharge
2 from a subsection (d) hospital that—

3 “(I) subject to clause (ii), has ac-
4 tual length of less than 3 days;

5 “(II) is classified to an MS-DRG
6 that subject to clause (ii), has a na-
7 tional average length of stay that,
8 based on the most recent data avail-
9 able as of the date of the enactment
10 of this subsection, is less than 3 days;
11 and

12 “(III) is classified to an MS-
13 DRG that is among the most highly
14 ranked of such discharges (such as
15 within the highest 50) among diag-
16 nosis-related groups for which pay-
17 ment under this section has been de-
18 nied for reasons of medical necessity
19 by recovery audit contractors.

20 “(ii) ADJUSTMENT IN LENGTH OF
21 STAY THRESHOLD.—The Secretary may,
22 by regulation, increase the duration of the
23 length of stay under subclauses (I) and
24 (II) of clause (i) .

1 “(iii) EXPANSION AUTHORITY.—Be-
2 ginning with fiscal year 2017, the Sec-
3 retary by regulation may expand those dis-
4 charges from subsection (d) hospitals that
5 are inpatient short-term hospital short-
6 term discharges for purposes of this sub-
7 section.

8 “(iv) TEMPORARY EXCLUSION OF
9 MEDICARE DEPENDENT HOSPITALS AND
10 SOLE COMMUNITY HOSPITALS.—The term
11 ‘inpatient short-term hospital discharge’
12 does not include, for fiscal years 2016
13 through 2019, a discharge from a medi-
14 care-dependent, small rural hospital (as de-
15 fined in subsection (d)(5)(G)) or from a
16 sole community hospital.

17 “(C) OVERNIGHT OUTPATIENT HOSPITAL
18 SERVICES.—The term ‘overnight outpatient
19 hospital services’ means hospital outpatient
20 services in a subsection (d) hospital with an ob-
21 servation stay of more than 24 hours.

22 “(11) UNIFIED HOSPITAL PAYMENT SYSTEM
23 STUDY.—No later than June 1, 2021, the Medicare
24 Payment Advisory Commission shall submit a report
25 to Congress on a prototype design to further blend

1 payments for outpatient and inpatient hospital serv-
2 ices under sections 1833(t) and 1886(d) of the So-
3 cial Security Act in order to transition to one unified
4 hospital prospective payment system.”.

5 (c) SPECIAL TRANSITIONAL RULES FOR SHORT-
6 TERM HOSPITAL STAYS; DEVELOPMENT OF HOSPITAL
7 PAYMENT CODE CROSSWALKS.—Section 1886 of the So-
8 cial Security Act is further amended by adding at the end
9 the following new subsection:

10 “(u) SPECIAL TRANSITIONAL RULES FOR SHORT-
11 TERM HOSPITAL STAYS; DEVELOPMENT OF INPATIENT-
12 TO-OUTPATIENT CROSSWALK.—

13 “(1) ALTERNATIVE PAYMENT RATE FOR INPA-
14 TIENT SHORT-TERM HOSPITAL STAYS.—In the case
15 of inpatient short-term hospital discharges (as de-
16 fined in subsection (t)(10)(B)) occurring in a fiscal
17 year (beginning with fiscal year 2016 and ending
18 with fiscal year 2019), the payment rate under this
19 section shall be, instead of the payment rate under
20 subsection (d), the payment rate specified by the
21 Secretary under paragraph (2) for that fiscal year.

22 “(2) PAYMENT RATE FOR INPATIENT SHORT-
23 TERM HOSPITAL DISCHARGES BASED ON INPATIENT
24 SHORT-TERM PAYMENT POOL FOR FISCAL YEARS
25 2016 THROUGH 2019.—

1 “(A) INPATIENT SHORT-TERM PAYMENT
2 POOL.—

3 “(i) ESTABLISHMENT.—The Secretary
4 shall establish by regulation an inpatient
5 short-term payment pool (in this sub-
6 section referred to as an ‘inpatient short-
7 term payment pool’) for inpatient short-
8 term hospital discharges in a fiscal year
9 (beginning with fiscal year 2016 and end-
10 ing with fiscal year 2019).

11 “(ii) INITIAL AMOUNT IN THE
12 POOL.—The amount in the inpatient short-
13 term payment pool for fiscal year 2016 is
14 an amount equal to not less than **[X]** and
15 not greater than **[Y]** percent of the pay-
16 ments made under subsection (d) for all
17 discharges in fiscal year 2014. Such per-
18 cent is set in a manner so as to result in
19 a reduction in payments under this section
20 equivalent to **[Z]** percent. .

21 “(iii) AMOUNT IN POOL IN SUBSE-
22 QUENT YEARS.—With respect to each of
23 fiscal years 2017 through 2019, the
24 amount in the inpatient short-term pay-
25 ment pool for such fiscal year is an

1 amount equal to not less than **[X]** and
2 not greater than **[Y]** percent of the pay-
3 ments made under subsection (d) for all
4 discharges in the fiscal year that is two
5 years prior to such fiscal year. Such per-
6 cent is set in a manner so as to result in
7 a reduction in payments under this section
8 equivalent to **[Z]** percent.

9 “(B) PAYMENT RATES.—

10 “(i) IN GENERAL.—For each fiscal
11 year to which subparagraph (A) applies the
12 Secretary shall compute an inpatient short-
13 term adjustment factor to the base oper-
14 ating DRG payment amount (as defined in
15 clause (ii)) that would otherwise apply with
16 respect to inpatient short-term hospital
17 discharges occurring in such fiscal year.
18 Such factor shall be computed in a manner
19 so that the total of the payments under
20 this subsection is estimated to equal the
21 inpatient short-term payment pool amount
22 under subparagraph (A) for such fiscal
23 year. Insofar as the Secretary determines
24 that the aggregate amount of such pay-
25 ments with respect to discharges in a fiscal

1 year is less or greater than the inpatient
2 short-term payment pool for such fiscal
3 year, the Secretary shall decrease or in-
4 crease, respectively, the amount in such
5 payment pool for the succeeding fiscal year
6 by the amount of such excess or deficit, re-
7 spectively.

8 “(ii) BASE OPERATING DRG PAYMENT
9 AMOUNT.—In this paragraph, the term
10 ‘base operating DRG payment amount’
11 means the base operating DRG payment
12 amount (as defined in subsection
13 (o)(7)(D)). Nothing in this subparagraph
14 shall be construed as interfering with the
15 aggregate payment adjustments under sub-
16 paragraphs (B) and (F) of subsection
17 (d)(5) that are attributable to inpatient
18 short-term hospital stays (and, with re-
19 spect to such subparagraph (F), paid di-
20 rectly with respect to individual dis-
21 charges).

22 “(3) NO IMPACT ON DGME PAYMENTS.—Noth-
23 ing in this subsection shall be construed as affecting
24 the payment to hospitals under subsection (h) and

1 the amount of payment under such subsection shall
2 be computed as if this subsection did not apply.

3 “(4) DUAL SUBMISSION OF CLAIMS; CROSS-
4 WALK OF ICD–10 CODES, CPT CODES, AND HCPCS;
5 CROSSWALK OF DRGS AND APCS.—

6 “(A) DUAL SUBMISSION OF CLAIMS FOR
7 INPATIENT SHORT-TERM HOSPITAL DIS-
8 CHARGES AND OVERNIGHT OUTPATIENT HOS-
9 PITAL SERVICES DURING 2016.—

10 “(i) IN GENERAL.—For short-term
11 hospital stays in a subsection (d) hospital
12 occurring during fiscal year 2016, the hos-
13 pital shall submit information necessary to
14 process a claim for such a stay as an inpa-
15 tient hospital discharge under subsection
16 (d) and as hospital outpatient hospital
17 services under section 1833(t).

18 “(ii) AUDITING BY RACS; PAYMENT
19 REDUCTION FOR FAILURE TO SUBMIT IN-
20 FORMATION.—Recovery audit contractors
21 may audit discharges and services de-
22 scribed in clause (i) for the sole purpose of
23 ensuring claims are submitted in accord-
24 ance with such clause. If a recovery audit
25 contractor determines that information is

1 not submitted for a such discharge or serv-
2 ices in accordance with such clause—

3 “(I) payment for the discharge or
4 services shall be reduced by 10 per-
5 cent; and

6 “(II) the contractor shall be
7 awarded the amount of such reduc-
8 tion.

9 “(iii) NO CHANGE IN PAYMENT RATES
10 AS A RESULT OF DUAL SUBMISSION RE-
11 QUIREMENT.—Nothing in this subpara-
12 graph (other than clause (ii)) shall be con-
13 strued as changing the payment rate for
14 inpatient hospital services. All hospital out-
15 patient services described in clause (i) for
16 which claims are submitted in accordance
17 with such clause shall be reimbursed in the
18 amount of zero dollars.

19 “(B) ICD10–TO–CPT–TO–HCPCS CROSS-
20 WALK.—

21 “(i) IN GENERAL.—Not later than Oc-
22 tober 1, 2015 (or October 1, 2017, in the
23 case of other than short-term hospital
24 stays), the Secretary shall develop general
25 equivalency maps (referred to in this sub-

1 section as ‘crosswalks’) to link the relevant
2 ICD–10 inpatient codes to relevant CPT
3 and HCPCS outpatient codes, and vice
4 versa, in order to permit comparisons of
5 inpatient hospital services, for which pay-
6 ment is made under subsection (d) and
7 hospital outpatient department services,
8 for which payment is made under section
9 1833(t).

10 “(ii) CONSULTATION REQUIRED.—In
11 developing under clause (i) the general
12 equivalency maps described in such clause,
13 the Secretary shall consult with the Medi-
14 care Payment Advisory Commission and
15 the Inspector General of the Department
16 of Health and Human Services.

17 “(iii) CODE TERMINOLOGY.— In this
18 subparagraph, the terms ‘ICD–10 codes’
19 and ‘CPT and HCPCS codes’ include pro-
20 cedure as well as diagnostic codes.

21 “(iv) DEVELOPMENT THROUGH NO-
22 TICE AND COMMENT RULEMAKING.—In
23 carrying out clause (i) and in accordance
24 with this subparagraph, the Secretary shall
25 develop a proposed ICD10–to–CPT–to–

1 HCPCS crosswalk which shall be made
2 available for public comment for a period
3 of not less than 60 days.

4 “(v) USE OF THE ICD COORDINATION
5 AND MAINTENANCE COMMITTEE.—The
6 Secretary also shall instruct the ICD–9
7 Coordination and Maintenance Committee
8 to convene a meeting to receive input from
9 the public regarding the proposed ICD10–
10 to–CPT–to–HCPCS crosswalk.

11 “(vi) PUBLICATION OF FINAL CROSS-
12 WALK.—Taking into consideration com-
13 ments received on the proposed crosswalk,
14 the Secretary shall publish a final ICD10–
15 to–CPT–to–HCPCS crosswalk under
16 clause (i) and shall post such crosswalk on
17 the Internet Website of the Centers for
18 Medicare & Medicaid Services.

19 “(vii) UPDATING.—The Secretary
20 shall update such crosswalk on an annual
21 basis.

22 “(C) DRG–TO–APC CROSSWALK.—

23 “(i) IN GENERAL.—Not later than 1
24 year after the date the Secretary develops
25 the crosswalks under subparagraph (B),

1 the Secretary shall, using the ICD10-to-
2 CPT-to-HCPCS crosswalks so developed,
3 develop crosswalks between diagnosis-re-
4 lated group (DRG) codes for inpatient hos-
5 pital services and Ambulatory Payment
6 Class (APC) codes for outpatient hospital
7 services.

8 “(ii) APPLICATION OF SAME PROC-
9 ESSES.—The provisions of clauses (iv)
10 through (vii) of subparagraph (B) shall
11 apply to the development of the crosswalks
12 under clause (i) in the same manner as
13 they apply to the development of the cross-
14 walks under subparagraph (B)(i).”.

15 (d) CONTINUATION OF CERTAIN MEDICAL REVIEW
16 ACTIVITIES.—

17 (1) 6-MONTH EXTENSION OF RAC AUDIT MORA-
18 TORIUM.—Section 111 of the Protecting Access to
19 Medicare Act of 2014 (Public Law 113–93; 42
20 U.S.C. 1395ddd note) is amended—

21 (A) in subsection (a), by striking “through
22 the first 6 months of fiscal year 2015” and in-
23 serting “through fiscal year 2015”; and

1 (B) in subsection (b), by striking “through
2 March 31, 2015” and inserting “through Sep-
3 tember 30, 2015”.

4 (2) FURTHER EXTENSION OF MORATORIUM TO
5 INPATIENT SHORT-TERM HOSPITAL DISCHARGES
6 THROUGH TRANSITION.—The Secretary of Health
7 and Human Services shall not permit recovery audit
8 contractors under section 1893(h) of the Social Se-
9 curity Act (42 U.S.C. 1395ddd(h)) to conduct audits
10 with respect to inpatient short-term hospital dis-
11 charges (as defined in paragraph (2) of section
12 1886(t) of such Act, as added by subsection (a)) oc-
13 ccurring during fiscal years 2016 through 2019 ex-
14 cept as required under paragraph (3)(C)(ii) of such
15 section.

16 (e) FUNDING.—For purposes of carrying out this sec-
17 tion and section 102 (including the amendments made by
18 such sections), the Secretary of Health and Human Serv-
19 ices shall provide for the transfer to the Centers for Medi-
20 care & Medicaid Services Program Management Account,
21 from the Federal Hospital Insurance Trust Fund under
22 section 1817 of the Social Security Act (42 U.S.C. 1395i)
23 and the Federal Supplementary Medical Insurance Trust
24 Fund under section 1841 of such Act (42 U.S.C. 1395t),
25 in such proportion as the Secretary determines appro-

1 priate in order to directly hire no more than 4 full time
2 employees to carry out the administration of this section.

3 **SEC. 102. PER DIEM PAYMENT RATE FOR SHORT LENGTHS**
4 **OF STAY.**

5 Section 1886(d) of the Social Security Act is amend-
6 ed by adding at the end the following new paragraph:

7 “(14) PER DIEM PAYMENT SYSTEM FOR UN-
8 USUALLY SHORT LENGTH OF STAY (LOS) DIS-
9 CHARGES.—

10 “(A) IN GENERAL.—Not later October 1,
11 2015, the Secretary shall establish a short LOS
12 policy with respect to payment for unusually
13 short LOS discharges (as defined in subpara-
14 graph (D)) in the amount determined under
15 this paragraph. Such payment shall be instead
16 of the payment that would otherwise have been
17 made for such discharge under this subsection.

18 “(B) PER DIEM RATE DETERMINATION.—
19 Under the short LOS policy under this para-
20 graph the payment rate for a short LOS dis-
21 charge classified within a diagnosis-related
22 group shall be computed as follows:

23 “(i) The Secretary shall first compute
24 for each fiscal year 80 percent of the appli-
25 cable payment rate otherwise applicable

1 with respect to discharges so classified, be-
2 fore the application of any payment adjust-
3 ments and without regard to this para-
4 graph. The Secretary shall compute such
5 rate based upon data available for the
6 most recent fiscal year.

7 “(ii) Based upon the amount com-
8 puted under clause (i) for discharges so
9 classified, the Secretary shall compute a
10 per diem payment rate.

11 “(iii) The Secretary shall, after the
12 application of clause (ii), adjust the per
13 diem rate so computed, in a budget neutral
14 manner, so that the per diem payment rate
15 for the first 2 days in any discharge is
16 greater than the payment rate for subse-
17 quent days.

18 “(iv) The payment rate for the spe-
19 cific discharge involved shall be based on
20 the per diem rate for the days involved in
21 such discharge and then shall be subject to
22 an area wage adjustment, an adjustment
23 for indirect medical education costs, an ad-
24 justment for disproportionate share hos-
25 pitals, and similar adjustments in the same

1 manner as such adjustments would other-
2 wise apply to a payment rate under sub-
3 section (d).

4 “(C) CONSIDERATION.—In carrying out
5 subparagraph (B), the Secretary may take into
6 account the model for payment for post-acute
7 care discharge transfers applied under subpara-
8 graph (I) or (J) of subsection (d)(5).

9 “(D) UNUSUALLY SHORT LOS DISCHARGE
10 DEFINED.—In this paragraph, the term ‘unusu-
11 ally short LOS discharge’ means, with respect
12 to a discharge that is classified within a diag-
13 nosis-related group, a discharge from inpatient
14 hospital services from a subsection (d) hospital
15 if—

16 “(i) the discharge is not an inpatient
17 short-term hospital discharge (as defined
18 in subsection (t)(10)); and

19 “(ii) the length of stay for the dis-
20 charge is significantly shorter (as deter-
21 mined by the Secretary using a metric
22 such as standard deviation) from the me-
23 dian length of stay for discharges classified
24 within such group.”.

1 **SEC. 103. REPEAL OF THE TWO MIDNIGHTS PAYMENT RE-**
2 **DUCTION.**

3 (a) FINDINGS ON THE CMS TWO-MIDNIGHT PAY-
4 MENT REDUCTION.—Congress finds the following:

5 (1) In the fiscal year 2014 IPPS final rule,
6 CMS implemented a budget-neutral payment reduc-
7 tion under the presumption that physicians would
8 admit more patients as inpatients due to the new
9 two-midnights standard. CMS reduced the IPPS
10 baseline by 0.2 percent—a \$220 million cut for
11 2014.

12 (2) Many researchers have modeled the impact
13 of the two-midnights policy and have found that the
14 assumption by CMS may be in error.

