

**[DISCUSSION DRAFT]**

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

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IN THE HOUSE OF REPRESENTATIVES

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

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**A BILL**

To amend title XVIII of the Social Security Act to 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. (Roskam) Developing an Innovative Strategy for Antimicrobial 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 (B) and (F) of subsection (d)(5)  
4 that are attributable to inpatient short-term  
5 hospital stays (and, with respect to  
6 such subparagraph (F), paid directly with  
7 respect to individual discharges).

8  
9 “(ii) NO SEPARATE PAYMENT ADJUSTMENT.—The Secretary shall not adjust or  
10 vary the payment rate for short-term hospital  
11 stays based on indirect medical teaching  
12 expenses or disproportionate share hospital  
13 payment adjustments (of the type  
14 provided under subparagraphs (B) and (F)  
15 of subsection (d)(5)).

16  
17 “(D) EXCLUSION OF HOSPITAL SPECIFIC  
18 RATES.—In computing the base payment rate  
19 the Secretary shall not include any hospital  
20 specific 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  
25 community 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 OPPTS 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. (ROSKAM) DEVELOPING AN INNOVATIVE STRAT-**  
10 **EGY FOR ANTIMICROBIAL RESISTANT MICRO-**  
11 **ORGANISMS ACT OF 2014.**

12 (a) ADDITIONAL PAYMENT FOR NEW ANTI-  
13 MICROBIAL DRUGS UNDER MEDICARE.—Section  
14 1886(d)(5) of the Social Security Act (42 U.S.C.  
15 1395ww(d)(5)) is amended by adding at the end the fol-  
16 lowing new subparagraph:

17 “(M)(i) Effective for discharges beginning on or after  
18 October 1, 2015, the Secretary shall, after notice and op-  
19 portunity for public comment (in the publications required  
20 by subsection (e)(5) for a fiscal year or otherwise), recog-  
21 nize the costs of new antimicrobial drugs under the pay-  
22 ment system established under this subsection.

23 “(ii) Pursuant to clause (i), the Secretary shall pro-  
24 vide for additional payment to be made under this sub-  
25 section with respect to discharges involving new anti-

1 microbial drugs in the amount provided for under section  
2 1847A for drugs and biologicals that are described in sec-  
3 tion 1842(o)(1)(C).

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

9 “(I) is indicated to treat an infection caused by,  
10 or likely to be caused by, a qualifying pathogen (as  
11 defined under section 505E(f) of the Federal Food,  
12 Drug, and Cosmetic Act (21 U.S.C. 355f(f))) for  
13 which there is an unmet medical need and which is  
14 associated with high rates of mortality or significant  
15 patient morbidity (as determined by the Secretary,  
16 in consultation with the Director of the Centers for  
17 Disease Control and Prevention and the infectious  
18 disease professional community); and

19 “(II) is used in facilities that participate in the  
20 Antimicrobial Use and Resistance Module of the Na-  
21 tional Healthcare Safety Network of the Centers for  
22 Disease Control and Prevention (or, in the case that  
23 such Module is not available, is used in facilities that  
24 participate in such successor or similar reporting  
25 module or program relating to antimicrobials as the

1 Secretary shall specify to the extent available to  
2 such facilities, as determined by the Secretary).

3 “(iv) Not later than July 1, 2015, the Secretary shall  
4 first publish in the Federal Register a list of the new anti-  
5 microbial drugs.”.

6 (b) STUDY AND REPORT ON REMOVING BARRIERS TO  
7 DEVELOPMENT OF NEW ANTIMICROBIAL DRUGS.—

8 (1) STUDY.—The Comptroller General of the  
9 United States shall, in consultation with the Direc-  
10 tor of the United States Patent and Trademark Of-  
11 fice, the Director of the National Institutes of  
12 Health, the Commissioner of Food and Drugs, and  
13 the Director of the Centers for Disease Control and  
14 Prevention, conduct a study to—

15 (A) identify and examine the barriers that  
16 prevent the development of new antimicrobial  
17 drugs, as defined in section 1886(d)(5)(M)(iii)  
18 of the Social Security Act (42 U.S.C.  
19 1395ww(d)(5)(M)(iii)); and

20 (B) develop recommendations for actions  
21 to be taken in order to overcome any barriers  
22 identified under subparagraph (A).

23 (2) REPORT.—Not later than one year after the  
24 date of the enactment of this Act, the Comptroller

1 General shall submit to Congress a report on the  
2 study conducted under paragraph (1).

3 **SEC. 206. (BUCHANAN) HAND SANITATION DEMONSTRATION PROGRAM.**  
4

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

8 **“SEC. 1866F. HAND SANITATION DEMONSTRATION PROGRAM.**  
9

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

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

16 “(2) implement solutions to eliminate those bar-  
17 riers.

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

22 “(c) DEFINITIONS.—In this section:

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

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

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

5           “(C) A hospital that is paid under section  
6           1814(b)(3).

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

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

20          “(d) PARTICIPATION.—

21                 “(1) APPLICATION.—To participate in a dem-  
22                 onstration project under this section, an eligible hos-  
23                 pital shall submit an application to the Secretary at  
24                 such time, in such manner, and containing such in-  
25                 formation as the Secretary may require.

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

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

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

12                  “(1) identify barriers to hand sanitation, which  
13                  may include—

14                          “(A) ineffective use of soap dispensers or  
15                          sinks;

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

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

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

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

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

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

6           “(H) forgetting; and

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

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

13           “(B) real-time behavior modification feed-  
14           back to healthcare workers;

15           “(C) trained and certified independent ob-  
16           servers;

17           “(D) peer-to-peer coaching;

18           “(E) just-in-time training; and

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

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

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

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

11       (b) REQUIREMENTS FOR HAND WASHING QUALITY  
12 MEASURES.—

13           (1) SELECTION.—Not later than October 1,  
14 2015, the Secretary shall select one or more hand  
15 washing quality measures to be used for the quality  
16 reporting requirement described in paragraph (2).  
17 The Secretary may use information from the dem-  
18 onstration program conducted pursuant to section  
19 1866F of the Social Security Act (as added by sub-  
20 section (a)) to inform the selection of hand washing  
21 quality measures under this paragraph.