15 (b) IN GENERAL.—The Secretary of Health and
16 Human Services shall implement the rule for the Medicare
17 program hospital inpatient prospective payment systems
18 for fiscal year 2014 (promulgated on August 19, 2013,
19 78 Federal Register 50746 through 50977) as if the 0.2
20 percent reduction to the operating IPPS standardized
21 amount, the hospital-specific rates, the Puerto Rico-spe-
22 cific standardized amounts, the national capital Federal
23 rate, and Puerto Rico-specific capital rate, as described
24 in such rule, were not included in the final rule.

25 (c) APPLICATION.—Subsection (b) shall not affect
26 payment made for items and services furnished before Oc-

1 tober 1, 2015. The Secretary shall further adjust the pay-
2 ment rates under the hospital inpatient prospective pay-
3 ment systems under section 1886 of the Social Security
4 Act (42 U.S.C. 1395ww) for fiscal year 2016 in such a
5 manner to increase payment rates under such systems for
6 such fiscal year by the amount by which—

7 (1) the payment rates that would have been ap-
8 plied under such systems for fiscal year 2014 if sub-
9 section (b) had applied with respect to items and
10 services furnished during such fiscal year 2014, ex-
11 ceeds

12 (2) the payment rates actually applied under
13 such systems for such fiscal year 2014 without ap-
14 plication of subsection (b) (and taking into account
15 the 0.2 percent reduction described in such sub-
16 section).

17 **Subtitle B—Audits**

18 **SEC. 104. MONITORING PERFORMANCE OF THE RECOVERY**

19 **AUDIT CONTRACTOR (RAC) PROGRAM.**

20 (a) FINDINGS ON THE LACK OF PUBLIC AVAIL-
21 ABILITY OF STATISTICS REGARDING THE RECOVERY
22 AUDIT PROGRAM.—Congress finds the following:

23 (1) The Subcommittee on Health of the Com-
24 mittee on Ways and Means of the House of Rep-
25 resentatives held a hearing on May 20, 2014, that

1 examined a number issues that have surrounded the
2 relationship between Recovery Audit Contractors,
3 the Medicare appeals process, and Medicare pro-
4 viders.

5 (2) Witnesses testifying at the hearing offered
6 mixed messages about the statistics surrounding the
7 amount of audits versus successful appeals.

8 (3) These witnesses used different methodolo-
9 gies from which to derive the statistics to best sup-
10 port their respective points of view.

11 (4) There is a need for a consistent, objective
12 source of publicly available statistics on the RAC
13 program in order to evaluate and improve that pro-
14 gram for all involved.

15 (b) ESTABLISHMENT OF A RECOVERY AUDIT CON-
16 TRACTOR (RAC) COMPARE WEBSITE.—Section 1893 of
17 the Social Security Act (42 U.S.C. 1395ddd) is amended
18 by adding at the end the following new subsection:

19 “(j) RAC COMPARE WEBSITE.—

20 “(1) IN GENERAL.—No later than October 1,
21 2015, the Secretary shall establish a RAC Compare
22 Website (in this subsection referred to as the ‘RAC
23 website’).

1 “(2) CONTENT.—The Secretary shall publicly
2 report on the RAC website at least the following in-
3 formation for each RAC contractor:

4 “(A) The total number of claims processed,
5 for each CMS payment system (as defined in
6 paragraph (3)), in each fiscal year for each
7 RAC region.

8 “(B) Of such total number of claims for
9 each payment system in each RAC region in a
10 fiscal year—

11 “(i) the total number paid;

12 “(ii) the number denied (within the
13 meaning of paragraph (4)) by the recovery
14 audit contractor; and

15 “(iii) the total number of denied
16 claims overturned on appeal by an admin-
17 istrative law judge or the departmental ap-
18 peals board.

19 In carrying out this paragraph, the Secretary
20 shall determine how to report the information
21 described in such paragraph in a meaningful
22 manner. In carrying out clause (iii), the Sec-
23 retary shall recognize that denied claims often
24 are overturned on appeal in years after the year
25 in which such claims are initially submitted.

1 “(3) CMS PAYMENT SYSTEM DEFINED.—In
2 this subsection, the term ‘CMS payment system’
3 means each of the following payment systems:

4 “(A) INPATIENT HOSPITAL SERVICES.—In-
5 patient hospital payment systems under each of
6 the following:

7 “(i) IPPS.—Section 1886(d).

8 “(ii) CAH.—Section 1814(l).

9 “(iii) PPS-EXEMPT.—Section
10 1886(b).

11 “(iv) PUERTO RICO HOSPITALS.—
12 Section 1886(d)(9).

13 “(B) OUTPATIENT HOSPITAL SERVICES.—
14 Outpatient hospital payment systems under
15 each of the following:

16 “(i) IN GENERAL.—Section 1833(t).

17 “(ii) CAH.—Section 1834(g).

18 “(C) PFS.—The physician fee schedule
19 under section 1848.

20 “(D) DMEPOS.—Payment systems for
21 durable medical equipment and for prosthetics,
22 orthotics, and supplies treating each as a sepa-
23 rate payment system under each of the fol-
24 lowing:

25 “(i) Section 1834(a).

1 “(ii) Section 1834(h).

2 “(iii) Section 1847.

3 “(E) ESRD.—The payment system for
4 end-stage renal disease services under section
5 1881.

6 “(F) ASC.—The payment system for am-
7 bulatory surgical centers under section 1833(i).

8 “(G) CLINICAL LABORATORIES.—The pay-
9 ment system for clinical diagnostic laboratory
10 services under section 1833(h).

11 “(H) HH.—The payment system for home
12 health services under section 1895.

13 “(I) SNF.—The payment system for
14 skilled nursing facility services under section
15 1888.

16 “(J) IRF.—The payment system for inpa-
17 tient rehabilitation facility services under sec-
18 tion 1886(j).

19 “(K) IPF.—The payment system for inpa-
20 tient psychiatric facility services under section
21 1886(s).

22 “(L) LTCH.—The payment system for
23 long-term care hospitals under section 1886(m).

24 “(M) AMBULANCE.—The payment system
25 for ambulance services under section 1834(l).

1 “(4) CLAIM DENIALS BY RACS.—In this sub-
2 section, a claim shall be treated as denied by a re-
3 covery audit contractor if the claim is fully or par-
4 tially reversed by the contractor, except that those
5 claims that are dismissed or remanded shall not be
6 considered as claim denials.”.

7 **SEC. 105. IMPROVEMENTS TO THE RAC PROGRAM.**

8 (a) MAXIMUM LOOK-BACK PERIOD OF 3 YEARS FOR
9 RAC AUDIT AND RECOVERY ACTIVITIES.—

10 (1) IN GENERAL.—Section 1893(h)(4)(B) of
11 the Social Security Act (42 U.S.C.
12 1395ddd(h)(4)(B)) is amended by striking “4 fiscal
13 years” and inserting “3 fiscal years”.

14 (2) MAXIMUM LOOK-BACK PERIOD.—The
15 amendment made by paragraph (3) shall apply with
16 respect to payments made for items and services fur-
17 nished on or after the date of the enactment of this
18 Act.

19 (b) PERIOD FOR DISCUSSION.—

20 (1) IN GENERAL.—Section 1893(h) of the So-
21 cial Security Act (42 U.S.C. 1395ddd(h)) is amend-
22 ed by adding at the end the following new para-
23 graph:

24 “(10) PERIOD FOR DISCUSSION BEFORE INITI-
25 ATING COLLECTION.—The contract with a recovery

1 audit contractor under this subsection shall provide
2 that if the contractor identifies all or part of a claim
3 for full or partial denial, the contractor must—

4 “(A) allow the provider or supplier a pe-
5 riod of at least 30 days for discussion with the
6 contractor before the contractor transmits the
7 claim to a medicare administrative contractor
8 for adjustment or recoupment; and

9 “(B) confirm with the provider or supplier
10 a request for such discussion within 3 business
11 days of the date of such request.”.

12 (2) EFFECTIVE DATE.—The amendment made
13 by paragraph (1) shall apply as soon as possible
14 after the date of the enactment of this Act to con-
15 tracts entered into before, on, or after such date.

16 (c) LIMITS ON ADRS.—

17 (1) IN GENERAL.—Section 1893(h) of the So-
18 cial Security Act (42 U.S.C. 1395ddd(h)) is further
19 amended by adding at the end the following new
20 paragraph:

21 “(11) LIMITS ON ADDITIONAL DOCUMENTATION
22 REQUESTS (ADRS).—The contract with a recovery
23 audit contractor under this subsection shall include
24 the establishment of limits for additional documenta-
25 tion requests. Such limits shall—

1 “(A) vary by payment system; and

2 “(B) be adjusted in accordance with the
3 denial rate for the provider of services or sup-
4 plier involved so that a provider or supplier
5 with a low denial rate has a lower limit and a
6 provider or supplier with a high denial rate has
7 a higher limit.”.

8 (2) EFFECTIVE DATE.—The amendment made
9 by paragraph shall apply as soon as possible after
10 the date of the enactment of this Act to contracts
11 entered into before, on, or after such date.

12 (d) PREVENTING DUPLICATIVE AUDITS.—

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

16 “(f) PREVENTING DUPLICATIVE AUDITS.—The Sec-
17 retary shall require that all entities with a contract to con-
18 duct pre- and post-payment review of claims under this
19 title submit a record of such review to the recovery audit
20 data warehouse (or successor system) that is managed by
21 the Centers for Medicare & Medicaid Services.”.

22 (2) EFFECTIVE DATE.—The Secretary of
23 Health and Human Services shall modify contracts
24 referred to in section 1874(f) of the Social Security
25 Act, as added by paragraph (1), that are in effect

1 as of the date of the enactment of this Act in order
2 to meet the requirements of such section not later
3 than 1 year after such date of enactment.

4 **Subtitle C—Appeals**

5 **SEC. 106. RETROSPECTIVE HOSPITAL SOLUTIONS TO AD-** 6 **DRESS PROBLEMS IN THE MEDICARE AP-** 7 **PEALS PROCESS.**

8 (a) FINDINGS.—Congress finds the following:

9 (1) At the beginning of 2014, the Administra-
10 tion temporarily suspended the assignment of new
11 requests for Medicare appeals at the Administrative
12 Law Judge level.

13 (2) This has resulted in a backlog of more than
14 800,000 appeals as of the date of this Discussion
15 Draft.

16 (3) On Friday, August 29, 2014, the Centers
17 for Medicare & Medicaid Services established the
18 “Hospital Appeals Settlement for Fee-for-Service
19 Denials Based on Patient Status Reviews for Admis-
20 sion Prior to October 1, 2013”. In this settlement
21 process the Centers failed to—

22 (A) offer hospitals the ability to choose
23 which claims to settle;

24 (B) make interest payments on settled
25 claims;

1 (C) count settled claims at full reimburse-
2 ment levels for purposes of calculating a hos-
3 pital's direct graduate medical education reim-
4 bursement; and

5 (D) consider settlement as the final resolu-
6 tion of the claim.

7 (4) On September 15, 2014, Representative
8 Brady, as chairman of the Subcommittee on Health
9 of the Committee on Ways and Means, sent a letter
10 to Secretary Burwell questioning—

11 (A) the Centers' statutory authority to
12 enter into settlement with hospitals;

13 (B) the Center's "all or nothing" settlement
14 approach; and

15 (C) the empirical analysis used to justify
16 offering a settlement rate of 68 percent.

17 (5) The Centers has historically denied Medi-
18 care providers the full ability to rebill services ren-
19 dered and, in most instances, the Centers has used
20 a "timely filing requirement" threshold of one year
21 after a service is rendered before rebilling is per-
22 mitted. Representative Adrian Smith has introduced
23 H.R. 2329 in the 113th Congress to afford hospitals
24 the ability to rebill certain services.

1 (b) VOLUNTARY SETTLEMENT PROCESS FOR MED-
2 ICAL MS-DRGs.—Section 1869(b)(1) of the Social Secu-
3 rity Act (42 U.S.C. 1395ff(b)(1)) is amended by adding
4 at the end the following new subparagraph:

5 “(H) VOLUNTARY SETTLEMENT PROCESS
6 FOR MEDICAL MS-DRGs.—

7 “(i) IN GENERAL.—The Secretary
8 shall establish by regulation a voluntary
9 settlement process consistent with this sub-
10 paragraph under which, in the case of a re-
11 quest for a hearing by an administrative
12 law judge relating to a denial of a claim
13 for services occurring beginning on July 1,
14 2007, and ending on September 30, 2013,
15 for payment under section 1886(d) for in-
16 patient hospital services furnished by a
17 subsection (d) hospital and classified as a
18 medical MS–DRG as not being reasonable
19 and necessary, the appellant is provided an
20 opportunity to accept a settlement offered
21 with respect to such claim under terms and
22 conditions, including a settlement rate,
23 specified in the regulation. Such process
24 may be based on the process for hospital
25 appeals settlement for fee-for-service deni-

1 als based on patient status reviews. Under
2 such process a hospital may elect, with re-
3 spect to an individual medical MS-DRG,
4 to use such process or not use such process
5 (and continue an appeal with respect to
6 such MS-DRG).

7 “(ii) INELIGIBLE CLAIMS.—Such
8 process shall not apply to a claim for
9 which—

10 “(I) an appeal has been re-
11 quested with the Departmental Ap-
12 peals Board; or

13 “(II) a request for a hearing be-
14 fore an administrative law judge has
15 not been filed.

16 “(iii) SETTLEMENT RATE CONSIDER-
17 ATIONS.—The Secretary shall establish the
18 settlement rate under such process using
19 an analysis of empirical data and other
20 factors. Such rate shall take into account
21 an appropriate factor to reflect the interest
22 on denied claims for the average amount of
23 time that appeals of such claims have been
24 pending at the administrative law judge

1 level. Such analysis shall consider at
2 least—

3 “(I) the extent to which denied
4 claims for inpatient hospital services
5 involve medical MS-DRGs; and

6 “(II) information maintained by
7 other government agencies, including
8 the Office of the Inspector General of
9 the Department of Health and
10 Human Services and the Medicare
11 Payment Advisory Commission.

12 “(iv) DEADLINE AND CONTENTS OF
13 PROPOSED REGULATION.—The Secretary
14 shall provide for the publication of a pro-
15 posed regulation to carry out this subpara-
16 graph not later than 90 days after the date
17 of the enactment of this subparagraph.
18 Such publication shall include the proposed
19 settlement rate as well as the analysis and
20 factors described in clause (iv).

21 “(v) NOTICE AND OFFER.—

22 “(I) NOTICE OF OFFER.—Not
23 later than 30 days after the date of
24 publication of the final regulation to
25 carry out this subparagraph, the Sec-

1 retary shall provide to the appellant
2 notice of the settlement offer, with in-
3 structions for how to accept the offer.

4 “(II) ACCEPTANCE.—Under such
5 process the appellant shall be provided
6 60 days after the date of such notice
7 to accept the offer.

8 “(III) ACKNOWLEDGMENT OF
9 RECEIPT OF REQUEST TO ACCEPT.—
10 Such process the Secretary shall pro-
11 vide a receipt for such a notice to ac-
12 cept the offer.

13 “(vi) TERMS OF ACCEPTANCE.—
14 Under such process the appellant may ac-
15 cept the offer on an individual discharge
16 basis and acceptance of the offer shall be
17 considered final resolution of the claim
18 such that—

19 “(I) the appellant may not seek
20 further appeal or review of the claim
21 nor seek any other administrative or
22 judicial review of the claim; and

23 “(II) the Secretary may not sub-
24 ject the claim to further audit, includ-
25 ing through the Comprehensive Error

1 Rate Testing program, except in the
2 case of suspected fraud or misrepre-
3 sentation of facts.

4 “(vii) TREATMENT OF SETTLE-
5 MENT.—The Secretary shall treat a settle-
6 ment of a claim for inpatient hospital serv-
7 ices under this subparagraph, as payment
8 of the claim for purposes of applying cost
9 reporting principles, such as in calculating
10 the percentage of expenditures under part
11 A for inpatient hospital services for pur-
12 poses of calculating a hospital’s part A
13 percentage in applying section 1886(h) (re-
14 lating to payment for costs of graduate
15 medical education).

16 “(viii) PROCESS FOR ADJUSTMENT OF
17 RAC CONTINGENCY FEES.—In carrying out
18 the settlement process under this subpara-
19 graph and the process referred to in the
20 last sentence of clause (i), the Secretary
21 shall establish a separate settlement proc-
22 ess for the contingency fees of recovery
23 audit contractors under section 1893(h).
24 Under such process the Secretary shall ad-
25 just the contingency fees of such contrac-

1 tors through an offset against future con-
2 tingency fees, through a requirement that
3 such contractors repay payments associ-
4 ated with a reduced contingency fee based
5 on a reduced settlement reimbursement, or
6 otherwise.”.

7 (c) REBILLING OPTION FOR SURGICAL MS-DRGs.—

8 (1) IN GENERAL.—Subject to paragraph (4),
9 the Secretary of Health and Human Services shall
10 allow, with regard to any rebilling limitation, sub-
11 section (d) hospitals the opportunity to rebill under
12 section 1834(t) of the Social Security Act (42
13 U.S.C. 1395m(t)) for inpatient hospital services
14 classified as surgical MS-DRGs that have been de-
15 nied as not reasonable and necessary and that are
16 pending at the administrative law judge level, for
17 items and services furnished during the period be-
18 ginning on July 1, 2007 and ending on September
19 30, 2013. Such opportunity shall be available to hos-
20 pitals only if the rebilling is submitted not later than
21 6 months after the date of the notice under para-
22 graph (2).