22           (2) REPORTING MEASURES UNDER THE SOCIAL  
23 SECURITY ACT.—Not later than October 1, 2016,  
24 the Secretary shall require reporting of the selected  
25 hand washing quality measures pursuant to section



1 1886(b)(3)(B)(viii) of the Social Security Act (42  
2 U.S.C. 1395ww(b)(3)(B)(viii)).

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

5 (A) in the system described in section  
6 1886(b)(3)(B)(viii) of such Act (42 U.S.C.  
7 1395ww(b)(3)(B)(viii)), not later than October  
8 1, 2016; and

9 (B) in the program described in section  
10 1886(o) of such Act (42 U.S.C. 1395ww(o)),  
11 not later than October 1, 2018.

12 (4) PUBLIC REPORTING.—Not later than Octo-  
13 ber 1, 2017, the Secretary shall make available to  
14 the public the hand washing quality measures se-  
15 lected under paragraph (1).

16 **SEC. 207. H.R. 3769 - (SMITH) EXTENSION OF NONENFORCE-**  
17 **MENT INSTRUCTION FOR THE MEDICARE DI-**  
18 **RECT SUPERVISION REQUIREMENT FOR**  
19 **THERAPEUTIC HOSPITAL OUTPATIENT SERV-**  
20 **ICES FOR CRITICAL ACCESS HOSPITALS AND**  
21 **RURAL HOSPITALS; STUDY OF IMPACT OF**  
22 **FAILURE TO EXTEND SUCH INSTRUCTION.**

23 (a) EXTENSION OF THERAPY SUPERVISION NON-  
24 ENFORCEMENT INSTRUCTION.—The Secretary of Health  
25 and Human Services shall, during the extension period,

1 extend the therapy supervision nonenforcement instruc-  
2 tion.

3 (b) DEFINITIONS.—In this section:

4 (1) THERAPY SUPERVISION NONENFORCEMENT  
5 INSTRUCTION.—The term “therapy supervision non-  
6 enforcement instruction” means the enforcement in-  
7 struction on supervision requirements for outpatient  
8 therapeutic services in critical access and small rural  
9 hospitals, as extended for calendar year 2013 by the  
10 Centers for Medicare & Medicaid Services (released  
11 as of November 1, 2012).

12 (2) CRITICAL ACCESS HOSPITAL; SMALL RURAL  
13 HOSPITAL.—The terms “critical access hospital” and  
14 “small rural hospital” have the meanings given such  
15 terms for purposes of the therapy supervision non-  
16 enforcement instruction.

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

22 (c) STUDY AND REPORT ON IMPACT OF FAILURE TO  
23 EXTEND THERAPY SUPERVISION NONENFORCEMENT IN-  
24 STRUCTION.—

1           (1) STUDY.—The Secretary of Health and  
2           Human Services shall conduct a study on the impact  
3           (including the economic impact and the impact upon  
4           hospital staffing needs, if any) on critical access hos-  
5           pitals and small rural hospitals of not extending the  
6           therapy supervision nonenforcement instruction.

7           (2) REPORT.—The Secretary of Health and  
8           Human Services shall submit to Congress a report  
9           on the findings of the study conducted under para-  
10          graph (1), including recommendations regarding on  
11          whether the therapy supervision nonenforcement in-  
12          struction should be extended or made permanent.

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

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

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

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

22               (3) by striking paragraph (8).

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

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

3 (a) IN GENERAL.—For purposes of clarifying the  
4 methodology for payment under the Medicare program  
5 under title XVIII of the Social Security Act to providers  
6 for the costs of nursing and allied health education activi-  
7 ties for cost reporting periods beginning on or after the  
8 date of the enactment of this Act, the Secretary of Health  
9 and Human Services shall apply section 413.85 of title  
10 42, Code of Regulations—

11 (1) by treating a provider as meeting all of the  
12 requirements described in paragraph (f)(1) of such  
13 section if the provider or a wholly owned subsidiary  
14 educational institution of such provider singly or col-  
15 lectively meets all of such requirements;

16 (2) in the case of a provider that would meet  
17 the requirements of paragraph (g)(3) of such sec-  
18 tion, with respect to a nursing or allied health edu-  
19 cation program, except that the transfer described in  
20 such paragraph of such a program to a wholly  
21 owned subsidiary educational institution in order to  
22 meet accreditation standards occurred after October  
23 1, 2003, by treating such provider as meeting the  
24 requirements of such paragraph (and eligible for  
25 payments under such paragraph) with respect to  
26 such program; and

1           (3) by defining the term “wholly owned sub-  
2           sidiary educational institution”, as referenced in  
3           such section, as such term is defined under sub-  
4           section (b).

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

6           (1) PROVIDER.—The term “provider” has the  
7           meaning given such term in section 400.202 of title  
8           42, Code of Federal Regulations.

9           (2) WHOLLY OWNED SUBSIDIARY EDUCATIONAL  
10          INSTITUTION.—The term “wholly owned subsidiary  
11          educational institution” means, with respect to a  
12          provider, an educational institution that—

13                (A) is organized as a legal entity distinct  
14                from the provider;

15                (B) has the provider as its sole owner or  
16                sole member; and

17                (C) is organized in the same State in  
18                which the provider is organized or registered to  
19                do business.

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

22          (a) IN GENERAL.—Subsection (n)(6)(B) of section  
23          1886 of the Social Security Act (42 U.S.C. 1395ww) is  
24          amended by striking “subsection (d) hospital” and insert-

1 ing “hospital that is a subsection (d) hospital or a sub-  
2 section (d) Puerto Rico hospital”.

3 (b) CONFORMING AMENDMENTS.—

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

6 (A) in subsection (b)(3)(B)(ix)—

7 (i) in subclause (I), by striking  
8 “(n)(6)(A)” and inserting “(n)(6)(B)”;  
9 and

10 (ii) in subclause (II), by striking “a  
11 subsection (d) hospital” and inserting “an  
12 eligible hospital”; and

13 (B) in subsection (n)(4)(A)(iii), by striking  
14 “paragraph (6)(B)” and inserting “paragraph  
15 (6)(A)”.

16 (2) Paragraphs (2) and (4)(A) of section  
17 1853(m) of the Social Security Act (42 U.S.C.  
18 1395w–23(m)) are each amended by striking  
19 “1886(n)(6)(A)” and inserting “1886(n)(6)(B)”.

20 (c) IMPLEMENTATION.—Notwithstanding any other  
21 provision of law, the Secretary of Health and Human  
22 Services may implement the amendments made by this  
23 section by program instruction or otherwise.