23 (2) NOTICE.—Not later than 60 days after the
24 date of the enactment of this Act, the Secretary
25 shall provide notice to hospitals of the rebilling op-

1 portunity under paragraph (1) and the method for
2 doing such rebilling.

3 (3) NO IMPACT ON RAC CONTINGENCY FEES OR
4 BENEFICIARY COST-SHARING.— With respect to dis-
5 charges that are rebilled under this subsection—

6 (A) any contingency fee initially paid out
7 to recovery audit contractors shall not be sub-
8 ject to adjustment or repayment; and

9 (B) any beneficiary cost-sharing obliga-
10 tions shall not be subject to adjustment.

11 The application of subparagraph (B) shall not result
12 in a hospital obtaining any additional payment that
13 a beneficiary would otherwise be liable to pay.

14 (4) EXCEPTION.—Any hospital that elects to
15 participate in the “Hospitals Appeals Settlement for
16 Fee-for-Service Denials Based on Patient Status Re-
17 views for Admission Prior to October 1, 2013” pro-
18 gram is not eligible for any rebilling of previously
19 denied surgical discharges under paragraph (1) re-
20 garding patient status.

21 **SEC. 107. RETROSPECTIVE NON-HOSPITAL SOLUTIONS TO**
22 **ADDRESS PROBLEMS IN THE MEDICARE AP-**
23 **PEALS PROCESS.**

24 Section 1869(b)(1) of the Social Security Act (42
25 U.S.C. 1395ff(b)(1)), as amended by section 106(b), is

1 further amended by adding at the end the following new
2 subparagraphs:

3 “(I) EXPEDITING DECISIONS ON PART B
4 CLAIMS TO REDUCE ALJ BACKLOG.—Not later
5 than 60 days after the date of the enactment of
6 this subparagraph, the Secretary shall establish
7 (and make publicly available the details of) a
8 voluntary process under which, in the case of a
9 request for a hearing by an administrative law
10 judge filed on or after such date of enactment
11 (or filed before such date of enactment but
12 pending as of such date) with respect to a claim
13 for services under part B, the appellant is pro-
14 vided an opportunity to resolve the claim
15 through extrapolation of the results of a review
16 decision on a statistically valid sample of claims
17 for the same or similar services. Under such
18 process—

19 “(i) the Secretary shall use a statisti-
20 cian or an individual with comparable
21 training in constructing the sample and ex-
22 trapolating the review results;

23 “(ii) in the case of such a request for
24 a hearing filed before such date of enact-
25 ment but pending as of such date—

1 “(I) not later than 90 days after
2 the date of the enactment of this sub-
3 paragraph, the Secretary shall provide
4 notice of the process, with instructions
5 for how to elect the process; and

6 “(II) the appellant is provided 60
7 days from the date of such notice to
8 use such process with respect to such
9 claim;

10 “(iii) in the case of such a request for
11 a hearing filed on or after such date of en-
12 actment, not later than 90 days after the
13 date of the enactment of this subpara-
14 graph, the Secretary shall take such meas-
15 ures as are necessary to ensure that the
16 filing process under this subsection pro-
17 vides for notice of the availability of the
18 process established under this subpara-
19 graph; and

20 “(iv) of all appellants that are eligible
21 to use the process under this subparagraph
22 and that elect to use such process, the Sec-
23 retary shall give priority to appellants with
24 respect to a request for a hearing filed be-

1 fore such date of enactment but pending as
2 of such date.

3 Nothing in clause (iv) shall be construed as af-
4 fecting the priority, with respect to a request
5 otherwise filed for a hearing under this section,
6 of a claim that is not eligible for (and for which
7 the appellant has not elected to use) the process
8 under this subparagraph.

9 “(J) AUTHORIZING VOLUNTARY SETTLE-
10 MENT PROCESS FOR PART B CLAIMS.—

11 “(i) IN GENERAL.—The Secretary
12 may establish a voluntary settlement proc-
13 ess under which, in the case of a request
14 for a hearing by an administrative law
15 judge filed on or before the date of the en-
16 actment of this subparagraph with respect
17 to a claim for items and services under
18 part B, the appellant is provided an oppor-
19 tunity to accept a settlement offered with
20 respect to claims for the same or similar
21 services.

22 “(ii) MODEL.—Such process may be
23 modeled after the voluntary settlement
24 process established under subparagraph
25 (H), except that any deadlines specified

1 under such subparagraph need not apply
2 and the settlement amount shall be based
3 on the extent to which the appeals for
4 claims for the same or similar services fur-
5 nished by the provider of services or sup-
6 plier involved have been determined favor-
7 ably to such provider or supplier.”.

8 **SEC. 108. PROSPECTIVE SOLUTIONS TO ADDRESS PROB-**
9 **LEMS IN THE MEDICARE APPEALS PROCESS.**

10 (a) DATA COLLECTION REQUIREMENTS.—

11 (1) IN GENERAL.—Section 1869(b) of the So-
12 cial Security Act (42 U.S.C. 1395ff(b)) is amended
13 by adding at the end the following new paragraph:

14 “(4) DATA COLLECTION REQUIREMENTS.—The
15 provisions of subsection (c)(3)(I) shall apply, to
16 carry out the purposes of this section, to—

17 “(A) medicare administrative contractors
18 with respect to requests filed for reconsider-
19 ation of claims pursuant to a contract under
20 section 1874A;

21 “(B) administrative law judges with re-
22 spect to requests filed for hearings under this
23 section of determinations made for claims; and

24 “(C) the Departmental Appeals Board of
25 the Department of Health and Human Services

1 with respect to requests for reviews of decisions
2 on hearings filed under this section;
3 in the same manner as such provisions apply with
4 respect to qualified independent contractors to carry
5 out the purposes of this section.”.

6 (2) CONFORMING AMENDMENT.—Section
7 1869(e)(4)(A) of the Social Security Act (42 U.S.C.
8 1395ff(e)(4)(A)) is amended, in the second sentence,
9 by inserting “, medicare administrative contractors,
10 administrative law judges, and the Departmental
11 Appeals Board of the Department of Health and
12 Human Services” after “qualified independent con-
13 tractors”.

14 (b) COMPREHENSIVE ELECTRONIC SYSTEM TO IM-
15 PROVE TRACKING, EFFICIENCY, AND TRANSPARENCY.—
16 Section 1869 of the Social Security Act (42 U.S.C.
17 1395ff) is amended by adding at the end the following
18 new subsection:

19 “(j) COMPREHENSIVE ELECTRONIC SYSTEM FOR
20 MANAGING APPEALS.—

21 “(1) IN GENERAL.—Not later than July 1,
22 2015, the Secretary shall implement an electronic
23 system for managing appeals of determinations pro-
24 vided for under this section. Such system shall—

1 “(A) contain basic information (such as
2 the payment system under this title and total
3 allowed charges) on each claim for which an ap-
4 peal has been filed under this section, with re-
5 spect to each level of appeal;

6 “(B) enable information to be extracted
7 from the claims processing system for each pay-
8 ment system, with respect to claims that are
9 subject to such appeals;

10 “(C) enable the appellant involved to sub-
11 mit clinical documentation and other informa-
12 tion in support of the appeal involved directly to
13 the applicable contractor;

14 “(D) contain information in support of the
15 effort to uphold the decision the appellant seeks
16 to overturn and enable the Secretary (and rel-
17 evant contractors) to share information for the
18 claim through subsequent levels of appeal; and

19 “(E) contain information and other fea-
20 tures that the Secretary determines appro-
21 priate.

22 “(2) AVAILABILITY OF INFORMATION.—For
23 purposes of carrying out this subsection, each appli-
24 cable contractor under this section shall make avail-
25 able to the Secretary such information as needed by

1 the Secretary to establish and maintain the elec-
2 tronic system under paragraph (1).”.

3 (c) PUBLIC INFORMATION ON PENDING APPEALS
4 AND DETERMINATIONS.—Section 1869 of the Social Secu-
5 rity Act is further amended by adding at the end the fol-
6 lowing new subsection:

7 “(k) POSTING OF INFORMATION ON PENDING AP-
8 PEALS AND DETERMINATIONS.—

9 “(1) IN GENERAL.—Not later than 6 months
10 after the date of the enactment of this subsection,
11 the Secretary shall make available on the public
12 website of the Department of Health and Human
13 Services information on appeals of determinations
14 (and determinations with respect to such appeals)
15 provided for under this section.

16 “(2) UPDATING AT LEAST BI-ANNUALLY.—The
17 Secretary shall update such information not less fre-
18 quently than bi-annually.

19 “(3) INFORMATION TO BE INCLUDED.—Such
20 information, with respect to claims for which a re-
21 quest for such an appeal was filed, shall include at
22 each level of appeal under this section, as applicable,
23 at least the following information:

1 “(A) The total number of such claims and
2 total charges allowed with respect to such
3 claims.

4 “(B) Of such total number and total al-
5 lowed charges—

6 “(i) such number and charges with re-
7 spect items and services for which payment
8 is sought under part A; and

9 “(ii) such number and charges with
10 respect to items and services for which
11 payment is sought under part B.

12 “(C) The number of such claims with re-
13 spect to items and services described in clauses
14 (i) and (ii) of subparagraph (B), presented by
15 type of provider of services or supplier and by
16 payment system under the respective part and
17 by item or service or category of such items and
18 services.

19 “(D) In applying subparagraph (C) in the
20 case of durable medical equipment, prosthetics,
21 orthotics, and supplies for which amounts are
22 payable under section 1834(a), information de-
23 scribed in such subparagraph with respect to
24 type of provider of services or supplier and pay-
25 ment system presented in a manner that sepa-

1 rates durable medical equipment from pros-
2 thetics, orthotics, and supplies.

3 “(E) The most frequent reason for the ini-
4 tial determination under this section denying
5 payment under this title, presented by type of
6 provider of services or supplier, as applicable
7 and by payment system and presented, to the
8 extent feasible, by item or service or category of
9 such items and services.

10 “(F) The number of such claims and total
11 allowed charges described in subparagraph (A)
12 for which a determination under this section
13 1869 denying payment was made by a recovery
14 audit contractor, specifically indicating the
15 number and percent of such denials by reason
16 of section 1862(a)(1)(A) (relating to medical
17 necessity).

18 “(G) The number and percentage of such
19 claims described in subparagraph (A) for which
20 a determination is made under this section in
21 favor of the appellant at each level of appeal,
22 presented in a manner that separates favorable
23 determinations from partially favorable deter-
24 minations.

1 “(H) The number of determinations under
2 this section by administrative law judges with
3 respect to claims that had a hearing as com-
4 pared to the number of determinations under
5 this section by administrative law judges that
6 were made on the record.

7 “(4) INCLUSION OF ANALYSIS OF VARIATIONS
8 IN INITIAL COVERAGE DETERMINATIONS.—

9 “(A) IN GENERAL.—Such information also
10 shall include an analysis of the extent to which
11 initial determinations made under this section
12 by medicare administrative contractors pursu-
13 ant to contracts under section 1874A (including
14 with respect to payment and coverage deter-
15 minations under part B for durable medical
16 equipment) vary significantly by contractor re-
17 gion for the same or similar services. Such
18 analysis shall include initial determinations
19 based on local coverage decisions made under
20 this section.

21 “(B) CONSULTATION WITH MEDICARE AD-
22 MINISTRATIVE CONTRACTORS.—In conducting
23 the analysis under subparagraph (A), the Sec-
24 retary shall consult with medicare administra-
25 tive contractors to determine if standardization

1 or other improvements are appropriate to gen-
2 erate more consistent initial determinations
3 under this section.”.

4 (d) TREATMENT OF CERTAIN DOCUMENTATION CRE-
5 ATED BY ORTHOTISTS AND PROSTHETISTS.—Section
6 1893 of the Social Security Act (42 U.S.C. 1395ddd) is
7 amended by adding at the end the following new sub-
8 section:

9 “(j) TREATMENT OF CERTAIN DOCUMENTATION
10 CREATED BY ORTHOTISTS AND PROSTHETISTS.—

11 “(1) IN GENERAL.—For purposes of deter-
12 mining under this title the reasonableness and med-
13 ical necessity of prosthetic devices and orthotics and
14 prosthetics, documentation created by orthotists and
15 prosthetists relating to the need for such devices,
16 orthotics, and prosthetics shall be considered part of
17 the medical record.

18 “(2) DOCUMENTATION ON MEDICAL NECESSITY
19 FOR LOWER LIMB PROSTHETIC DEVICES.—The Sec-
20 retary shall make public the elements that need to
21 be documented in the medical record from the eval-
22 uation of the need for a lower limb prosthetic device
23 to establish that it is reasonable and necessary
24 under this title. Such elements shall be established
25 in consultation with stakeholders and shall be made

1 public no later than 90 days after the date of the
2 enactment of this subsection.”.

3 **Subtitle D—Quality and**
4 **Transparency**

5 **SEC. 109. HOSPITAL ASSESSMENT DATA.**

6 (a) IN GENERAL.—Section 1899B of the Social Secu-
7 rity Act (42 U.S.C. 1395lll) is amended—

8 (1) by redesignating subsections (j), (k), (l),
9 and (m) as subsections (k), (l), (m), and (n), respec-
10 tively; and

11 (2) by inserting after subsection (i) the fol-
12 lowing new subsection:

13 “(j) ASSESSMENT DATA REQUIREMENTS FOR INPA-
14 TIENT HOSPITALS, PPS-EXEMPT CANCER HOSPITALS,
15 AND CRITICAL ACCESS HOSPITALS.—

16 “(1) IN GENERAL.—Not later than October 1,
17 2018, the Secretary shall require subsection (d) hos-
18 pitals, hospitals described in section
19 1886(d)(1)(B)(v), and critical access hospitals,
20 under the applicable reporting provisions, to report
21 to the Secretary standardized patient assessment
22 data with respect to inpatient hospital services fur-
23 nished by such a hospital or critical access hospital
24 to individuals who are entitled to benefits under part
25 A. Under the applicable reporting provisions, each

1 such hospital and critical access hospital shall collect
2 and submit such data, with respect to items and
3 services furnished to such an individual admitted to
4 such hospital or critical access hospital, upon dis-
5 charge of such individual. Such standardized patient
6 assessment data shall be with respect to the fol-
7 lowing categories:

8 “(A) Medical conditions and co-
9 morbidities, such as diabetes, congestive heart
10 failure, and pressure ulcers.

11 “(B) Functional status, such as mobility
12 and self care, before discharge from a hospital
13 provider.

14 “(C) Cognitive function, such as ability to
15 express ideas and to understand, and mental
16 status, such as depression and dementia.

17 “(D) Living situation and access to family
18 caregivers and other caregivers at home.

19 “(E) Other categories so long as they are
20 necessary for assessing Medicare beneficiary
21 need for post-acute care services, the resulting
22 quality of care, or developing post-acute care
23 payment models.

1 “(2) APPLICABLE REPORTING PROVISION DE-
2 FINED.—For purposes of this subsection, the term
3 ‘applicable reporting provision’ means—

4 “(A) for subsection (d) hospitals (as de-
5 fined in section 1886(d)(1)(B)), section
6 1886(b)(3)(B)(viii);

7 “(B) for critical access hospitals (as de-
8 scribed in section 1820(e)(2)(B)), section
9 1814(l)(5); and

10 “(C) for a hospital described in section
11 1886(d)(1)(B)(v), section 1866(k).”.

12 (b) PAYMENT CONSEQUENCES UNDER THE APPLICA-
13 BLE REPORTING PROVISIONS.—

14 (1) SUBSECTION (D) HOSPITALS.—Section
15 1886(b)(3)(B)(viii) of the Social Security Act (42
16 U.S.C. 1395ww(b)(3)(B)(viii)) is amended by adding
17 at the end the following new subclause:

18 “(XII) Effective for payments beginning
19 with fiscal year 2019, in addition to data other-
20 wise required to be submitted on measures se-
21 lected under this clause, the Secretary shall re-
22 quire to be submitted the standardized patient
23 assessment data required under section
24 1899B(j)(1). To the extent such standardized
25 data are duplicative of any other data required

1 to be reported under this clause, the submission
2 of such standardized data shall be required
3 under this clause in lieu of the submission of
4 such other data.”.

5 (2) CRITICAL ACCESS HOSPITALS.—Section
6 1814(l) of the Social Security Act (42 U.S.C.
7 1395f(1)) is amended—

8 (A) by redesignating paragraph (5) as
9 paragraph (6); and

10 (B) by inserting after paragraph (4) the
11 following new paragraph:

12 “(5)(A) For cost reporting periods beginning in
13 fiscal year 2019 or a subsequent fiscal year, in the
14 case of a critical access hospital that does not sub-
15 mit to the Secretary, in accordance with subpara-
16 graph (B), standardized patient assessment data re-
17 quired under section 1899B(j) with respect to such
18 a fiscal year, paragraph (1) shall be applied to such
19 critical access hospital for such fiscal year by reduc-
20 ing the percent described in such paragraph, after
21 application of paragraph (4), by 2 percentage points.
22 Such reduction shall apply only with respect to the
23 fiscal year involved and the Secretary shall not take
24 into account such reduction in computing the pay-

1 ment amount under this subsection for a subsequent
2 fiscal year.

3 “(B) A critical access hospital shall submit to
4 the Secretary, in a manner and within the time-
5 frames prescribed by the Secretary, standardized pa-
6 tient assessment data required under section
7 1899B(j)(1). To the extent such standardized data
8 are duplicative of any other data required to be re-
9 ported under this subsection, the submission of such
10 standardized data shall be required under this sub-
11 section in lieu of the submission of such other
12 data.”.