24 (d) EFFECTIVE DATE.—The amendments made by  
25 this section shall apply as if included in the enactment

1 of the American Recovery and Reinvestment Act of 2009  
2 (Public Law 111–3), except that, in order to take into ac-  
3 count delays in the implementation of this section, in ap-  
4 plying subsections (b)(3)(B)(ix), (n)(2)(E)(ii), and  
5 (n)(2)(G)(i) of section 1886 of the Social Security Act (42  
6 U.S.C. 1395ww), as amended by this section, any ref-  
7 erence in such subsections to a particular year shall be  
8 treated with respect to a subsection (d) Puerto Rico hos-  
9 pital as a reference to the year that is 2 years after such  
10 particular year.

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

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

16 “Anesthesiologist Services Provided in Certain Rural  
17 Hospitals

18 “(m)(1) Notwithstanding any other provision of this  
19 title, coverage and payment shall be provided under this  
20 part for physicians’ services that are anesthesia services  
21 furnished by a physician who is an anesthesiologist in a  
22 rural hospital described in paragraph (3) in the same  
23 manner as payment is made under the exception provided  
24 in section 9320(k) of the Omnibus Budget Reconciliation  
25 Act of 1986, as amended by section 6132 of the Omnibus

1 Budget Reconciliation Act of 1989 (42 U.S.C. 1395k  
2 note) (relating to payment on a reasonable cost, pass-  
3 through basis), for certified registered nurse anesthetist  
4 services furnished by a certified registered nurse anes-  
5 thetist in a hospital described in such section.

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

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

13 “(A) any reference in such section to a ‘cer-  
14 tified registered nurse anesthetist’ or ‘anesthetist’ is  
15 deemed a reference to a ‘physician who is an anes-  
16 thesiologist’ or ‘anesthesiologist’, respectively; and

17 “(B) any reference to ‘January 1, 1988’ or  
18 ‘1987’ is deemed a reference to such date and year  
19 as the Secretary shall specify.”.

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



1 **SEC. 212. H.R. 4663 - (BLACK) PROTECT PATIENT ACCESS**  
2 **AND PROMOTE HOSPITAL EFFICIENCY ACT.**

3 (a) IN GENERAL.—Section 1814(a)(3) of the Social  
4 Security Act (42 U.S.C. 1395f(a)(3)) is amended by in-  
5 serting “(or, in the case of such inpatient hospital services  
6 ordered by a nurse practitioner, clinical nurse specialist,  
7 physician assistant (as such terms are defined in section  
8 1861(aa)(5)), or a certified nurse-midwife (as such term  
9 is defined in section 1861(gg)) who is privileged and  
10 credentialed at the hospital at which such services are to  
11 be furnished, the nurse practitioner, clinical nurse spe-  
12 cialist, physician assistant, or certified nurse-midwife)”  
13 after “a physician”.

14 (b) NO EFFECT ON STATE SCOPE OF PRACTICE  
15 LAW.—Nothing in this section, including the amendment  
16 made by this section, shall be construed as, or have the  
17 effect of, changing any State scope of practice law for any  
18 health care professional.

19 **SEC. 213. H.R. 3796 - (BLACK) COMPREHENSIVE CARE PAY-**  
20 **MENT INNOVATION ACT.**

21 Title XVIII of the Social Security Act is amended by  
22 inserting after section 1866F, as added by section 109,  
23 the following new section:

24 “NATIONAL VOLUNTARY PAYMENT BUNDLING  
25 “SEC. 1866G. (a) ESTABLISHMENT AND IMPLEMEN-  
26 TATION.—

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

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

8           “(3) APPLICABLE BENEFICIARY DEFINED.—In  
9           this section, the term ‘applicable beneficiary’ means  
10          an individual who is entitled to, or enrolled for, ben-  
11          efits under part A and enrolled for benefits under  
12          part B, but not enrolled under part C or in a PACE  
13          program under section 1894, and who is admitted to  
14          a hospital for an applicable condition.

15          “(b) QUALIFIED ENTITY AND APPLICATION PROC-  
16          ESS.—

17                 “(1) DEFINITIONS.—In this section:

18                         “(A) IN GENERAL.—The term ‘qualified  
19                         entity’ means a qualified applicant that has an  
20                         application approved by the Secretary to receive  
21                         bundled payments for furnishing applicable  
22                         services to applicable individuals under this sec-  
23                         tion.

24                         “(B) QUALIFIED APPLICANT.—The term  
25                         ‘qualified applicant’ means a corporation, part-

1           nership, or limited liability company, that is au-  
2           thorized in writing by a group of providers of  
3           services and suppliers, including at least a hos-  
4           pital, that are otherwise participating under  
5           this title to act as their agent for the purpose  
6           of receiving and distributing bundled payments  
7           on their behalf under this section. A qualified  
8           applicant may (but is not required to) be a pro-  
9           vider of services or supplier that is otherwise  
10          participating under this title.

11          “(2) APPLICATION.—

12                 “(A) IN GENERAL.—A qualified applicant  
13                 may submit to the Secretary an application to  
14                 become a qualified entity to receive bundled  
15                 payments under this section.

16                 “(B) CONTENTS.—An application under  
17                 subparagraph (A) with respect to a group of  
18                 providers of services and suppliers—

19                         “(i) shall contain such information  
20                         and assurances as the Secretary may speci-  
21                         fy, including with respect to the require-  
22                         ments under subsection (c)(1); and

23                         “(ii) shall indicate the applicable con-  
24                         ditions with respect to which the group  
25                         seeks to furnish applicable services during

1           the episode of care involved and the bun-  
2           dled payment methodology under sub-  
3           section (g) or (h) under which the group  
4           would be paid for such services.

5           “(3) CHOICE AMONG APPLICABLE CONDI-  
6           TIONS.—A qualified entity may select one or more  
7           applicable conditions for bundled payments under  
8           this section. Nothing in this section shall be con-  
9           strued as requiring, or authorizing the Secretary to  
10          require, a qualified entity to select any particular ap-  
11          plicable condition under this section.