13 (3) PPS-EXEMPT CANCER HOSPITALS.—

14 (A) IN GENERAL.—Section 1866(k) of the
15 Social Security Act (42 U.S.C. 1395cc(k)) is
16 amended—

17 (i) by striking paragraph (2) and in-
18 serting the following:

19 “(2) SUBMISSION OF DATA.—

20 “(A) IN GENERAL.—

21 “(i) QUALITY MEASURES.—For fiscal
22 year 2014 and each subsequent fiscal year,
23 each hospital described in such section
24 shall submit to the Secretary data on qual-

1 ity measures specified under paragraph
2 (3).

3 “(ii) STANDARDIZED PATIENT AS-
4 SESSMENT DATA.—For fiscal year 2019
5 and each subsequent fiscal year, in addi-
6 tion to such data on quality measures,
7 each hospital described in such section
8 shall submit to the Secretary standardized
9 patient assessment data required under
10 section 1899B(j)(1). To the extent such
11 standardized data are duplicative of any
12 other data required to be reported under
13 this subsection, the submission of such
14 standardized data shall be required under
15 this subsection in lieu of the submission of
16 such other data.

17 “(B) ADMINISTRATION.—Data required
18 under subparagraph (A) shall be submitted in
19 a form and manner, and at a time, specified by
20 the Secretary for purposes of this subsection.”;

21 (ii) in paragraph (4), by striking
22 “paragraph (4)” and inserting “paragraph
23 (2)(A)(i)”; and

24 (iii) by adding at the end the fol-
25 lowing new paragraph:

1 “(5) REDUCTION FOR FAILURE TO REPORT
2 STANDARDIZED PATIENT ASSESSMENT DATA.—For
3 fiscal year 2019 or a subsequent fiscal year, in the
4 case of a hospital described in section
5 1886(d)(1)(B)(v) that does not submit to the Sec-
6 retary, in accordance with subparagraphs (A)(ii) and
7 (B) of paragraph (2), standardized patient assess-
8 ment data required under section 1899B(j)(1) with
9 respect to such fiscal year, the applicable percentage
10 increase under subparagraph (B)(ii) of section
11 1886(b)(3) otherwise applicable to such hospital for
12 purposes of subparagraph (E) of such section for
13 such fiscal year shall be reduced by 2 percentage
14 points. Such reduction shall apply only with respect
15 to the fiscal year involved and the Secretary shall
16 not take into account such reduction in computing
17 the payment amount under section 1886(b) for a
18 subsequent fiscal year.”.

19 (B) CONFORMING AMENDMENT.—Section
20 1886(b)(3)(B)(ii)(VIII) of the Social Security
21 Act (42 U.S.C. 1395ww(b)(3)(B)(ii)(VIII)) is
22 amended by inserting “subject to section
23 1866(k)(5),” before “subsequent fiscal years”.

1 **SEC. 110. COST INFORMATION ON HOSPITAL PAYMENTS.**

2 (a) REPORTING OF CERTAIN HOSPITAL PAYMENT
3 DATA.—

4 (1) IN GENERAL.—Section 1866 of the Social
5 Security Act (42 U.S.C. 1395cc) is amended—

6 (A) in subsection (a)(1)—

7 (i) in subparagraph (V), by striking
8 “and” at the end;

9 (ii) in subparagraph (W), as added by
10 section 3005 of Public Law 111–148—

11 (I) by moving such subparagraph
12 2 ems to the left; and

13 (II) by striking the period at the
14 end and inserting a comma;

15 (iii) in subparagraph (W), as added
16 by section 6406(b) of Public Law 111–
17 148—

18 (I) by moving such subparagraph
19 2 ems to the left;

20 (II) by redesignating such sub-
21 paragraph as subparagraph (X); and

22 (III) by striking the period at the
23 end and inserting “, and”; and

24 (iv) by inserting after subparagraph
25 (X), as redesignated by clause (iii)(II), the
26 following new subparagraph:

1 “(Y) in the case of a subsection (d) hospital (as
2 defined in section 1886(d)(1)(B)), to report payment
3 data to the Secretary in accordance subsection (j).”;
4 and

5 (B) by adding at the end the following new
6 subsection:

7 “(j) REPORTING OF CERTAIN HOSPITAL PAYMENT
8 DATA.—

9 “(1) IN GENERAL.—A subsection (d) hospital
10 (as defined in section 1886(d)(1)(B)) shall submit to
11 the Secretary data on the actual amounts collected
12 by the hospital from uninsured and insured patients
13 over the preceding 2 years for each of the proce-
14 dures described in paragraph (2).

15 “(2) PROCEDURES DESCRIBED.—The proce-
16 dures described in this paragraph are the 50 most
17 common diagnosis-related groups and ambulatory
18 payment classification groups for which payment is
19 made under this title, as determined by the Sec-
20 retary based on claims data, in both the inpatient
21 and outpatient settings.

22 “(3) TRANSPARENCY.—

23 “(A) IN GENERAL.—In order to be bene-
24 ficial to consumers, the reporting of data under

1 this subsection shall be done in a manner that
2 is transparent to the general public.

3 “(B) PUBLIC AVAILABILITY OF INFORMA-
4 TION.—The Secretary shall post data submitted
5 under paragraph (1) on a publicly accessible
6 and searchable Internet website in a form and
7 manner that—

8 “(i) allows for meaningful compari-
9 sons of hospital collections and related
10 policies by zip code; and

11 “(ii) is readily understandable by a
12 typical consumer.

13 “(C) LINKING OF DATA.—A subsection (d)
14 hospital shall include a link to the data posted
15 under subparagraph (B) on the home Internet
16 website of the hospital.”.

17 (2) EFFECTIVE DATE.—The amendments made
18 by this subsection shall apply to contracts entered
19 into, or renewed, on or after the date of the enact-
20 ment of this Act.

21 (b) INCLUSION OF INFORMATION ON CHARITY CARE
22 FURNISHED BY HOSPITALS IN MEDPAC’S ANNUAL RE-
23 PORT.—Each annual report submitted to Congress after
24 the date of the enactment of this Act by the Medicare Pay-
25 ment Advisory Commission under section 1805 of the So-

1 cial Security Act (42 U.S.C. 1395b–6) shall contain infor-
2 mation on the percentage that charity care makes up of
3 the total care furnished by hospitals and critical access
4 hospitals.

5 **TITLE II—HOSPITAL PRIORITIES**
6 **OF THE COMMITTEE ON WAYS**
7 **AND MEANS FOR THE 113TH**
8 **CONGRESS (AS LISTED IN**
9 **ORDER OF MEMBER SENIOR-**
10 **ITY)**

11 **SEC. 201. (JOHNSON) REPEAL OF OBAMACARE MORATO-**
12 **RIUM ON PHYSICIAN-OWNED HOSPITALS.**

13 (a) IN GENERAL.—Section 1877(i) of the Social Se-
14 curity Act (42 U.S.C. 1395nn(i)) is amended—

15 (1) in paragraph (1)(A)—

16 (A) in the matter preceding clause (i), by
17 striking “had”;

18 (B) in clause (i), by inserting “had” before
19 “physician ownership”; and

20 (C) by amending clause (ii) to read as fol-
21 lows:

22 “(ii) either—

23 “(I) had a provider agreement
24 under section 1866 in effect on such
25 date; or

1 “(II) was under construction on
2 such date.”; and

3 (2) in paragraph (3)—

4 (A) by amending subparagraph (E) to read
5 as follows:

6 “(E) APPLICABLE HOSPITAL.—In this
7 paragraph, the term ‘applicable hospital’ means
8 a hospital that does not discriminate against
9 beneficiaries of Federal health care programs
10 and does not permit physicians practicing at
11 the hospital to discriminate against such bene-
12 ficiaries.”; and

13 (B) in subparagraph (F)(iii), by striking
14 “subparagraph (E)(iii)” and inserting “sub-
15 paragraph (E)”.

16 (b) EFFECTIVE DATE.—The amendments made by
17 subsection (a) shall be effective as if included in the enact-
18 ment of subsection (i) of section 1877 of the Social Secu-
19 rity Act (42 U.S.C. 1395nn).

1 **SEC. 202. H.R. 2053 – (BRADY) TO AMEND TITLE XVIII OF**
2 **THE SOCIAL SECURITY ACT TO APPLY BUDG-**
3 **ET NEUTRALITY ON A STATE-SPECIFIC BASIS**
4 **IN THE CALCULATION OF THE MEDICARE**
5 **HOSPITAL WAGE INDEX FLOOR FOR NON-**
6 **RURAL AREAS.**

7 (a) IN GENERAL.—Section 1886(d)(3)(E) of the So-
8 cial Security Act (42 U.S.C. 1395ww(d)(3)(E)) is amend-
9 ed by adding at the end the following new clause:

10 “(iv) APPLICATION OF BUDGET NEU-
11 TRALITY RELATING TO FLOOR ON WAGE
12 AREA INDEX IN NON-RURAL AREAS.—

13 “(I) APPLICATION ON A STATE-
14 SPECIFIC BASIS BEGINNING IN FISCAL
15 YEAR 2016.—Subject to subclause (II),
16 in the case of discharges occurring on
17 or after October 1, 2015, for purposes
18 of applying section 4410(b) of the
19 Balanced Budget Act of 1997, the
20 Secretary shall administer such sec-
21 tion 4410(b) and paragraph (e) of
22 section 412.64 of title 42, Code of
23 Federal Regulations, as if paragraph
24 (e)(4)(ii) of such section 412.64 had
25 never applied and by using the meth-
26 odology promulgated in the Federal

1 Register on August 19, 2008 (73 Fed.
2 Reg. 48570) (applied as if such meth-
3 odology had been fully implemented
4 for fiscal year 2011 using a 100 per-
5 cent State-specific adjustment to the
6 area wage index).

7 “(II) CONSTRUCTION.—Nothing
8 in subclause (I) shall be construed as
9 preventing the Secretary, for dis-
10 charges occurring on or after October
11 1, 2015, from modifying the regula-
12 tions under such section 412.64 in
13 carrying out the budget neutrality re-
14 quirements of such section 4410(b).”.

15 (b) CONFORMING AMENDMENT TERMINATING APPLI-
16 CATION OF BUDGET NEUTRALITY ON A NATIONWIDE
17 BASIS.—Section 3141 of the Patient Protection and Af-
18 fordable Care Act (42 U.S.C. 1395ww note) is amended
19 by inserting “and before October 1, 2015,” after “2010,”.

20 **SEC. 203. H.R. 4418 - (RYAN) EXPANDING THE AVAILABILITY**
21 **OF MEDICARE DATA ACT.**

22 (a) EXPANDING USES OF MEDICARE DATA BY
23 QUALIFIED ENTITIES.—

24 (1) ADDITIONAL ANALYSES.—

1 (A) IN GENERAL.—Subject to subpara-
2 graph (B), to the extent consistent with appli-
3 cable information, privacy, security, and diselo-
4 sure laws (including paragraph (3)), notwith-
5 standing paragraph (4)(B) of section 1874(e) of
6 the Social Security Act (42 U.S.C. 1395kk(e))
7 and the second sentence of paragraph (4)(D) of
8 such section, beginning July 1, 2015, a quali-
9 fied entity may use the combined data described
10 in paragraph (4)(B)(iii) of such section received
11 by such entity under such section, and informa-
12 tion derived from the evaluation described in
13 such paragraph (4)(D), to conduct additional
14 non-public analyses (as determined appropriate
15 by the Secretary) and provide or sell such anal-
16 yses to authorized users for non-public use (in-
17 cluding for the purposes of assisting providers
18 of services and suppliers to develop and partici-
19 pate in quality and patient care improvement
20 activities, including developing new models of
21 care).

22 (B) LIMITATIONS WITH RESPECT TO ANAL-
23 YSES.—

24 (i) EMPLOYERS.—Any analyses pro-
25 vided or sold under subparagraph (A) to

1 an employer described in paragraph
2 (9)(A)(iii) may only be used by such em-
3 ployer for purposes of providing health in-
4 surance to employees and retirees of the
5 employer.

6 (ii) HEALTH INSURANCE ISSUERS.—A
7 qualified entity may not provide or sell an
8 analysis to a health insurance issuer de-
9 scribed in paragraph (9)(A)(iv) unless the
10 issuer is providing the qualified entity with
11 data under section 1874(e)(4)(B)(iii) of
12 the Social Security Act (42 U.S.C.
13 1395kk(e)(4)(B)(iii)).

14 (2) ACCESS TO CERTAIN DATA.—

15 (A) ACCESS.—To the extent consistent
16 with applicable information, privacy, security,
17 and disclosure laws (including paragraph (3)),
18 notwithstanding paragraph (4)(B) of section
19 1874(e) of the Social Security Act (42 U.S.C.
20 1395kk(e)) and the second sentence of para-
21 graph (4)(D) of such section, beginning July 1,
22 2015, a qualified entity may—

23 (i) provide or sell the combined data
24 described in paragraph (4)(B)(iii) of such
25 section to authorized users described in

1 clauses (i), (ii), and (v) of paragraph
2 (9)(A) for non-public use, including for the
3 purposes described in subparagraph (B);
4 or

5 (ii) subject to subparagraph (C), pro-
6 vide Medicare claims data to authorized
7 users described in clauses (i), (ii), and (v),
8 of paragraph (9)(A) for non-public use, in-
9 cluding for the purposes described in sub-
10 paragraph (B).

11 (B) PURPOSES DESCRIBED.—The purposes
12 described in this subparagraph are assisting
13 providers of services and suppliers in developing
14 and participating in quality and patient care
15 improvement activities, including developing
16 new models of care.

17 (C) MEDICARE CLAIMS DATA MUST BE
18 PROVIDED AT NO COST.—A qualified entity may
19 not charge a fee for providing the data under
20 subparagraph (A)(ii).

21 (3) PROTECTION OF INFORMATION.—

22 (A) IN GENERAL.—Except as provided in
23 subparagraph (B), an analysis or data that is
24 provided or sold under paragraph (1) or (2)

1 shall not contain information that individually
2 identifies a patient.

3 (B) INFORMATION ON PATIENTS OF THE
4 PROVIDER OF SERVICES OR SUPPLIER.—To the
5 extent consistent with applicable information,
6 privacy, security, and disclosure laws, an anal-
7 ysis or data that is provided or sold to a pro-
8 vider of services or supplier under paragraph
9 (1) or (2) may contain information that individ-
10 ually identifies a patient of such provider or
11 supplier, including with respect to items and
12 services furnished to the patient by other pro-
13 viders of services or suppliers.

14 (C) PROHIBITION ON USING ANALYSES OR
15 DATA FOR MARKETING PURPOSES.—An author-
16 ized user shall not use an analysis or data pro-
17 vided or sold under paragraph (1) or (2) for
18 marketing purposes.

19 (4) DATA USE AGREEMENT.—A qualified entity
20 and an authorized user described in clauses (i), (ii),
21 and (v) of paragraph (9)(A) shall enter into an
22 agreement regarding the use of any data that the
23 qualified entity is providing or selling to the author-
24 ized user under paragraph (2). Such agreement shall
25 describe the requirements for privacy and security of

1 the data and, as determined appropriate by the Sec-
2 retary, any prohibitions on using such data to link
3 to other individually identifiable sources of informa-
4 tion. If the authorized user is not a covered entity
5 under the rules promulgated pursuant to the Health
6 Insurance Portability and Accountability Act of
7 1996, the agreement shall identify the relevant regu-
8 lations, as determined by the Secretary, that the
9 user shall comply with as if it were acting in the ca-
10 pacity of such a covered entity.

11 (5) NO REDISCLOSURE OF ANALYSES OR
12 DATA.—

13 (A) IN GENERAL.—Except as provided in
14 subparagraph (B), an authorized user that is
15 provided or sold an analysis or data under
16 paragraph (1) or (2) shall not redisclose or
17 make public such analysis or data or any anal-
18 ysis using such data.

19 (B) PERMITTED REDISCLOSURE.—A pro-
20 vider of services or supplier that is provided or
21 sold an analysis or data under paragraph (1) or
22 (2) may, as determined by the Secretary, redis-
23 close such analysis or data for the purposes of
24 performance improvement and care coordination

1 activities but shall not make public such anal-
2 ysis or data or any analysis using such data.

3 (6) OPPORTUNITY FOR PROVIDERS OF SERV-
4 ICES AND SUPPLIERS TO REVIEW.—Prior to a quali-
5 fied entity providing or selling an analysis to an au-
6 thorized user under paragraph (1), to the extent
7 that such analysis would individually identify a pro-
8 vider of services or supplier who is not being pro-
9 vided or sold such analysis, such qualified entity
10 shall provide such provider or supplier with the op-
11 portunity to appeal and correct errors in the manner
12 described in section 1874(e)(4)(C)(ii) of the Social
13 Security Act (42 U.S.C. 1395kk(e)(4)(C)(ii)).

14 (7) ASSESSMENT FOR A BREACH.—

15 (A) IN GENERAL.—In the case of a breach
16 of a data use agreement under this section or
17 section 1874(e) of the Social Security Act (42
18 U.S.C. 1395kk(e)), the Secretary shall impose
19 an assessment on the qualified entity both in
20 the case of—

21 (i) an agreement between the Sec-
22 retary and a qualified entity; and

23 (ii) an agreement between a qualified
24 entity and an authorized user.

1 (B) ASSESSMENT.—The assessment under
2 subparagraph (A) shall be an amount up to
3 \$100 for each individual entitled to, or enrolled
4 for, benefits under part A of title XVIII of the
5 Social Security Act or enrolled for benefits
6 under part B of such title—

7 (i) in the case of an agreement de-
8 scribed in subparagraph (A)(i), for whom
9 the Secretary provided data on to the
10 qualified entity under paragraph (2); and

11 (ii) in the case of an agreement de-
12 scribed in subparagraph (A)(ii), for whom
13 the qualified entity provided data on to the
14 authorized user under paragraph (2).