12          “(4) EXPEDITED APPLICATION PROCESS FOR  
13          QUALIFIED APPLICANTS SUCCESSFULLY PARTICI-  
14          PATING IN THE CMI BUNDLED PAYMENT DEM-  
15          ONSTRATION.—In the case of any qualified applicant  
16          that the Secretary determines has successfully par-  
17          ticipated in any of the payment and service delivery  
18          models tested by the Center for Medicare and Med-  
19          icaid Innovation under section 1115A through the  
20          Bundled Payments for Care Improvement (BPCI)  
21          Initiative, the Secretary shall provide for an expe-  
22          dited application process under this subsection.

23          “(c) REQUIREMENTS FOR QUALIFIED ENTITIES.—

24                 “(1) REQUIREMENTS.—

1           “(A) IN GENERAL.—The Secretary shall  
2           develop requirements for qualified entities to re-  
3           ceive bundled payments for furnishing applica-  
4           ble services for applicable conditions during an  
5           episode of care under this section.

6           “(B) AGREEMENT PERIOD.—Under such  
7           requirements, a qualified entity shall agree to  
8           receive bundled payments for the furnishing of  
9           such services for a 5-year period (each such  
10          year in such period referred to in this section  
11          as an ‘agreement year’).

12          “(C) BENEFICIARY TRANSPARENCY.—Such  
13          requirements shall ensure transparency between  
14          a qualified entity and applicable beneficiaries  
15          such that notice is provided to an applicable  
16          beneficiary sufficiently in advance, to the extent  
17          practicable, of the beneficiary’s inpatient admis-  
18          sion for the applicable condition and episode of  
19          care involved. Such a notice shall include—

20                  “(i) appropriate notice of bundled  
21                  payments for the applicable condition for  
22                  the episode of care involved; and

23                  “(ii) a statement informing the bene-  
24                  ficiary of the beneficiary’s right to select  
25                  the providers of services and suppliers fur-

1 nishing items and services related to the  
2 episode of care.

3 “(D) METHODOLOGY AND MEASURES FOR  
4 QUALITY AND EFFICIENCY ARRANGEMENTS.—  
5 Insofar as a qualified entity uses or seeks to  
6 implement a quality and efficiency arrangement  
7 under subsection (i), the qualified entity shall  
8 specify in the application to the Secretary in de-  
9 tail the methodology for allocating savings  
10 under the arrangement and the specific meas-  
11 ures to be used to assess the quality of care  
12 under the arrangement.

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

14 “(A) CLAIMS DATA.—The Secretary shall  
15 furnish to a group of providers of services and  
16 suppliers interested in submitting an applica-  
17 tion under subsection (b)(2) claims data under  
18 parts A and B, including complete claims files,  
19 for applicable conditions relating to the pro-  
20 viders and suppliers in the group that are suffi-  
21 ciently specific to permit such group to deter-  
22 mine whether to submit such application. Such  
23 claims data shall also be furnished to a quali-  
24 fied entity monthly during the agreement period  
25 described in paragraph (1)(B) of any approved

1 application with respect to an applicable condi-  
2 tion.

3 “(B) QUALITY DATA.—The Secretary shall  
4 furnish to a qualified entity data on quality  
5 measures with respect to any applicable condi-  
6 tion under an approved application during the  
7 agreement period for the entity for each episode  
8 of care and across the continuum of care.

9 “(d) APPLICABLE CONDITIONS.—

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

14 “(A) Hip/Knee joint replacement.

15 “(B) Lumbar spine fusion.

16 “(C) Coronary artery bypass graft.

17 “(D) Heart valve replacement.

18 “(E) Percutaneous coronary intervention  
19 with stent.

20 “(F) Colon resection.

21 “(2) DISCRETION TO ADD CONDITIONS.—Such  
22 term also includes such additional procedures or  
23 conditions as the Secretary may select. In selecting  
24 such procedures or conditions, the Secretary may

1 take into consideration the factors described in sec-  
2 tion 1866D(a)(2)(B).

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

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

8 “(A) Acute care inpatient services.

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

11 “(C) Outpatient hospital services.

12 “(D) Post-acute care services, including  
13 home health services, skilled nursing services,  
14 inpatient rehabilitation services, and inpatient  
15 hospital services furnished by a long-term care  
16 hospital.

17 “(E) Other services the Secretary deter-  
18 mines appropriate.

19 “(2) EPISODE OF CARE.—

20 “(A) IN GENERAL.—Subject to subpara-  
21 graph (B), the term ‘episode of care’ means,  
22 with respect to an applicable condition and an  
23 applicable beneficiary, the period consisting  
24 of—



1 “(i) the 3 days prior to the admission  
2 of the applicable beneficiary to a hospital  
3 with respect to the applicable condition;

4 “(ii) the duration of the applicable  
5 beneficiary’s initial inpatient stay in such  
6 hospital for the applicable condition; and

7 “(iii) the 90 days following the dis-  
8 charge of the applicable beneficiary from  
9 such hospital.

10 “(B) ESTABLISHMENT OF PERIOD BY THE  
11 SECRETARY.—The Secretary, as appropriate,  
12 may establish a period (other than the period  
13 described in subparagraph (A)) for an episode  
14 of care under this section based on data anal-  
15 yses.

16 “(3) DISCHARGING HOSPITAL.—The term ‘dis-  
17 charging hospital’ means, with respect to applicable  
18 services in an episode of care, the hospital referred  
19 to in paragraph (2)(A).

20 “(f) BUNDLED PAYMENT DEVELOPMENT.—

21 “(1) IN GENERAL.—Subject to the succeeding  
22 provisions of this subsection, the Secretary shall de-  
23 velop bundled payments for qualified entities. A bun-  
24 dled payment shall provide for comprehensive pay-  
25 ment for the costs of applicable services furnished to

1 an applicable beneficiary during an episode of care  
2 for an applicable condition, including readmissions  
3 related to the applicable condition but excluding un-  
4 related readmissions, under either a fee-for-service  
5 model with shared savings and losses (under sub-  
6 section (g)) or under a prospective payment model  
7 for advanced qualified entities (under subsection  
8 (h)). Bundled payments shall be based on the spend-  
9 ing targets computed under paragraph (2).

10 “(2) COMPUTATION OF SPENDING TARGETS.—

11 “(A) IN GENERAL.—The Secretary shall  
12 compute under this paragraph, for each quali-  
13 fied entity for each applicable condition for an  
14 episode of care beginning in an agreement year  
15 (beginning with 2015) that is attributable to a  
16 discharging hospital, a spending target equal to  
17 the updated amount computed under subpara-  
18 graph (C) for that entity, episode, and year.