15 (C) DEPOSIT OF AMOUNTS COLLECTED.—
16 Any amounts collected pursuant to this para-
17 graph shall be deposited in Federal Supple-
18 mentary Medical Insurance Trust Fund under
19 section 1841 of the Social Security Act (42
20 U.S.C. 1395t).

21 (8) ANNUAL REPORTS.—Any qualified entity
22 that provides or sells an analysis or data under
23 paragraph (1) or (2) shall annually submit to the
24 Secretary a report that includes—

1 (A) a summary of the analyses provided or
2 sold, including the number of such analyses, the
3 number of purchasers of such analyses, and the
4 total amount of fees received for such analyses;

5 (B) a description of the topics and pur-
6 poses of such analyses;

7 (C) information on the entities who re-
8 ceived the data under paragraph (2), the uses
9 of the data, and the total amount of fees re-
10 ceived for providing, selling, or sharing the
11 data; and

12 (D) other information determined appro-
13 priate by the Secretary.

14 (9) DEFINITIONS.—In this subsection and sub-
15 section (b):

16 (A) AUTHORIZED USER.—The term “au-
17 thorized user” means the following:

18 (i) A provider of services.

19 (ii) A supplier.

20 (iii) An employer (as defined in sec-
21 tion 3(5) of the Employee Retirement In-
22 surance Security Act of 1974).

23 (iv) A health insurance issuer (as de-
24 fined in section 2791 of the Public Health
25 Service Act).

1 (v) A medical society or hospital asso-
2 ciation.

3 (vi) Any entity not described in
4 clauses (i) through (v) that is approved by
5 the Secretary (other than an employer or
6 health insurance issuer not described in
7 clauses (iii) and (iv), respectively, as deter-
8 mined by the Secretary).

9 (B) PROVIDER OF SERVICES.—The term
10 “provider of services” has the meaning given
11 such term in section 1861(u) of the Social Se-
12 curity Act (42 U.S.C. 1395x(u)).

13 (C) QUALIFIED ENTITY.—The term “quali-
14 fied entity” has the meaning given such term in
15 section 1874(e)(2) of the Social Security Act
16 (42 U.S.C. 1395kk(e)).

17 (D) SECRETARY.—The term “Secretary”
18 means the Secretary of Health and Human
19 Services.

20 (E) SUPPLIER.—The term “supplier” has
21 the meaning given such term in section 1861(d)
22 of the Social Security Act (42 U.S.C.
23 1395x(d)).

1 (b) ACCESS TO MEDICARE DATA BY QUALIFIED
2 CLINICAL DATA REGISTRIES TO FACILITATE QUALITY
3 IMPROVEMENT.—

4 (1) ACCESS.—

5 (A) IN GENERAL.—To the extent con-
6 sistent with applicable information, privacy, se-
7 curity, and disclosure laws, beginning July 1,
8 2015, the Secretary shall, at the request of a
9 qualified clinical data registry under section
10 1848(m)(3)(E) of the Social Security Act (42
11 U.S.C. 1395w-4(m)(3)(E)), provide the data
12 described in subparagraph (B) (in a form and
13 manner determined to be appropriate) to such
14 qualified clinical data registry for purposes of
15 linking such data with clinical outcomes data
16 and performing risk-adjusted, scientifically valid
17 analyses and research to support quality im-
18 provement or patient safety, provided that any
19 public reporting of such analyses or research
20 that identifies a provider of services or supplier
21 shall only be conducted with the opportunity of
22 such provider or supplier to appeal and correct
23 errors in the manner described in subsection
24 (a)(6).

1 (B) DATA DESCRIBED.—The data de-
2 scribed in this subparagraph is—

3 (i) claims data under the Medicare
4 program under title XVIII of the Social
5 Security Act; and

6 (ii) if the Secretary determines appro-
7 priate, claims data under the Medicaid
8 program under title XIX of such Act and
9 the State Children’s Health Insurance Pro-
10 gram under title XXI of such Act.

11 (2) FEE.—Data described in paragraph (1)(B)
12 shall be provided to a qualified clinical data registry
13 under paragraph (1) at a fee equal to the cost of
14 providing such data. Any fee collected pursuant to
15 the preceding sentence shall be deposited in the Cen-
16 ters for Medicare & Medicaid Services Program
17 Management Account.

18 (c) EXPANSION OF DATA AVAILABLE TO QUALIFIED
19 ENTITIES.—Section 1874(e) of the Social Security Act
20 (42 U.S.C. 1395kk(e)) is amended—

21 (1) in the subsection heading, by striking
22 “MEDICARE”; and

23 (2) in paragraph (3)—

24 (A) by inserting after the first sentence the
25 following new sentence: “Beginning July 1,

1 2015, if the Secretary determines appropriate,
2 the data described in this paragraph may also
3 include standardized extracts (as determined by
4 the Secretary) of claims data under titles XIX
5 and XXI for assistance provided under such ti-
6 tles for one or more specified geographic areas
7 and time periods requested by a qualified enti-
8 ty.”; and

9 (B) in the last sentence, by inserting “or
10 under titles XIX or XXI” before the period at
11 the end.

12 (d) REVISION OF PLACEMENT OF FEES.—Section
13 1874(e)(4)(A) of the Social Security Act (42 U.S.C.
14 1395kk(e)(4)(A)) is amended, in the second sentence—

15 (1) by inserting “, for periods prior to July 1,
16 2015,” after “deposited”; and

17 (2) by inserting the following before the period
18 at the end: “, and, beginning July 1, 2015, into the
19 Centers for Medicare & Medicaid Services Program
20 Management Account”.

21 **SEC. 204. H.R. 2500 (SECTION 4) – (NUNES) AMBULATORY**
22 **SURGICAL CENTER QUALITY AND ACCESS**
23 **ACT OF 2013.**

24 (a) ASC REPRESENTATIVE.—The second sentence of
25 section 1833(t)(9)(A) of the Social Security Act (42

1 U.S.C. 1395l(t)(9)(A)) is amended by inserting “and sup-
2 pliers subject to the prospective payment system (includ-
3 ing at least one ambulatory surgical center representa-
4 tive)” after “an appropriate selection of representatives of
5 providers”.

6 (b) EFFECTIVE DATE.—The amendment made by
7 subsection (a) shall take effect on the date of the enact-
8 ment of this Act.

9 **SEC. 205. H.R. 4187 – (ROSKAM) DEVELOPING AN INNOVA-**
10 **TIVE STRATEGY FOR ANTIMICROBIAL RE-**
11 **SISTANT MICROORGANISMS ACT OF 2014.**

12 Section 1886(d)(5) of the Social Security Act (42
13 U.S.C. 1395ww(d)(5)) is amended by adding at the end
14 the following new subparagraph:

15 “(M)(i) Effective for discharges beginning on or after
16 October 1, 2015, the Secretary shall, after notice and op-
17 portunity for public comment (in the publications required
18 by subsection (e)(5) for a fiscal year or otherwise), recog-
19 nize the costs of new antimicrobial drugs under the pay-
20 ment system established under this subsection. The Sec-
21 retary shall ensure the timeframes specified under section
22 412.87(b)(2) of title 42, Code of Federal Regulations, as
23 in effect as of the date of the enactment of this subpara-
24 graph, are enforced for purposes of this subparagraph.

1 “(ii) Pursuant to clause (i), the Secretary shall apply
2 section 412.88(a)(2) of title 42, Code of Federal Regula-
3 tions, with respect to discharges occurring on or after Oc-
4 tober 1, 2015, as if the additional amount described in
5 such section referenced an amount equal to the lesser of
6 the amount described in clause (i) or (ii) of such section
7 or the amount provided for under section 1847A for drugs
8 and biologicals that are described in section
9 1842(o)(1)(C).

10 “(iii) For purposes of this subparagraph, the term
11 ‘new antimicrobial drug’ means a product that is approved
12 for use, or a product for which an indication is first ap-
13 proved for use, by the Federal Food and Drug Administra-
14 tion on or after January 1, 2014, and that—

15 “(I) is indicated to treat an infection caused by,
16 or likely to be caused by, a qualifying pathogen
17 which is associated with high rates of mortality or
18 significant patient morbidity (as determined by the
19 Secretary, in consultation with the Director of the
20 Centers for Disease Control and Prevention and the
21 infectious disease professional community); and

22 “(II) is used in facilities that participate in the
23 Antimicrobial Use and Resistance Module of the Na-
24 tional Healthcare Safety Network of the Centers for
25 Disease Control and Prevention (or, in the case that

1 such Module is not available, is used in facilities that
2 participate in such successor or similar reporting
3 module or program relating to antimicrobials as the
4 Secretary shall specify to the extent available to
5 such facilities, as determined by the Secretary).”.

6 **SEC. 206. (BUCHANAN) HAND SANITATION DEMONSTRATION PROGRAM.**
7

8 (a) IN GENERAL.—Title XVIII of the Social Security
9 Act is amended by inserting after section 1866E (42
10 U.S.C. 1395cc–5) the following new section:

11 **“SEC. 1866F. HAND SANITATION DEMONSTRATION PROGRAM.**
12

13 “(a) ESTABLISHMENT.—The Secretary shall estab-
14 lish a demonstration program (in this section referred to
15 as ‘demonstration program’) under which the Secretary
16 shall approve demonstration projects that—

17 “(1) identify barriers to hand sanitation in eli-
18 gible hospitals; and

19 “(2) implement solutions to eliminate those bar-
20 riers.

21 “(b) ADMINISTRATION BY CONTRACT.—Except as
22 otherwise provided in this section, the Secretary may ad-
23 minister the demonstration program in accordance with
24 section 1866B.

25 “(c) DEFINITIONS.—In this section:

1 “(1) ELIGIBLE HOSPITAL.—The term ‘eligible
2 hospital’ means any of the following:

3 “(A) A subsection (d) hospital as defined
4 in section 1886(d)(1)(B).

5 “(B) A subsection (d) Puerto Rico hospital
6 as defined in section 1886(d)(9)(A).

7 “(C) A hospital that is paid under section
8 1814(b)(3).

9 “(D) A hospital that is located in Amer-
10 ican Samoa, Guam, the Commonwealth of the
11 Northern Mariana Islands, the Virgin Islands of
12 the United States, or in any other territory or
13 possession of the United States, and that would
14 be a subsection (d) hospital if it were located in
15 one of the 50 States.

16 “(2) CONGRESSIONAL DISTRICT.—The term
17 ‘Congressional district’ means a Congressional dis-
18 trict in any of the 50 States or in the District of Co-
19 lumbia, Puerto Rico, American Samoa, Guam, the
20 Commonwealth of the Northern Mariana Islands, or
21 the Virgin Islands of the United States.

22 “(d) PARTICIPATION.—

23 “(1) APPLICATION.—To participate in a dem-
24 onstration project under this section, an eligible hos-
25 pital shall submit an application to the Secretary at

1 such time, in such manner, and containing such in-
2 formation as the Secretary may require.

3 “(2) SELECTION.—To the extent practicable,
4 the Secretary shall select at least 1 eligible hospital
5 from each Congressional district in the United
6 States to participate in the demonstration program.

7 “(3) PRIORITY.—In selecting hospitals under
8 paragraph (2), the Secretary may give priority to eli-
9 gible hospitals that are in the bottom quartile of per-
10 formance on measures of hospital acquired condi-
11 tions.

12 “(e) DEMONSTRATION PROJECT.—Each eligible hos-
13 pital selected under subsection (d) shall—

14 “(1) identify barriers to hand sanitation, which
15 may include—

16 “(A) ineffective use of soap dispensers or
17 sinks;

18 “(B) lack of collecting or reporting hand
19 hygiene compliance data accurately or fre-
20 quently;

21 “(C) lack of accountability and just-in-time
22 training of staff of the eligible hospital;

23 “(D) absence of emphasis on hand hygiene
24 as part of the safety culture of the eligible hos-
25 pital;

1 “(E) ineffective or insufficient education of
2 staff of the eligible hospital on hand sanitation;

3 “(F) distractions or other interferences,
4 such as already wearing gloves or having both
5 hands occupied;

6 “(G) the perception that hand sanitation is
7 not needed if wearing gloves; and

8 “(H) forgetting; and

9 “(2) implement appropriate solutions to elimi-
10 nate such barriers, which may include—

11 “(A) technology-based real-time devices,
12 including wristbands and sensors, to remind
13 healthcare workers how and when to use hand
14 hygiene techniques;

15 “(B) real-time behavior modification feed-
16 back to healthcare workers;

17 “(C) trained and certified independent ob-
18 servers;

19 “(D) peer-to-peer coaching;

20 “(E) just-in-time training; and

21 “(F) solutions endorsed by the Joint Com-
22 mission Center for Transforming Healthcare,
23 including Targeted Solutions Tools, robust
24 process improvement, and Six Sigma.

1 “(f) TIMELINE FOR DEMONSTRATION PROGRAM.—
2 The Secretary shall begin the demonstration program not
3 later than June 30, 2015.

4 “(g) REPORT TO CONGRESS.—The Secretary shall
5 collect data on the barriers to hand sanitation identified
6 and the effectiveness of each solution implemented, and
7 submit findings in a report to Congress not later than De-
8 cember 31, 2017.

9 “(h) COSTS.—There shall be transferred to the Sec-
10 retary, from the Federal Hospital Insurance Trust Fund
11 established under section 1817, such sums as are nec-
12 essary, not to exceed \$100,000,000, to carry out the provi-
13 sions of this section.”.

14 (b) REQUIREMENTS FOR HAND WASHING QUALITY
15 MEASURES.—

16 (1) SELECTION.—Not later than October 1,
17 2015, the Secretary shall select one or more hand
18 washing quality measures to be used for the quality
19 reporting requirement described in paragraph (2).
20 The Secretary may use information from the dem-
21 onstration program conducted pursuant to section
22 1866F of the Social Security Act (as added by sub-
23 section (a)) to inform the selection of hand washing
24 quality measures under this paragraph.

1 (2) REPORTING MEASURES UNDER THE SOCIAL
2 SECURITY ACT.—Not later than October 1, 2016,
3 the Secretary shall require reporting of the selected
4 hand washing quality measures pursuant to section
5 1886(b)(3)(B)(viii) of the Social Security Act (42
6 U.S.C. 1395ww(b)(3)(B)(viii)).

7 (3) INCLUSIONS.—The Secretary shall include
8 the selected hand washing quality measures—

9 (A) in the system described in section
10 1886(b)(3)(B)(viii) of such Act (42 U.S.C.
11 1395ww(b)(3)(B)(viii)), not later than October
12 1, 2016; and

13 (B) in the program described in section
14 1886(o) of such Act (42 U.S.C. 1395ww(o)),
15 not later than October 1, 2018.

16 (4) PUBLIC REPORTING.—Not later than Octo-
17 ber 1, 2017, the Secretary shall make available to
18 the public the hand washing quality measures se-
19 lected under paragraph (1).

1 **SEC. 207. H.R. 3769 – (SMITH) EXTENSION OF NONENFORCE-**
2 **MENT INSTRUCTION FOR THE MEDICARE DI-**
3 **RECT SUPERVISION REQUIREMENT FOR**
4 **THERAPEUTIC HOSPITAL OUTPATIENT SERV-**
5 **ICES FOR CRITICAL ACCESS HOSPITALS AND**
6 **RURAL HOSPITALS; STUDY OF IMPACT OF**
7 **FAILURE TO EXTEND SUCH INSTRUCTION.**

8 (a) EXTENSION OF THERAPY SUPERVISION NON-
9 ENFORCEMENT INSTRUCTION.—The Secretary of Health
10 and Human Services shall, during the extension period,
11 extend the therapy supervision nonenforcement instruc-
12 tion.

13 (b) DEFINITIONS.—In this section:

14 (1) THERAPY SUPERVISION NONENFORCEMENT
15 INSTRUCTION.—The term “therapy supervision non-
16 enforcement instruction” means the enforcement in-
17 struction on supervision requirements for outpatient
18 therapeutic services in critical access and small rural
19 hospitals, as extended for calendar year 2013 by the
20 Centers for Medicare & Medicaid Services (released
21 as of November 1, 2012).

22 (2) CRITICAL ACCESS HOSPITAL; SMALL RURAL
23 HOSPITAL.—The terms “critical access hospital” and
24 “small rural hospital” have the meanings given such
25 terms for purposes of the therapy supervision non-
26 enforcement instruction.

1 (3) EXTENSION PERIOD.—The term “extension
2 period” means calendar year 2015, and includes a
3 subsequent calendar year unless the report under
4 subsection (c)(2) has been submitted at least 90
5 days before the end of the previous calendar year.

6 (c) STUDY AND REPORT ON IMPACT OF FAILURE TO
7 EXTEND THERAPY SUPERVISION NONENFORCEMENT IN-
8 STRUCTION.—

9 (1) STUDY.—The Secretary of Health and
10 Human Services shall conduct a study on the impact
11 (including the economic impact and the impact upon
12 hospital staffing needs, if any) on critical access hos-
13 pitals and small rural hospitals of not extending the
14 therapy supervision nonenforcement instruction.

15 (2) REPORT.—The Secretary of Health and
16 Human Services shall submit to Congress a report
17 on the findings of the study conducted under para-
18 graph (1), including recommendations regarding on
19 whether the therapy supervision nonenforcement in-
20 struction should be extended or made permanent.

21 **SEC. 208. H.R. 3991 - (SMITH) CRITICAL ACCESS HOSPITAL**
22 **RELIEF ACT OF 2014.**

23 (a) IN GENERAL.—Section 1814(a) of the Social Se-
24 curity Act (42 U.S.C. 1395f(a)) is amended—

1 (1) in paragraph (6), by adding “and” at the
2 end;

3 (2) in paragraph (7), at the end of subpara-
4 graph (D)(ii), by striking “and” and inserting a pe-
5 riod; and

6 (3) by striking paragraph (8).

7 (b) APPLICATION.—The amendments made by sub-
8 section (a) shall apply with respect to items and services
9 furnished on or after January 1, 2015.

10 **SEC. 209. H.R. 5227 – (SCHOCK) MAKING THE EDUCATION OF**
11 **NURSES DEPENDABLE FOR SCHOOLS ACT.**

12 (a) IN GENERAL.—For purposes of clarifying the
13 methodology for payment under the Medicare program
14 under title XVIII of the Social Security Act to providers
15 for the costs of nursing and allied health education activi-
16 ties for cost reporting periods beginning on or after the
17 date of the enactment of this Act, the Secretary of Health
18 and Human Services shall apply section 413.85 of title
19 42, Code of Regulations—

20 (1) by treating a provider as meeting all of the
21 requirements described in paragraph (f)(1) of such
22 section if the provider or a wholly owned subsidiary
23 educational institution of such provider singly or col-
24 lectively meets all of such requirements;

1 (2) in the case of a provider that would meet
2 the requirements of paragraph (g)(3) of such sec-
3 tion, with respect to a nursing or allied health edu-
4 cation program, except that the transfer described in
5 such paragraph of such a program to a wholly
6 owned subsidiary educational institution in order to
7 meet accreditation standards occurred after October
8 1, 2003, by treating such provider as meeting the
9 requirements of such paragraph (and eligible for
10 payments under such paragraph) with respect to
11 such program; and

12 (3) by defining the term “wholly owned sub-
13 sidiary educational institution”, as referenced in
14 such section, as such term is defined under sub-
15 section (b).

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

17 (1) PROVIDER.—The term “provider” has the
18 meaning given such term in section 400.202 of title
19 42, Code of Federal Regulations.

20 (2) WHOLLY OWNED SUBSIDIARY EDUCATIONAL
21 INSTITUTION.—The term “wholly owned subsidiary
22 educational institution” means, with respect to a
23 provider, an educational institution that—

24 (A) is organized as a legal entity distinct
25 from the provider;

1 (B) has the provider as its sole owner or
2 sole member; and

3 (C) is organized in the same State in
4 which the provider is organized or registered to
5 do business.

6 **SEC. 210. H.R. 1379 - (SCHOCK) PUERTO RICO HOSPITAL**
7 **HITECH AMENDMENTS ACT OF 2013.**

8 (a) IN GENERAL.—Subsection (n)(6)(B) of section
9 1886 of the Social Security Act (42 U.S.C. 1395ww) is
10 amended by striking “subsection (d) hospital” and insert-
11 ing “hospital that is a subsection (d) hospital or a sub-
12 section (d) Puerto Rico hospital”.

13 (b) CONFORMING AMENDMENTS.—

14 (1) Section 1886 of the Social Security Act (42
15 U.S.C. 1395ww) is amended—

16 (A) in subsection (b)(3)(B)(ix)—

17 (i) in subclause (I), by striking
18 “(n)(6)(A)” and inserting “(n)(6)(B)”;
19 and

20 (ii) in subclause (II), by striking “a
21 subsection (d) hospital” and inserting “an
22 eligible hospital”; and

23 (B) in subsection (n)(4)(A)(iii), by striking
24 “paragraph (6)(B)” and inserting “paragraph
25 (6)(A)”.

1 (2) Paragraphs (2) and (4)(A) of section
2 1853(m) of the Social Security Act (42 U.S.C.
3 1395w-23(m)) are each amended by striking
4 “1886(n)(6)(A)” and inserting “1886(n)(6)(B)”.

5 (c) IMPLEMENTATION.—Notwithstanding any other
6 provision of law, the Secretary of Health and Human
7 Services may implement the amendments made by this
8 section by program instruction or otherwise.

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply as if included in the enactment
11 of the American Recovery and Reinvestment Act of 2009
12 (Public Law 111-3), except that, in order to take into ac-
13 count delays in the implementation of this section, in ap-
14 plying subsections (b)(3)(B)(ix), (n)(2)(E)(ii), and
15 (n)(2)(G)(i) of section 1886 of the Social Security Act (42
16 U.S.C. 1395ww), as amended by this section, any ref-
17 erence in such subsections to a particular year shall be
18 treated with respect to a subsection (d) Puerto Rico hos-
19 pital as a reference to the year that is 2 years after such
20 particular year.

21 **SEC. 211. H.R. 4781 - (JENKINS) MEDICARE ACCESS TO**
22 **RURAL ANESTHESIOLOGY ACT OF 2014.**

23 (a) IN GENERAL.—Section 1814 of the Social Secu-
24 rity Act (42 U.S.C. 1395f) is amended by adding at the
25 end the following new subsection:

1 “Anesthesiologist Services Provided in Certain Rural
2 Hospitals

3 “(m)(1) Notwithstanding any other provision of this
4 title, coverage and payment shall be provided under this
5 part for physicians’ services that are anesthesia services
6 furnished by a physician who is an anesthesiologist in a
7 rural hospital described in paragraph (3) in the same
8 manner as payment is made under the exception provided
9 in section 9320(k) of the Omnibus Budget Reconciliation
10 Act of 1986, as amended by section 6132 of the Omnibus
11 Budget Reconciliation Act of 1989 (42 U.S.C. 1395k
12 note) (relating to payment on a reasonable cost, pass-
13 through basis), for certified registered nurse anesthetist
14 services furnished by a certified registered nurse anes-
15 thetist in a hospital described in such section.

16 “(2) No payment shall be made under any other pro-
17 vision of this title for physicians’ services for which pay-
18 ment is made under this subsection.

19 “(3) A rural hospital described in this paragraph is
20 a hospital described in section 9320(k) of the Omnibus
21 Budget Reconciliation Act of 1986, as so amended (42
22 U.S.C. 1395k note), except that—

23 “(A) any reference in such section to a ‘cer-
24 tified registered nurse anesthetist’ or ‘anesthetist’ is

1 deemed a reference to a ‘physician who is an anes-
2 thesiologist’ or ‘anesthesiologist’, respectively; and

3 “(B) any reference to ‘January 1, 1988’ or
4 ‘1987’ is deemed a reference to such date and year
5 as the Secretary shall specify.”.

6 (b) EFFECTIVE DATE.—The amendment made by
7 subsection (a) shall apply to services furnished during cost
8 reporting periods beginning on or after the date of the
9 enactment of this Act.

10 **SEC. 212. H.R. 4663 – (BLACK) PROTECT PATIENT ACCESS**
11 **AND PROMOTE HOSPITAL EFFICIENCY ACT.**

12 (a) IN GENERAL.—Section 1814(a)(3) of the Social
13 Security Act (42 U.S.C. 1395f(a)(3)) is amended by in-
14 serting “(or, in the case of such inpatient hospital services
15 ordered by a nurse practitioner, clinical nurse specialist,
16 physician assistant (as such terms are defined in section
17 1861(aa)(5)), or a certified nurse-midwife (as such term
18 is defined in section 1861(gg)) who is privileged and
19 credentialed at the hospital at which such services are to
20 be furnished, the nurse practitioner, clinical nurse spe-
21 cialist, physician assistant, or certified nurse-midwife)”
22 after “a physician”.

23 (b) NO EFFECT ON STATE SCOPE OF PRACTICE
24 LAW.—Nothing in this section, including the amendment
25 made by this section, shall be construed as, or have the

1 effect of, changing any State scope of practice law for any
2 health care professional.

3 **SEC. 213. H.R. 3796 – (BLACK) COMPREHENSIVE CARE PAY-**
4 **MENT INNOVATION ACT.**

5 Title XVIII of the Social Security Act is amended by
6 inserting after section 1866F, as added by section 109,
7 the following new section:

8 “NATIONAL VOLUNTARY PAYMENT BUNDLING

9 “SEC. 1866G. (a) ESTABLISHMENT AND IMPLEMEN-
10 TATION.—

11 “(1) IN GENERAL.—The Secretary shall provide
12 for bundled payments under this section for inte-
13 grated care furnished by a qualified entity during an
14 episode of care to an applicable beneficiary for appli-
15 cable conditions involving a hospitalization.

16 “(2) DEADLINE.—The Secretary shall imple-
17 ment this section not later than January 1, 2015.

18 “(3) APPLICABLE BENEFICIARY DEFINED.—In
19 this section, the term ‘applicable beneficiary’ means
20 an individual who is entitled to, or enrolled for, ben-
21 efits under part A and enrolled for benefits under
22 part B, but not enrolled under part C or in a PACE
23 program under section 1894, and who is admitted to
24 a hospital for an applicable condition.

25 “(b) QUALIFIED ENTITY AND APPLICATION PROC-
26 ESS.—

1 “(1) DEFINITIONS.—In this section:

2 “(A) IN GENERAL.—The term ‘qualified
3 entity’ means a qualified applicant that has an
4 application approved by the Secretary to receive
5 bundled payments for furnishing applicable
6 services to applicable individuals under this sec-
7 tion.

8 “(B) QUALIFIED APPLICANT.—The term
9 ‘qualified applicant’ means a corporation, part-
10 nership, or limited liability company, that is au-
11 thorized in writing by a group of providers of
12 services and suppliers, including at least a hos-
13 pital, that are otherwise participating under
14 this title to act as their agent for the purpose
15 of receiving and distributing bundled payments
16 on their behalf under this section. A qualified
17 applicant may (but is not required to) be a pro-
18 vider of services or supplier that is otherwise
19 participating under this title.

20 “(2) APPLICATION.—

21 “(A) IN GENERAL.—A qualified applicant
22 may submit to the Secretary an application to
23 become a qualified entity to receive bundled
24 payments under this section.

1 “(B) CONTENTS.—An application under
2 subparagraph (A) with respect to a group of
3 providers of services and suppliers—

4 “(i) shall contain such information
5 and assurances as the Secretary may speci-
6 fy, including with respect to the require-
7 ments under subsection (c)(1); and

8 “(ii) shall indicate the applicable con-
9 ditions with respect to which the group
10 seeks to furnish applicable services during
11 the episode of care involved and the bun-
12 dled payment methodology under sub-
13 section (g) or (h) under which the group
14 would be paid for such services.

15 “(3) CHOICE AMONG APPLICABLE CONDI-
16 TIONS.—A qualified entity may select one or more
17 applicable conditions for bundled payments under
18 this section. Nothing in this section shall be con-
19 strued as requiring, or authorizing the Secretary to
20 require, a qualified entity to select any particular ap-
21 plicable condition under this section.

22 “(4) EXPEDITED APPLICATION PROCESS FOR
23 QUALIFIED APPLICANTS SUCCESSFULLY PARTICI-
24 PATING IN THE CMI BUNDLED PAYMENT DEM-
25 ONSTRATION.—In the case of any qualified applicant

1 that the Secretary determines has successfully par-
2 ticipated in any of the payment and service delivery
3 models tested by the Center for Medicare and Med-
4 icaid Innovation under section 1115A through the
5 Bundled Payments for Care Improvement (BPCI)
6 Initiative, the Secretary shall provide for an expe-
7 dited application process under this subsection.

8 “(c) REQUIREMENTS FOR QUALIFIED ENTITIES.—

9 “(1) REQUIREMENTS.—

10 “(A) IN GENERAL.—The Secretary shall
11 develop requirements for qualified entities to re-
12 ceive bundled payments for furnishing applica-
13 ble services for applicable conditions during an
14 episode of care under this section.

15 “(B) AGREEMENT PERIOD.—Under such
16 requirements, a qualified entity shall agree to
17 receive bundled payments for the furnishing of
18 such services for a 5-year period (each such
19 year in such period referred to in this section
20 as an ‘agreement year’).

21 “(C) BENEFICIARY TRANSPARENCY.—Such
22 requirements shall ensure transparency between
23 a qualified entity and applicable beneficiaries
24 such that notice is provided to an applicable
25 beneficiary sufficiently in advance, to the extent

1 practicable, of the beneficiary’s inpatient admis-
2 sion for the applicable condition and episode of
3 care involved. Such a notice shall include—

4 “(i) appropriate notice of bundled
5 payments for the applicable condition for
6 the episode of care involved; and

7 “(ii) a statement informing the bene-
8 ficiary of the beneficiary’s right to select
9 the providers of services and suppliers fur-
10 nishing items and services related to the
11 episode of care.

12 “(D) METHODOLOGY AND MEASURES FOR
13 QUALITY AND EFFICIENCY ARRANGEMENTS.—
14 Insofar as a qualified entity uses or seeks to
15 implement a quality and efficiency arrangement
16 under subsection (i), the qualified entity shall
17 specify in the application to the Secretary in de-
18 tail the methodology for allocating savings
19 under the arrangement and the specific meas-
20 ures to be used to assess the quality of care
21 under the arrangement.

22 “(2) PROVISION OF DATA BY SECRETARY.—

23 “(A) CLAIMS DATA.—The Secretary shall
24 furnish to a group of providers of services and
25 suppliers interested in submitting an applica-

1 tion under subsection (b)(2) claims data under
2 parts A and B, including complete claims files,
3 for applicable conditions relating to the pro-
4 viders and suppliers in the group that are suffi-
5 ciently specific to permit such group to deter-
6 mine whether to submit such application. Such
7 claims data shall also be furnished to a quali-
8 fied entity monthly during the agreement period
9 described in paragraph (1)(B) of any approved
10 application with respect to an applicable condi-
11 tion.

12 “(B) QUALITY DATA.—The Secretary shall
13 furnish to a qualified entity data on quality
14 measures with respect to any applicable condi-
15 tion under an approved application during the
16 agreement period for the entity for each episode
17 of care and across the continuum of care.

18 “(d) APPLICABLE CONDITIONS.—

19 “(1) INITIAL CONDITIONS.—In this section, the
20 term ‘applicable condition’ means any of the fol-
21 lowing procedures furnished as part of inpatient hos-
22 pital services:

23 “(A) Hip/Knee joint replacement.

24 “(B) Lumbar spine fusion.

25 “(C) Coronary artery bypass graft.

1 “(D) Heart valve replacement.

2 “(E) Percutaneous coronary intervention
3 with stent.

4 “(F) Colon resection.

5 “(2) DISCRETION TO ADD CONDITIONS.—Such
6 term also includes such additional procedures or
7 conditions as the Secretary may select. In selecting
8 such procedures or conditions, the Secretary may
9 take into consideration the factors described in sec-
10 tion 1866D(a)(2)(B).

11 “(e) APPLICABLE SERVICES; EPISODE OF CARE.—In
12 this section:

13 “(1) APPLICABLE SERVICES.—The term ‘appli-
14 cable services’ means the following items and serv-
15 ices:

16 “(A) Acute care inpatient services.

17 “(B) Physicians’ services delivered in and
18 outside of an acute care hospital setting.

19 “(C) Outpatient hospital services.

20 “(D) Post-acute care services, including
21 home health services, skilled nursing services,
22 inpatient rehabilitation services, and inpatient
23 hospital services furnished by a long-term care
24 hospital.

1 “(E) Other services the Secretary deter-
2 mines appropriate.

3 “(2) EPISODE OF CARE.—

4 “(A) IN GENERAL.—Subject to subpara-
5 graph (B), the term ‘episode of care’ means,
6 with respect to an applicable condition and an
7 applicable beneficiary, the period consisting
8 of—

9 “(i) the 3 days prior to the admission
10 of the applicable beneficiary to a hospital
11 with respect to the applicable condition;

12 “(ii) the duration of the applicable
13 beneficiary’s initial inpatient stay in such
14 hospital for the applicable condition; and

15 “(iii) the 90 days following the dis-
16 charge of the applicable beneficiary from
17 such hospital.

18 “(B) ESTABLISHMENT OF PERIOD BY THE
19 SECRETARY.—The Secretary, as appropriate,
20 may establish a period (other than the period
21 described in subparagraph (A)) for an episode
22 of care under this section based on data anal-
23 yses.

24 “(3) DISCHARGING HOSPITAL.—The term ‘dis-
25 charging hospital’ means, with respect to applicable

1 services in an episode of care, the hospital referred
2 to in paragraph (2)(A).

3 “(f) BUNDLED PAYMENT DEVELOPMENT.—

4 “(1) IN GENERAL.—Subject to the succeeding
5 provisions of this subsection, the Secretary shall de-
6 velop bundled payments for qualified entities. A bun-
7 dled payment shall provide for comprehensive pay-
8 ment for the costs of applicable services furnished to
9 an applicable beneficiary during an episode of care
10 for an applicable condition, including readmissions
11 related to the applicable condition but excluding un-
12 related readmissions, under either a fee-for-service
13 model with shared savings and losses (under sub-
14 section (g)) or under a prospective payment model
15 for advanced qualified entities (under subsection
16 (h)). Bundled payments shall be based on the spend-
17 ing targets computed under paragraph (2).

18 “(2) COMPUTATION OF SPENDING TARGETS.—

19 “(A) IN GENERAL.—The Secretary shall
20 compute under this paragraph, for each quali-
21 fied entity for each applicable condition for an
22 episode of care beginning in an agreement year
23 (beginning with 2015) that is attributable to a
24 discharging hospital, a spending target equal to

1 the updated amount computed under subpara-
2 graph (C) for that entity, episode, and year.