19 “(B) INITIAL WEIGHTED AVERAGE CAL-  
20 CULATION FOR DISCHARGING HOSPITALS.—

21 “(i) IN GENERAL.—Using fee-for-serv-  
22 ice claims data from the base period (as  
23 defined in subparagraph (D)), subject to  
24 clause (ii), the Secretary shall first cal-  
25 culate a base average spending target for

1 each applicable condition for each dis-  
2 charging hospital equal to a weighted aver-  
3 age of spending under parts A and B for  
4 all applicable services for such applicable  
5 condition associated with initial admissions  
6 to such hospital computed as the sum of  
7 the following (with respect to such hos-  
8 pital):

9 “(I) 60 percent of the standard-  
10 ized spending per episode in the most  
11 recent year in the base period.

12 “(II) 30 percent of the standard-  
13 ized spending per episode in the pre-  
14 vious year.

15 “(III) 10 percent of the stand-  
16 ardized spending per episode in the  
17 second previous year.

18 “(ii) EXCLUSION OF OUTLIERS AND  
19 STANDARDIZATION.—In calculating the  
20 amount of the base average spending tar-  
21 get for an applicable condition under  
22 clause (i) for a discharging hospital, the  
23 Secretary shall—

24 “(I) exclude from the calculation  
25 payments for episodes of care for the

1 applicable condition that exceed the  
2 95th percentile of all such spending  
3 for such episodes of care and applica-  
4 ble condition, as estimated by the Sec-  
5 retary, based on the most recent data  
6 available; and

7 “(II) standardize the spending  
8 made in each year in the base period  
9 to each provider of service or supplier  
10 to remove the spending adjustments  
11 in effect in such year relating to pro-  
12 vider or supplier location (such as  
13 area wage indices) and provider type  
14 (such as indirect medical education  
15 adjustments and disproportionate  
16 share hospital adjustments).

17 “(C) TRENDING THE SPENDING TARGETS  
18 BASED ON NATIONAL GROWTH RATES TO  
19 AGREEMENT YEAR; PERIODIC REBASING FOR  
20 NEW AGREEMENT PERIODS.—

21 “(i) IN GENERAL.—The Secretary  
22 shall update the base average spending tar-  
23 gets for all discharging hospitals under  
24 subparagraph (B) for each applicable con-  
25 dition and agreement year based on trends

1 in the national fee-for-service claims data  
2 for applicable services furnished during an  
3 episode of care for an applicable condition  
4 from the base period to the agreement year  
5 involved. Such update shall not vary by  
6 discharging hospital.

7 “(ii) PERIODIC REBASING FOR NEW  
8 AGREEMENT PERIODS.—At the start of  
9 each new agreement period, the Secretary  
10 shall update the base period and calculate  
11 new spending targets under the previous  
12 provisions of this paragraph for a dis-  
13 charging hospital and applicable condi-  
14 tions, including providing for adjustments  
15 by provider location and provider type of  
16 the type described in subparagraph  
17 (B)(ii)(II).

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

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

1           “(1) FEE-FOR-SERVICE-BASED PAYMENT.—If  
2           the payment model under this subsection is selected  
3           by a qualified entity, the Secretary shall pay pro-  
4           viders of services and suppliers of the entity for ap-  
5           plicable services for an applicable condition during  
6           an episode of care amounts payable under parts A  
7           and B for such services in the same manner as such  
8           providers and suppliers would otherwise be paid  
9           under such parts (referred to in this subsection as  
10          ‘fee-for-service payments’).

11          “(2) SHARED SAVINGS AND LOSSES.—

12                 “(A) COMPUTATION OF EACH QUALIFIED  
13                 ENTITY’S ACTUAL STANDARDIZED AVERAGE  
14                 SPENDING PER EPISODE OF CARE.—In applying  
15                 this subsection, in calculating the actual stand-  
16                 ardized average fee-for-service spending per epi-  
17                 isode of care for a discharging hospital for each  
18                 applicable condition in each agreement year, the  
19                 Secretary shall exclude outlier episodes of care  
20                 described in subsection (f)(2)(B)(ii)(I), as esti-  
21                 mated by the Secretary, based on data applica-  
22                 ble to payments in the agreement year and shall  
23                 standardize such spending per episode of care  
24                 in the manner provided in subsection  
25                 (f)(2)(B)(ii)(II). For the purpose of identifying

1 outlier episodes of care for each applicable con-  
2 dition, the percentile ranking of each episode of  
3 care and applicable condition and the 95th per-  
4 centile shall be based on payments standardized  
5 by adjustments for provider location and pro-  
6 vider type of the type described in subsection  
7 (f)(2)(B)(ii)(II).

8 “(B) COMPUTATION OF GROSS SHARED  
9 SAVINGS AND SHARED LOSSES FOR EACH AP-  
10 PPLICABLE CONDITION FOR EACH DISCHARGING  
11 HOSPITAL.—For purposes of applying subpara-  
12 graph (C), if actual standardized average fee-  
13 for-service payments to a qualified entity for all  
14 episodes of care for an applicable condition in  
15 an agreement year for a discharging hospital,  
16 as calculated under subparagraph (A), are—

17 “(i) less than the applicable spending  
18 target under subsection (f)(2)(C) for such  
19 condition, year, and hospital, there shall be  
20 a gross shared savings for such applicable  
21 condition, year, and hospital equal to 60  
22 percent of the difference between such ac-  
23 tual average payments and the spending  
24 target for such condition, year, and hos-  
25 pital; or

1           “(ii) greater than such applicable  
2           spending target, there shall be a gross  
3           shared loss for such applicable condition,  
4           year, and hospital equal to 60 percent of  
5           such difference.

6           “(C) RETROSPECTIVE RECONCILIATION.—

7           “(i) TOTALING GROSS SHARED SAV-  
8           INGS AND LOSSES FOR ALL CONDITIONS  
9           AND ALL DISCHARGING HOSPITALS FOR A  
10          QUALIFIED ENTITY.—At the end of each  
11          agreement year for each qualified entity,  
12          for purposes of applying clauses (ii) and  
13          (iii), the Secretary shall aggregate the  
14          gross shared savings and the gross shared  
15          losses under subparagraph (B) of such en-  
16          tity for the year for all applicable condi-  
17          tions and for all discharging hospitals.