3 “(B) INITIAL WEIGHTED AVERAGE CAL-
4 CULATION FOR DISCHARGING HOSPITALS.—

5 “(i) IN GENERAL.—Using fee-for-serv-
6 ice claims data from the base period (as
7 defined in subparagraph (D)), subject to
8 clause (ii), the Secretary shall first cal-
9 culate a base average spending target for
10 each applicable condition for each dis-
11 charging hospital equal to a weighted aver-
12 age of spending under parts A and B for
13 all applicable services for such applicable
14 condition associated with initial admissions
15 to such hospital computed as the sum of
16 the following (with respect to such hos-
17 pital):

18 “(I) 60 percent of the standard-
19 ized spending per episode in the most
20 recent year in the base period.

21 “(II) 30 percent of the standard-
22 ized spending per episode in the pre-
23 vious year.

1 “(III) 10 percent of the stand-
2 ardized spending per episode in the
3 second previous year.

4 “(ii) EXCLUSION OF OUTLIERS AND
5 STANDARDIZATION.—In calculating the
6 amount of the base average spending tar-
7 get for an applicable condition under
8 clause (i) for a discharging hospital, the
9 Secretary shall—

10 “(I) exclude from the calculation
11 payments for episodes of care for the
12 applicable condition that exceed the
13 95th percentile of all such spending
14 for such episodes of care and applica-
15 ble condition, as estimated by the Sec-
16 retary, based on the most recent data
17 available; and

18 “(II) standardize the spending
19 made in each year in the base period
20 to each provider of service or supplier
21 to remove the spending adjustments
22 in effect in such year relating to pro-
23 vider or supplier location (such as
24 area wage indices) and provider type
25 (such as indirect medical education

1 adjustments and disproportionate
2 share hospital adjustments).

3 “(C) TRENDING THE SPENDING TARGETS
4 BASED ON NATIONAL GROWTH RATES TO
5 AGREEMENT YEAR; PERIODIC REBASING FOR
6 NEW AGREEMENT PERIODS.—

7 “(i) IN GENERAL.—The Secretary
8 shall update the base average spending tar-
9 gets for all discharging hospitals under
10 subparagraph (B) for each applicable con-
11 dition and agreement year based on trends
12 in the national fee-for-service claims data
13 for applicable services furnished during an
14 episode of care for an applicable condition
15 from the base period to the agreement year
16 involved. Such update shall not vary by
17 discharging hospital.

18 “(ii) PERIODIC REBASING FOR NEW
19 AGREEMENT PERIODS.—At the start of
20 each new agreement period, the Secretary
21 shall update the base period and calculate
22 new spending targets under the previous
23 provisions of this paragraph for a dis-
24 charging hospital and applicable condi-
25 tions, including providing for adjustments

1 by provider location and provider type of
2 the type described in subparagraph
3 (B)(ii)(II).

4 “(D) BASE PERIOD DEFINED.—In this
5 paragraph, except as provided in subparagraph
6 (C)(ii), the term ‘base period’ means the most
7 recent 3-year period for which complete data
8 are available to carry out this subsection.

9 “(g) FEE-FOR-SERVICE BUNDLED PAYMENT MODEL
10 WITH SHARED SAVINGS AND SHARED LOSSES.—

11 “(1) FEE-FOR-SERVICE-BASED PAYMENT.—If
12 the payment model under this subsection is selected
13 by a qualified entity, the Secretary shall pay pro-
14 viders of services and suppliers of the entity for ap-
15 plicable services for an applicable condition during
16 an episode of care amounts payable under parts A
17 and B for such services in the same manner as such
18 providers and suppliers would otherwise be paid
19 under such parts (referred to in this subsection as
20 ‘fee-for-service payments’).

21 “(2) SHARED SAVINGS AND LOSSES.—

22 “(A) COMPUTATION OF EACH QUALIFIED
23 ENTITY’S ACTUAL STANDARDIZED AVERAGE
24 SPENDING PER EPISODE OF CARE.—In applying
25 this subsection, in calculating the actual stand-

1 standardized average fee-for-service spending per epi-
2 sode of care for a discharging hospital for each
3 applicable condition in each agreement year, the
4 Secretary shall exclude outlier episodes of care
5 described in subsection (f)(2)(B)(ii)(I), as esti-
6 mated by the Secretary, based on data applica-
7 ble to payments in the agreement year and shall
8 standardize such spending per episode of care
9 in the manner provided in subsection
10 (f)(2)(B)(ii)(II). For the purpose of identifying
11 outlier episodes of care for each applicable con-
12 dition, the percentile ranking of each episode of
13 care and applicable condition and the 95th per-
14 centile shall be based on payments standardized
15 by adjustments for provider location and pro-
16 vider type of the type described in subsection
17 (f)(2)(B)(ii)(II).

18 “(B) COMPUTATION OF GROSS SHARED
19 SAVINGS AND SHARED LOSSES FOR EACH AP-
20 PPLICABLE CONDITION FOR EACH DISCHARGING
21 HOSPITAL.—For purposes of applying subpara-
22 graph (C), if actual standardized average fee-
23 for-service payments to a qualified entity for all
24 episodes of care for an applicable condition in

1 an agreement year for a discharging hospital,
2 as calculated under subparagraph (A), are—

3 “(i) less than the applicable spending
4 target under subsection (f)(2)(C) for such
5 condition, year, and hospital, there shall be
6 a gross shared savings for such applicable
7 condition, year, and hospital equal to 60
8 percent of the difference between such ac-
9 tual average payments and the spending
10 target for such condition, year, and hos-
11 pital; or

12 “(ii) greater than such applicable
13 spending target, there shall be a gross
14 shared loss for such applicable condition,
15 year, and hospital equal to 60 percent of
16 such difference.

17 “(C) RETROSPECTIVE RECONCILIATION.—

18 “(i) TOTALING GROSS SHARED SAV-
19 INGS AND LOSSES FOR ALL CONDITIONS
20 AND ALL DISCHARGING HOSPITALS FOR A
21 QUALIFIED ENTITY.—At the end of each
22 agreement year for each qualified entity,
23 for purposes of applying clauses (ii) and
24 (iii), the Secretary shall aggregate the
25 gross shared savings and the gross shared

1 losses under subparagraph (B) of such en-
2 tity for the year for all applicable condi-
3 tions and for all discharging hospitals.

4 “(ii) PAYMENT TO ENTITY OF NET
5 SAVINGS.—Subject to clause (iv) and sub-
6 section (j)(3) (relating to quality perform-
7 ance thresholds), if such aggregate gross
8 shared savings exceeds such aggregate
9 gross shared losses for a qualified entity
10 for an agreement year, the Secretary shall
11 pay to the qualified entity a lump sum
12 amount equal to such excess for such year.

13 “(iii) COLLECTION FROM ENTITY OF
14 NET LOSSES.—Subject to clause (iv), if
15 such aggregate gross shared losses exceeds
16 such aggregate gross shared savings for a
17 qualified entity for an agreement year, the
18 qualified entity shall pay to the Secretary
19 (and the Secretary shall collect from the
20 entity) a lump sum amount equal to such
21 excess for such year.

22 “(iv) CAP ON PAYMENTS.—In no case
23 shall the payment under clause (ii) or (iii)
24 with respect to a qualified entity for an
25 agreement year exceed 10 percent of the

1 aggregate spending target for that quali-
2 fied entity for all applicable conditions and
3 all discharging hospitals for that year.

4 “(h) PROSPECTIVE BUNDLED PAYMENT MODEL FOR
5 ADVANCED QUALIFIED ENTITIES.—

6 “(1) IN GENERAL.—Subject to approval by the
7 Secretary, if the payment model under this sub-
8 section is selected, a qualified entity may elect to re-
9 ceive a prospective bundled payment for each episode
10 of care for each applicable condition and discharging
11 hospital in the agreement year equal to the spending
12 target for such episode, year, and hospital under
13 subsection (f)(2) and the provisions of subsection (g)
14 do not apply. Such spending target shall be ad-
15 justed, in the same manner described in subsection
16 (g)(2)(B), in order to take into account outlier epi-
17 sodes of care and standardized adjustments for pro-
18 vider location and provider type of the type de-
19 scribed in subsection (f)(2)(B)(ii)(II).

20 “(2) RULE OF CONSTRUCTION.—Nothing in
21 this section shall be construed as prohibiting a quali-
22 fied entity that receives bundled payments under
23 this subsection from participating in an accountable
24 care organization under section 1899.

1 “(3) RELATIONSHIP TO BPCI.—The Secretary
2 may not terminate the Bundled Payments for Care
3 Improvement initiative conducted pursuant to sec-
4 tion 1115A until the prospective bundled payment
5 model is implemented under this subsection.

6 “(i) QUALITY AND EFFICIENCY ARRANGEMENTS.—

7 “(1) IN GENERAL.—Subject to subsection
8 (c)(1)(D) (relating to application requirements for
9 notice of quality and efficiency arrangements and
10 their structure) and subsection (j)(3) (relating to
11 minimum quality performance thresholds), qualified
12 entities participating in either the fee-for-service
13 bundled payment model under subsection (g) or the
14 prospective bundled payment model under subsection
15 (h) may enter into quality and efficiency arrange-
16 ments under which physicians and other health care
17 practitioners work to improve the quality and effi-
18 ciency of care under this title.

19 “(2) TYPES OF ARRANGEMENTS.—The arrange-
20 ments under paragraph (1) shall take into account
21 the utilization of the resources of providers of serv-
22 ices and suppliers and may provide for a distribution
23 of a portion of any shared savings (or internal sav-
24 ing, as the case may be) realized under this section
25 to qualifying providers and suppliers.

1 “(j) QUALITY MEASURES.—

2 “(1) SELECTION; DEVELOPMENT.—

3 “(A) SELECTION.—For each applicable
4 condition, the Secretary shall select quality
5 measures related to care provided by providers
6 of services and suppliers through qualified enti-
7 ties to which bundled payments are made under
8 this section. In selecting quality measures, to
9 the extent appropriate and practicable, the Sec-
10 retary shall choose measures that—

11 “(i) are endorsed and validated by the
12 entity with a contract under section 1890;

13 “(ii) pertain to the National Quality
14 Strategy’s six priorities;

15 “(iii) are used by the Secretary under
16 other provisions of this title; and

17 “(iv) minimize the incremental data
18 extraction and reporting burden on pro-
19 viders and suppliers.

20 “(B) DEVELOPMENT OF ELECTRONICALLY
21 SPECIFIED EPISODIC MEASURES.—The Sec-
22 retary shall develop longitudinal quality and ef-
23 ficiency measures to assess performance of
24 qualified entities with respect to patient out-
25 comes and the care provided for each applicable

1 condition across the associated episodes of care.
2 Such measures shall be electronically specified
3 for submittal through the use of qualified elec-
4 tronic health records (as defined in section
5 3000(13) of the Public Health Service Act (42
6 U.S.C. 300jj(13))).

7 “(2) REPORTING ON QUALITY MEASURES.—

8 “(A) IN GENERAL.—A qualified entity
9 shall submit data to the Secretary on quality
10 measures selected under paragraph (1) for each
11 agreement year in a form and manner specified
12 by the Secretary consistent with the succeeding
13 provisions of this paragraph.

14 “(B) SUBMISSION OF DATA THROUGH
15 ELECTRONIC HEALTH RECORD.—To the extent
16 practicable, such data shall be submitted
17 through the use of a qualified electronic health
18 record (as defined in section 3000(13) of the
19 Public Health Service Act (42 U.S.C.
20 300jj(13))).

21 “(C) SUBMISSION OF DATA USED IN
22 OTHER PROGRAMS.—Insofar as quality meas-
23 ures established under paragraph (1) are the
24 same as those measures used by the Secretary
25 under other provisions of this title, such as

1 those selected under section 1886(b)(3)(B)(viii),
2 the Secretary shall use existing processes for
3 the submission of data for such measures under
4 this paragraph.

5 “(3) QUALITY PERFORMANCE THRESHOLDS.—

6 “(A) ESTABLISHMENT.—For each applica-
7 ble condition, the Secretary shall establish min-
8 imum quality performance thresholds for the
9 measures established under paragraph (1). In
10 the case of a quality and efficiency arrange-
11 ment, such performance thresholds shall be de-
12 veloped using the quality measures identified by
13 the qualified entity in its application under sub-
14 section (c)(1)(D) if approved by the Secretary.

15 “(B) LOSS OF SHARED SAVINGS PAYMENT
16 AND QUALITY AND EFFICIENCY ARRANGEMENTS
17 FOR FAILURE TO MEET MINIMUM QUALITY PER-
18 FORMANCE THRESHOLDS.—If a qualified entity
19 fails to meet the minimum quality performance
20 thresholds established under subparagraph (A)
21 for an agreement year—

22 “(i) no payment may be made to the
23 entity under subsection (g)(2)(C)(ii) with
24 respect to that year; and

1 “(ii) the entity may not implement
2 any quality and efficiency arrangement
3 under subsection (i) for that year.

4 “(C) ADJUSTMENT TO PROCESS MEASURES
5 FOR NEW TECHNOLOGIES AND INNOVATIVE
6 TREATMENTS.—In the case of a qualified entity
7 that furnishes a new technology or innovative
8 item or service (for which payment may be
9 made under this title) to applicable beneficiaries
10 for an applicable condition and episode of care
11 that changes the clinical process of care for
12 such applicable condition and episode of care
13 with respect to such beneficiaries, insofar as
14 such change results in the failure of the quali-
15 fied entity to meet the minimum quality thresh-
16 old established under paragraph (1) for one or
17 more applicable clinical process of care meas-
18 ures, the Secretary may provide for such ad-
19 justments or exceptions to, or exclusions of,
20 such clinical process of care measure or meas-
21 ures from the overall quality performance
22 thresholds established with respect to such ap-
23 plicable condition and episode of care. Nothing
24 in this subparagraph shall be construed to

1 apply to any clinical outcomes measure under
2 such quality performance thresholds.

3 “(k) WAIVERS.—

4 “(1) IN GENERAL.—The Secretary shall waive
5 such provisions of this title and title XI as may be
6 necessary to carry out the program, including the
7 following:

8 “(A) With respect to authorizing quality
9 and efficiency arrangements between qualified
10 entities and providers of services and suppliers,
11 section 1877(a) (relating to physician self-refer-
12 ral), paragraphs (1) and (2) of sections
13 1128A(b) (relating to the gainsharing civil
14 money penalties), and paragraphs (1) and (2)
15 of section 1128B(b) (relating to the anti-kick-
16 back statute).

17 “(B) Section 1128A(a)(5) of the Act (re-
18 lating to the inducement civil money penalties).

19 “(C) Section 1861(i) (relating to the 3-day
20 acute hospitalization prerequisite before eligi-
21 bility for post-hospital extended care services).

22 “(D) With respect to home health serv-
23 ices—

24 “(i) sections 1814(a)(2)(C) and
25 1835(a)(2)(A) (relating to the requirement

1 that an individual be confined to home in
2 order to be eligible for benefits for home
3 health services);

4 “(ii) limitations on the amount, fre-
5 quency, and duration on home health serv-
6 ices; and

7 “(iii) prohibitions of free preoperative
8 home safety assessments by home health
9 agencies for patients scheduled to undergo
10 surgery (such as under Advisory Opinion
11 No. 06–01 of the Inspector General of the
12 Department of Health and Human Serv-
13 ices).

14 “(2) AUTHORITY TO MODIFY WAIVERS UNDER
15 CERTAIN CIRCUMSTANCES.—

16 “(A) IN GENERAL.—In the case of a quali-
17 fied entity with respect to which one or more
18 waivers under paragraph (1) is in effect, if
19 upon a review of the performance or an audit
20 of the entity the Secretary finds a pattern of
21 deficiencies or harm to applicable beneficiaries,
22 the Secretary may modify or revoke any such
23 waiver at any time as applied to that qualified
24 entity.

1 “(B) TERMINATION OF CERTAIN WAIVERS
2 IN THE CASE OF EXCESS SHARED LOSSES.—

3 “(i) IN GENERAL.—Subject to the
4 process described in clause (ii), in the case
5 of a qualified entity that has selected the
6 payment model under subsection (g) and
7 has gross shared losses exceeding the cap
8 under subsection (g)(2)(C)(iv) with respect
9 to an applicable condition, the Secretary
10 shall terminate waivers described in para-
11 graphs (1)(C) and (1)(D) with respect to
12 such qualified entity and applicable condi-
13 tion.

14 “(ii) PRE-TERMINATION NOTICE.—
15 The Secretary shall establish a process
16 whereby a qualified entity is furnished no-
17 tice of any deficiency that may give rise to
18 a termination of waivers under clause (i)
19 not later than 6 months before the pro-
20 posed effective date of the termination.

21 “(l) INDEPENDENT EVALUATION AND REPORTS ON
22 PROGRAM.—

23 “(1) INDEPENDENT EVALUATION.—The Sec-
24 retary shall conduct an independent evaluation of
25 the impact of providing bundled payments to quali-

1 fied entities under this section. Such evaluation shall
2 include an examination of the extent to which the
3 bundling of payments this section have resulted in—

4 “(A) improved health outcomes;

5 “(B) improved access to care for applicable
6 beneficiaries;

7 “(C) reduced spending under this title; and

8 “(D) improvement in performance on qual-
9 ity measures selected under subsection
10 (j)(1)(A).

11 “(2) REPORTS.—

12 “(A) INTERIM REPORT.—Not later than
13 March 1, 2018, the Secretary shall submit to
14 Congress a report on the initial results of the
15 independent evaluation conducted under para-
16 graph (1).