18          “(ii) PAYMENT TO ENTITY OF NET  
19          SAVINGS.—Subject to clause (iv) and sub-  
20          section (j)(3) (relating to quality perform-  
21          ance thresholds), if such aggregate gross  
22          shared savings exceeds such aggregate  
23          gross shared losses for a qualified entity  
24          for an agreement year, the Secretary shall



1 pay to the qualified entity a lump sum  
2 amount equal to such excess for such year.

3 “(iii) COLLECTION FROM ENTITY OF  
4 NET LOSSES.—Subject to clause (iv), if  
5 such aggregate gross shared losses exceeds  
6 such aggregate gross shared savings for a  
7 qualified entity for an agreement year, the  
8 qualified entity shall pay to the Secretary  
9 (and the Secretary shall collect from the  
10 entity) a lump sum amount equal to such  
11 excess for such year.

12 “(iv) CAP ON PAYMENTS.—In no case  
13 shall the payment under clause (ii) or (iii)  
14 with respect to a qualified entity for an  
15 agreement year exceed 10 percent of the  
16 aggregate spending target for that quali-  
17 fied entity for all applicable conditions and  
18 all discharging hospitals for that year.

19 “(h) PROSPECTIVE BUNDLED PAYMENT MODEL FOR  
20 ADVANCED QUALIFIED ENTITIES.—

21 “(1) IN GENERAL.—Subject to approval by the  
22 Secretary, if the payment model under this sub-  
23 section is selected, a qualified entity may elect to re-  
24 ceive a prospective bundled payment for each episode  
25 of care for each applicable condition and discharging

1 hospital in the agreement year equal to the spending  
2 target for such episode, year, and hospital under  
3 subsection (f)(2) and the provisions of subsection (g)  
4 do not apply. Such spending target shall be ad-  
5 justed, in the same manner described in subsection  
6 (g)(2)(B), in order to take into account outlier epi-  
7 sodes of care and standardized adjustments for pro-  
8 vider location and provider type of the type de-  
9 scribed in subsection (f)(2)(B)(ii)(II).

10 “(2) RULE OF CONSTRUCTION.—Nothing in  
11 this section shall be construed as prohibiting a quali-  
12 fied entity that receives bundled payments under  
13 this subsection from participating in an accountable  
14 care organization under section 1899.

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

20 “(i) QUALITY AND EFFICIENCY ARRANGEMENTS.—

21 “(1) IN GENERAL.—Subject to subsection  
22 (c)(1)(D) (relating to application requirements for  
23 notice of quality and efficiency arrangements and  
24 their structure) and subsection (j)(3) (relating to  
25 minimum quality performance thresholds), qualified

1 entities participating in either the fee-for-service  
2 bundled payment model under subsection (g) or the  
3 prospective bundled payment model under subsection  
4 (h) may enter into quality and efficiency arrange-  
5 ments under which physicians and other health care  
6 practitioners work to improve the quality and effi-  
7 ciency of care under this title.

8 “(2) TYPES OF ARRANGEMENTS.—The arrange-  
9 ments under paragraph (1) shall take into account  
10 the utilization of the resources of providers of serv-  
11 ices and suppliers and may provide for a distribution  
12 of a portion of any shared savings (or internal sav-  
13 ing, as the case may be) realized under this section  
14 to qualifying providers and suppliers.

15 “(j) QUALITY MEASURES.—

16 “(1) SELECTION; DEVELOPMENT.—

17 “(A) SELECTION.—For each applicable  
18 condition, the Secretary shall select quality  
19 measures related to care provided by providers  
20 of services and suppliers through qualified enti-  
21 ties to which bundled payments are made under  
22 this section. In selecting quality measures, to  
23 the extent appropriate and practicable, the Sec-  
24 retary shall choose measures that—

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

3 “(ii) pertain to the National Quality  
4 Strategy’s six priorities;

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

7 “(iv) minimize the incremental data  
8 extraction and reporting burden on pro-  
9 viders and suppliers.

10 “(B) DEVELOPMENT OF ELECTRONICALLY  
11 SPECIFIED EPISODIC MEASURES.—The Sec-  
12 retary shall develop longitudinal quality and ef-  
13 ficiency measures to assess performance of  
14 qualified entities with respect to patient out-  
15 comes and the care provided for each applicable  
16 condition across the associated episodes of care.  
17 Such measures shall be electronically specified  
18 for submittal through the use of qualified elec-  
19 tronic health records (as defined in section  
20 3000(13) of the Public Health Service Act (42  
21 U.S.C. 300jj(13))).

22 “(2) REPORTING ON QUALITY MEASURES.—

23 “(A) IN GENERAL.—A qualified entity  
24 shall submit data to the Secretary on quality  
25 measures selected under paragraph (1) for each

1 agreement year in a form and manner specified  
2 by the Secretary consistent with the succeeding  
3 provisions of this paragraph.

4 “(B) SUBMISSION OF DATA THROUGH  
5 ELECTRONIC HEALTH RECORD.—To the extent  
6 practicable, such data shall be submitted  
7 through the use of a qualified electronic health  
8 record (as defined in section 3000(13) of the  
9 Public Health Service Act (42 U.S.C.  
10 300jj(13))).

11 “(C) SUBMISSION OF DATA USED IN  
12 OTHER PROGRAMS.—Insofar as quality meas-  
13 ures established under paragraph (1) are the  
14 same as those measures used by the Secretary  
15 under other provisions of this title, such as  
16 those selected under section 1886(b)(3)(B)(viii),  
17 the Secretary shall use existing processes for  
18 the submission of data for such measures under  
19 this paragraph.

20 “(3) QUALITY PERFORMANCE THRESHOLDS.—

21 “(A) ESTABLISHMENT.—For each applica-  
22 ble condition, the Secretary shall establish min-  
23 imum quality performance thresholds for the  
24 measures established under paragraph (1). In  
25 the case of a quality and efficiency arrange-

1           ment, such performance thresholds shall be de-  
2           veloped using the quality measures identified by  
3           the qualified entity in its application under sub-  
4           section (c)(1)(D) if approved by the Secretary.