17 “(B) FINAL REPORT.—Not later than
18 March 1, 2020, the Secretary shall submit to
19 Congress a report on the final results of the
20 independent evaluation conducted under para-
21 graph (1) and may include recommendations
22 for the expansion of bundled payment meth-
23 odologies and applicable conditions under this
24 section as the Secretary determines to be appro-
25 priate.

1 “(C) REPORT ON POLICIES TO ENSURE AC-
2 CESS TO NEW MEDICAL TECHNOLOGIES AND IN-
3 NOVATIVE TREATMENTS UNDER MEDICARE
4 SHARED SAVINGS PROGRAMS AND BUNDLED
5 PAYMENT PROGRAMS.—

6 “(i) STUDY.—The Secretary, acting
7 through the Administrator of the Centers
8 for Medicare & Medicaid Services, shall
9 conduct a study of payment adjustment
10 policies (described in clause (ii)) under this
11 title for new medical technologies and inno-
12 vative items and services to develop a set
13 of policies to incorporate such adjustments
14 into the following programs:

15 “(I) The Medicare Shared Sav-
16 ings Program (under section 1899).

17 “(II) Medicare bundled payment
18 programs (such as those established
19 under section 1866D and this sec-
20 tion).

21 “(III) Shared savings or bundled
22 payment programs tested by the Cen-
23 ter for Medicare and Medicaid Innova-
24 tion under section 1115A or under

1 other demonstration authority of the
2 Secretary.

3 “(ii) PAYMENT ADJUSTMENT PRO-
4 GRAMS DESCRIBED.—For purposes of
5 clause (i), the payment adjustment policies
6 described in this clause for new medical
7 technologies and innovative items and serv-
8 ices include the following:

9 “(I) The new technology add-on
10 payment policy established under sub-
11 paragraphs (K) and (L) of section
12 1886(d)(5) under the prospective pay-
13 ment system for inpatient hospital
14 services.

15 “(II) The pass-through payment
16 policy established under section
17 1833(t)(6) under the prospective pay-
18 ment system for covered OPD serv-
19 ices.

20 “(III) The New Technology Am-
21 bulatory Payment Classification pay-
22 ment policy established by the Sec-
23 retary through rulemaking for pur-
24 poses of the prospective payment sys-
25 tem for covered OPD services.

1 “(iii) REPORT.—Not later than one
2 year after the date of the enactment of this
3 section, the Secretary shall submit to Con-
4 gress a report on the study conducted
5 under clause (i) which shall include rec-
6 ommendations for such legislation and ad-
7 ministrative action as the Secretary deter-
8 mines to be appropriate.”.

9 **SEC. 214. (BLACK) TENNESSEE DSH ALLOTMENT FOR FIS-**
10 **CAL YEAR 2015 AND SUCCEEDING FISCAL**
11 **YEARS.**

12 Section 1923(f)(6)(A) of the Social Security Act (42
13 U.S.C. 1396r-4(f)(6)(A)) is amended by adding at the end
14 the following:

15 “(vi) ALLOTMENT FOR FISCAL YEAR
16 2015 AND SUCCEEDING FISCAL YEARS.—
17 Notwithstanding any other provision of
18 this subsection, any other provision of law,
19 or the terms of the TennCare Demonstra-
20 tion Project in effect for the State, the
21 DSH allotment for Tennessee for fiscal
22 year 2015, and for each fiscal year there-
23 after, shall be \$53,100,000 for each such
24 fiscal year.”.

1 **SEC. 215. H.R. 4857 – (REED) ENSURING EQUAL ACCESS TO**
2 **TREATMENTS ACT OF 2014.**

3 Section 1833(t)(2)(G) of the Social Security Act (42
4 U.S.C. 1395l(t)(2)(G)) is amended by striking “shall” and
5 all that follows and inserting the following: “shall—

6 “(i) create additional groups of cov-
7 ered OPD services that classify separately
8 those procedures that utilize contrast
9 agents from those that do not;

10 “(ii) create and implement, for serv-
11 ices furnished after the date of the enact-
12 ment of this clause and in a budget neutral
13 manner, additional groups of covered OPD
14 services that classify separately those pro-
15 cedures that utilize a drug (other than con-
16 trast agents and diagnostic radiopharma-
17 ceuticals) that both—

18 “(I) has a cost above the drug
19 packaging threshold; and

20 “(II) functions as a supply when
21 used in a diagnostic test or procedure;
22 from those that do not; and”.

23 **SEC. 216. H.R. 5232 – (YOUNG) NOTICE ACT.**

24 (a) IN GENERAL.—Section 1866(a)(1) of the Social
25 Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

1 (1) in subparagraph (V), by striking at the end
2 “and”;

3 (2) in the first subparagraph (W), by striking
4 at the end the period and inserting a comma;

5 (3) in the second subparagraph (W)—

6 (A) by redesignating such subparagraph as
7 subparagraph (X); and

8 (B) by striking at the end the period and
9 inserting “, and”; and

10 (4) by inserting after such subparagraph (X)
11 the following new subparagraph:

12 “(Y) in the case of a hospital, to provide to
13 each individual who is entitled to benefits under part
14 A and who the hospital classifies for more than 24
15 hours as an outpatient under observation status or
16 any other similar status, as the Secretary determines
17 appropriate (or to a person acting on the individual’s
18 behalf), not later than 36 hours after the time of
19 such classification of such individual under such sta-
20 tus (or, if sooner, upon discharge), an adequate oral
21 and written notification (as defined by the Secretary
22 pursuant to rulemaking and containing such lan-
23 guage as the Secretary prescribes consistent with
24 this paragraph) which—

1 “(i) explains the status of the individual as
2 an outpatient under such observation status or
3 any other such similar status and not as an in-
4 patient of the hospital;

5 “(ii) explains the reason for the classifica-
6 tion of such individual under such status;

7 “(iii) explains the implications of such sta-
8 tus as an outpatient on—

9 “(I) eligibility for coverage of items
10 and services under this title, including such
11 items and services furnished by the hos-
12 pital with respect to such individual while
13 under such status and for items and serv-
14 ices under this title for a subsequent dis-
15 charge to a skilled nursing facility or other
16 facility; and

17 “(II) cost-sharing requirements under
18 this title, including with respect to items
19 and services furnished by the hospital to
20 such individual while under such status
21 and with respect to items and services
22 under this title for a subsequent discharge
23 to a skilled nursing facility or other facil-
24 ity;

1 “(iv) includes the name and title of the
2 staff of the hospital who provided the oral noti-
3 fication and the date and time of such oral noti-
4 fication;

5 “(v) includes such additional information
6 as the Secretary deems appropriate; and

7 “(vi) in the case of the written notification,
8 is—

9 “(I) signed by such individual (or per-
10 son acting on the individual’s behalf) to ac-
11 knowledge receipt of such notification;

12 “(II) written and formatted using lan-
13 guage that is clear and easily understand-
14 able to Medicare beneficiaries; and

15 “(III) made available in different lan-
16 guages, as specified by the Secretary.”.

17 (b) **EFFECTIVE DATE.**—The amendments made by
18 subsection (a) shall apply with respect to items and serv-
19 ices furnished on or after the date that is six months after
20 the date of the enactment of this Act.

21 **SEC. 217. H.R. 4188 - (RENACCI) ESTABLISHING BENE-**
22 **FICIARY EQUITY IN THE HOSPITAL READMIS-**
23 **SION PROGRAM ACT.**

24 (a) **TRANSITIONAL ADJUSTMENT FOR DUAL ELIGI-**
25 **BLE POPULATION.**—Section 1886(q)(4)(C) of the Social

1 Security Act (42 U.S.C. 1395ww(q)(4)(C)) is amended by
2 adding at the end the following new clause:

3 “(iii) TRANSITIONAL ADJUSTMENT
4 FOR DUAL ELIGIBLES.—In applying clause
5 (i) for discharges occurring on or after Oc-
6 tober 1, 2015, and before the initial appli-
7 cation of clause (iv), the Secretary shall
8 provide for such risk adjustment as will
9 take into account a hospital’s proportion of
10 inpatients who are full-benefit dual eligible
11 individuals (as defined in section
12 1935(e)(6)) in order to ensure that hos-
13 pitals that treat the most vulnerable popu-
14 lations are not unfairly penalized by the
15 program under this subsection.”.

16 (b) ADJUSTMENTS AFTER COMPLETION OF IMPACT
17 REPORTS.—Section 1886(q)(4)(C) of the Social Security
18 Act (42 U.S.C. 1395ww(q)(4)(C)) is further amended by
19 adding at the end the following new clause:

20 “(iv) ADJUSTMENTS BASED ON IM-
21 PACT REPORTS.—Effective for discharges
22 occurring in fiscal years beginning on or
23 after the date that is 6 months after the
24 date of completion of the reports under
25 section 2(d)(1)(A)(ii) of the IMPACT Act

1 of 2014, the Secretary shall provide for
2 such risk adjustment as will take into ac-
3 count, based on such report (and, if appli-
4 cable, the reports submitted under section
5 2(d)(1)(B)(ii) of such Act), factors relating
6 to disparities in patient status in order to
7 ensure that hospitals that treat the most
8 vulnerable populations are not unfairly pe-
9 nalized by the program under this sub-
10 section.”.

11 (c) MEDPAC STUDY ON 30-DAY READMISSION
12 THRESHOLD.—The Medicare Payment Advisory Commis-
13 sion shall conduct a study on the appropriateness of using
14 a threshold of 30 days for readmissions under section
15 1886(q)(5)(E) of the Social Security Act (42 U.S.C.
16 1395ww(q)(5)(E)). The Commission shall submit to Con-
17 gress a report on such study in its report to Congress in
18 June 2016.

19 (d) ADDRESSING ISSUE OF NONCOMPLIANT PA-
20 TIENTS.—Section 1886(q)(4)(C) of the Social Security
21 Act (42 U.S.C. 1395ww(q)(4)(C)), as amended by sub-
22 sections (b) and (c), is further amended by adding at the
23 end the following new clause:

24 “(v) CONSIDERATION OF EXCLUSION
25 OF NONCOMPLIANT PATIENT CASES BASED

1 ON V CODES.—In promulgating regulations
2 to carry out this subsection for the applica-
3 ble period with respect to fiscal year 2017,
4 the Secretary shall consider the use of V
5 codes for potential exclusions of cases in
6 order to address the issue of noncompliant
7 patients.”.

8 (e) REMOVAL OF CERTAIN READMISSIONS.—Section
9 1886(q)(5)(E) of the Social Security Act (42 U.S.C.
10 1395ww(q)(5)(E)) is amended by adding at the end the
11 following: “For discharges occurring on or after October
12 1, 2015, such term does not include an admission that
13 is classified within one or more of the following: trans-
14 plants, burns, trauma, psychosis, or substance abuse.”.

15 **SEC. 218. (CAMP) CANCER EXEMPTION FOR CERTAIN**
16 **QUALIFYING HOSPITALS.**

17 (a) QUALIFICATIONS FOR NEW PPS-EXEMPT CAN-
18 CER HOSPITALS.—Section 1886(d)(1) of the Social Secu-
19 rity Act (42 U.S.C. 1395ww(d)(1)) is amended—

20 (1) in subparagraph (B)(v)—

21 (A) by striking “or” at the end of sub-
22 clause (II);

23 (B) by striking the semicolon at the end of
24 subclause (III) and inserting “, or”; and

1 (C) by adding after subclause (III) and be-
2 fore the flush matter following subclause (III)
3 the following new subclause:

4 “(IV) a hospital (not described in a previous
5 subclause) that meets the requirements of subpara-
6 graph (F) for the 12-month cost reporting period in-
7 volved and has an application approved consistent
8 with subparagraph (G);”;

9 (2) in subparagraph (E), by inserting “and sub-
10 subparagraph (F)” after “subparagraph (B)(v)”; and

11 (3) by adding at the end the following new sub-
12 paragraphs:

13 “(F) For purposes of subparagraph (B)(v)(IV), the
14 requirements of this subparagraph for a hospital for a 12-
15 month cost reporting period are as follows:

16 “(i) For the most recent cost reporting period
17 for which appropriate cost report data are available
18 (as determined by the Secretary), at least 50 percent
19 of the hospital’s total discharges have a principal
20 finding of neoplastic disease (as defined in subpara-
21 graph (E)).

22 “(ii) The hospital or its predecessor provider
23 entity has, for at least 12 years, served a com-
24 prehensive cancer center designated as such by the
25 National Cancer Institute of the National Institutes

1 of Health. In the previous sentence and in clause
2 (v), the term ‘predecessor provider entity’ means,
3 with respect to a hospital, an entity situated on or
4 adjacent to the physical campus of the hospital that
5 previously provided cancer-related services substan-
6 tially similar to the cancer-related services that are
7 being provided by the hospital.

8 “(iii) The hospital has its own unique CMS
9 Certification Number issued by the Secretary.

10 “(iv) The hospital, at the time of its application
11 described in subparagraph (G), is licensed or reg-
12 istered with its appropriate state regulatory agency
13 as having at least 90 inpatient beds.

14 “(v) The hospital or its predecessor provider en-
15 tity is accredited by the American College of Sur-
16 geons as serving as a comprehensive cancer center
17 designated by the National Cancer Institute of the
18 National Institutes of Health.

19 “(G)(i) Any hospital seeking to be classified as a hos-
20 pital under subparagraph (B)(v)(IV) must file an applica-
21 tion seeking such classification (in such form and manner
22 as the Secretary may specify) not later than 20 months
23 after the date of the enactment of this subparagraph.

24 “(ii) The Secretary shall make a determination on
25 such an application not later than 60 days after the date

1 it is filed. The Secretary shall approve the application if
2 the application is submitted consistent with clause (i) and
3 establishes (as determined by the Secretary) that the hos-
4 pital meets the requirements for classification under sub-
5 paragraph (B)(v)(IV). Approval of such an application
6 shall take effect for cost reporting periods beginning after
7 the date of such approval.

8 “(iii) The requirement of section 412.22(e)(1)(i) of
9 title 42, Code of Federal Regulations (as in effect as of
10 the date of the enactment of this subparagraph, or any
11 successor to such requirement) shall not apply to the qual-
12 ification of a hospital for classification under subpara-
13 graph (B)(v)(IV) pursuant to an application filed under
14 this subparagraph.”.

15 (b) INPATIENT PAYMENT TARGET AMOUNT FOR
16 NEWLY QUALIFIED HOSPITALS.—Section 1886(b)(3) of
17 the Social Security Act (42 U.S.C. 1395ww(b)(3)) is
18 amended—

19 (1) in subparagraph (E), by inserting “subject
20 to subparagraph (M),” after “clause (v) of sub-
21 section (d)(1)(B),”; and

22 (2) by adding at the end the following new sub-
23 paragraph:

24 “(M) In the case of a hospital described in subclause
25 (IV) of subsection (d)(1)(B)(v) located in a State with an-

1 other PPS-exempt cancer hospital, the term ‘target
2 amount’ means an amount that—

3 “(i) is based on the median target amount (as
4 defined in subparagraph (E)) calculated as of Janu-
5 ary 31, 2014, for all hospitals described in sub-
6 clauses (I), (II), and (III) of subsection (d)(1)(B)(v)
7 (as determined by the Secretary); and

8 “(ii) does not exceed the lowest target amount
9 (as defined in subparagraph (E)) for any hospital
10 described in subclause (I), (II), or (III) of such sub-
11 section that is located in such State.”.

12 (c) OUTPATIENT PAYMENT TARGET AMOUNT FOR
13 NEWLY QUALIFIED HOSPITALS.—Section 1833(t)(18)(B)
14 of the Social Security Act (42 U.S.C. 1395l(t)(18)(B)) is
15 amended by adding at the end the following new sentence:
16 “With respect to a hospital described under section
17 1886(d)(1)(B)(v)(IV), the Secretary shall provide such ad-
18 justment, if determined appropriate, only after such hos-
19 pital submits a cost report or other appropriate informa-
20 tion as determined by the Secretary.”

21 **SEC. 219. (CAMP) RETROSPECTIVE PAYMENT ADJUST-**
22 **MENTS DURING A CONTRACTOR CHANGE.**

23 Section 1874A of the Social Security Act (42 U.S.C.
24 1395kk–1) is amended by adding at the end the following
25 new subsection:

1 “(h) LIMITATION ON RECOUPMENT IN CASE OF MAC
2 TRANSITION.—

3 “(1) IN GENERAL.—In the case that a medicare
4 administrative contractor makes a payment under
5 subsection (a)(4)(B) to a medicare-dependent, small
6 rural hospital (as defined in section 1886(d)(5)(G))
7 and a different medicare administrative contractor
8 subsequently determines that such payment was an
9 overpayment, the different medicare administrative
10 contractor may not, in an attempt to recoup such
11 overpayment from such hospital, make a recoupment
12 from such hospital in an amount that is greater
13 than 25 percent of the amount by which such hos-
14 pital was overpaid by the medicare administrative
15 contractor that made such payment to such hospital.

16 “(2) EFFECTIVE DATE.—This subsection shall
17 apply with respect to payments made under sub-
18 section (a)(4)(B)—

19 “(A) that are made on or after the date
20 that is seven years before the date of the enact-
21 ment of this subsection; and

22 “(B) with respect to which the recoupment
23 described in paragraph (1) that is in excess of
24 the amount permitted under such paragraph
25 has not, on a date that is before the date of the

1 enactment of this subsection, been made by the
2 different medicare administrative contractor de-
3 scribed in such paragraph.”.