5           “(B) LOSS OF SHARED SAVINGS PAYMENT  
6           AND QUALITY AND EFFICIENCY ARRANGEMENTS  
7           FOR FAILURE TO MEET MINIMUM QUALITY PER-  
8           FORMANCE THRESHOLDS.—If a qualified entity  
9           fails to meet the minimum quality performance  
10          thresholds established under subparagraph (A)  
11          for an agreement year—

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

15                   “(ii) the entity may not implement  
16                   any quality and efficiency arrangement  
17                   under subsection (i) for that year.

18           “(C) ADJUSTMENT TO PROCESS MEASURES  
19           FOR NEW TECHNOLOGIES AND INNOVATIVE  
20           TREATMENTS.—In the case of a qualified entity  
21           that furnishes a new technology or innovative  
22           item or service (for which payment may be  
23           made under this title) to applicable beneficiaries  
24           for an applicable condition and episode of care  
25           that changes the clinical process of care for

1 such applicable condition and episode of care  
2 with respect to such beneficiaries, insofar as  
3 such change results in the failure of the quali-  
4 fied entity to meet the minimum quality thresh-  
5 old established under paragraph (1) for one or  
6 more applicable clinical process of care meas-  
7 ures, the Secretary may provide for such ad-  
8 justments or exceptions to, or exclusions of,  
9 such clinical process of care measure or meas-  
10 ures from the overall quality performance  
11 thresholds established with respect to such ap-  
12 plicable condition and episode of care. Nothing  
13 in this subparagraph shall be construed to  
14 apply to any clinical outcomes measure under  
15 such quality performance thresholds.

16 “(k) WAIVERS.—

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

21 “(A) With respect to authorizing quality  
22 and efficiency arrangements between qualified  
23 entities and providers of services and suppliers,  
24 section 1877(a) (relating to physician self-refer-  
25 ral), paragraphs (1) and (2) of sections

1 1128A(b) (relating to the gainsharing civil  
2 money penalties), and paragraphs (1) and (2)  
3 of section 1128B(b) (relating to the anti-kick-  
4 back statute).

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

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

10 “(D) With respect to home health serv-  
11 ices—

12 “(i) sections 1814(a)(2)(C) and  
13 1835(a)(2)(A) (relating to the requirement  
14 that an individual be confined to home in  
15 order to be eligible for benefits for home  
16 health services);

17 “(ii) limitations on the amount, fre-  
18 quency, and duration on home health serv-  
19 ices; and

20 “(iii) prohibitions of free preoperative  
21 home safety assessments by home health  
22 agencies for patients scheduled to undergo  
23 surgery (such as under Advisory Opinion  
24 No. 06–01 of the Inspector General of the



1 Department of Health and Human Serv-  
2 ices).

3 “(2) AUTHORITY TO MODIFY WAIVERS UNDER  
4 CERTAIN CIRCUMSTANCES.—

5 “(A) IN GENERAL.—In the case of a quali-  
6 fied entity with respect to which one or more  
7 waivers under paragraph (1) is in effect, if  
8 upon a review of the performance or an audit  
9 of the entity the Secretary finds a pattern of  
10 deficiencies or harm to applicable beneficiaries,  
11 the Secretary may modify or revoke any such  
12 waiver at any time as applied to that qualified  
13 entity.

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

16 “(i) IN GENERAL.—Subject to the  
17 process described in clause (ii), in the case  
18 of a qualified entity that has selected the  
19 payment model under subsection (g) and  
20 has gross shared losses exceeding the cap  
21 under subsection (g)(2)(C)(iv) with respect  
22 to an applicable condition, the Secretary  
23 shall terminate waivers described in para-  
24 graphs (1)(C) and (1)(D) with respect to

1 such qualified entity and applicable condi-  
2 tion.

3 “(ii) PRE-TERMINATION NOTICE.—

4 The Secretary shall establish a process  
5 whereby a qualified entity is furnished no-  
6 tice of any deficiency that may give rise to  
7 a termination of waivers under clause (i)  
8 not later than 6 months before the pro-  
9 posed effective date of the termination.

10 “(1) INDEPENDENT EVALUATION AND REPORTS ON  
11 PROGRAM.—

12 “(1) INDEPENDENT EVALUATION.—The Sec-  
13 retary shall conduct an independent evaluation of  
14 the impact of providing bundled payments to quali-  
15 fied entities under this section. Such evaluation shall  
16 include an examination of the extent to which the  
17 bundling of payments this section have resulted in—

18 “(A) improved health outcomes;

19 “(B) improved access to care for applicable  
20 beneficiaries;

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

22 “(D) improvement in performance on qual-  
23 ity measures selected under subsection  
24 (j)(1)(A).

25 “(2) REPORTS.—

1           “(A) INTERIM REPORT.—Not later than  
2           March 1, 2018, the Secretary shall submit to  
3           Congress a report on the initial results of the  
4           independent evaluation conducted under para-  
5           graph (1).

6           “(B) FINAL REPORT.—Not later than  
7           March 1, 2020, the Secretary shall submit to  
8           Congress a report on the final results of the  
9           independent evaluation conducted under para-  
10          graph (1) and may include recommendations  
11          for the expansion of bundled payment meth-  
12          odologies and applicable conditions under this  
13          section as the Secretary determines to be appro-  
14          priate.

15          “(C) REPORT ON POLICIES TO ENSURE AC-  
16          CESS TO NEW MEDICAL TECHNOLOGIES AND IN-  
17          NOVATIVE TREATMENTS UNDER MEDICARE  
18          SHARED SAVINGS PROGRAMS AND BUNDLED  
19          PAYMENT PROGRAMS.—

20                 “(i) STUDY.—The Secretary, acting  
21                 through the Administrator of the Centers  
22                 for Medicare & Medicaid Services, shall  
23                 conduct a study of payment adjustment  
24                 policies (described in clause (ii)) under this  
25                 title for new medical technologies and inno-

1 vative items and services to develop a set  
2 of policies to incorporate such adjustments  
3 into the following programs:

4 “(I) The Medicare Shared Sav-  
5 ings Program (under section 1899).

6 “(II) Medicare bundled payment  
7 programs (such as those established  
8 under section 1866D and this sec-  
9 tion).

10 “(III) Shared savings or bundled  
11 payment programs tested by the Cen-  
12 ter for Medicare and Medicaid Innova-  
13 tion under section 1115A or under  
14 other demonstration authority of the  
15 Secretary.

16 “(ii) PAYMENT ADJUSTMENT PRO-  
17 GRAMS DESCRIBED.—For purposes of  
18 clause (i), the payment adjustment policies  
19 described in this clause for new medical  
20 technologies and innovative items and serv-  
21 ices include the following:

22 “(I) The new technology add-on  
23 payment policy established under sub-  
24 paragraphs (K) and (L) of section  
25 1886(d)(5) under the prospective pay-

1                   ment system for inpatient hospital  
2                   services.

3                   “(II) The pass-through payment  
4                   policy established under section  
5                   1833(t)(6) under the prospective pay-  
6                   ment system for covered OPD serv-  
7                   ices.

8                   “(III) The New Technology Am-  
9                   bulatory Payment Classification pay-  
10                  ment policy established by the Sec-  
11                  retary through rulemaking for pur-  
12                  poses of the prospective payment sys-  
13                  tem for covered OPD services.

14                  “(iii) REPORT.—Not later than one  
15                  year after the date of the enactment of this  
16                  section, the Secretary shall submit to Con-  
17                  gress a report on the study conducted  
18                  under clause (i) which shall include rec-  
19                  ommendations for such legislation and ad-  
20                  ministrative action as the Secretary deter-  
21                  mines to be appropriate.”.

1 **SEC. 214. (BLACK) TENNESSEE DSH ALLOTMENT FOR FIS-**  
2 **CAL YEAR 2015 AND SUCCEEDING FISCAL**  
3 **YEARS.**

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

7 “(vi) ALLOTMENT FOR FISCAL YEAR  
8 2015 AND SUCCEEDING FISCAL YEARS.—  
9 Notwithstanding any other provision of  
10 this subsection, any other provision of law,  
11 or the terms of the TennCare Demonstra-  
12 tion Project in effect for the State, the  
13 DSH allotment for Tennessee for fiscal  
14 year 2015, and for each fiscal year there-  
15 after, shall be \$53,100,000 for each such  
16 fiscal year.”.

17 **SEC. 215. H.R. 4857 - (REED) ENSURING EQUAL ACCESS TO**  
18 **TREATMENTS ACT OF 2014.**

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

22 “(i) create additional groups of cov-  
23 ered OPD services that classify separately  
24 those procedures that utilize contrast  
25 agents from those that do not;

1                   “(ii) create and implement, for serv-  
2                   ices furnished after the date of the enact-  
3                   ment of this clause and in a budget neutral  
4                   manner, additional groups of covered OPD  
5                   services that classify separately those pro-  
6                   cedures that utilize a drug (other than con-  
7                   trast agents and diagnostic radiopharma-  
8                   ceuticals) that both—

9                                 “(I) has a cost above the drug  
10                                packaging threshold; and

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

14 **SEC. 216. H.R. 5232 - (YOUNG) NOTICE ACT.**

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

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

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

21                   (3) in the second subparagraph (W)—

22                                (A) by redesignating such subparagraph as  
23                                subparagraph (X); and

24                                (B) by striking at the end the period and  
25                                inserting “, and”; and

1           (4) by inserting after such subparagraph (X)  
2           the following new subparagraph:

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

16                 “(i) explains the status of the individual as  
17                 an outpatient under such observation status or  
18                 any other such similar status and not as an in-  
19                 patient of the hospital;

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

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

24                 “(I) eligibility for coverage of items  
25                 and services under this title, including such



1 items and services furnished by the hos-  
2 pital with respect to such individual while  
3 under such status and for items and serv-  
4 ices under this title for a subsequent dis-  
5 charge to a skilled nursing facility or other  
6 facility; and

7 “(II) cost-sharing requirements under  
8 this title, including with respect to items  
9 and services furnished by the hospital to  
10 such individual while under such status  
11 and with respect to items and services  
12 under this title for a subsequent discharge  
13 to a skilled nursing facility or other facil-  
14 ity;

15 “(iv) includes the name and title of the  
16 staff of the hospital who provided the oral noti-  
17 fication and the date and time of such oral noti-  
18 fication;

19 “(v) includes such additional information  
20 as the Secretary deems appropriate; and

21 “(vi) in the case of the written notification,  
22 is—

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

1 “(II) written and formatted using lan-  
2 guage that is clear and easily understand-  
3 able to Medicare beneficiaries; and

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

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

10 **SEC. 217. H.R. 4188 - (RENACCI) ESTABLISHING BENE-**  
11 **FICIARY EQUITY IN THE HOSPITAL READMIS-**  
12 **SION PROGRAM ACT.**

13 (a) TRANSITIONAL ADJUSTMENT FOR DUAL ELIGI-  
14 BLE POPULATION.—Section 1886(q)(4)(C) of the Social  
15 Security Act (42 U.S.C. 1395ww(q)(4)(C)) is amended by  
16 adding at the end the following new clause:

17 “(iii) TRANSITIONAL ADJUSTMENT  
18 FOR DUAL ELIGIBLES.—In applying clause  
19 (i) for discharges occurring on or after Oc-  
20 tober 1, 2015, and before the initial appli-  
21 cation of clause (iv), the Secretary shall  
22 provide for such risk adjustment as will  
23 take into account a hospital’s proportion of  
24 inpatients who are full-benefit dual eligible  
25 individuals (as defined in section

1           1935(c)(6)) in order to ensure that hos-  
2           pitals that treat the most vulnerable popu-  
3           lations are not unfairly penalized by the  
4           program under this subsection.”.

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

9                   “(iv) ADJUSTMENTS BASED ON IM-  
10           PACT REPORTS.—Effective for discharges  
11           occurring in fiscal years beginning on or  
12           after the date that is 6 months after the  
13           date of completion of the reports under  
14           section 2(d)(1)(A)(ii) of the IMPACT Act  
15           of 2014, the Secretary shall provide for  
16           such risk adjustment as will take into ac-  
17           count, based on such report (and, if appli-  
18           cable, the reports submitted under section  
19           2(d)(1)(B)(ii) of such Act), factors relating  
20           to disparities in patient status in order to  
21           ensure that hospitals that treat the most  
22           vulnerable populations are not unfairly pe-  
23           nalized by the program under this sub-  
24           section.”.

1 (c) MEDPAC STUDY ON 30-DAY READMISSION  
2 THRESHOLD.—The Medicare Payment Advisory Commis-  
3 sion shall conduct a study on the appropriateness of using  
4 a threshold of 30 days for readmissions under section  
5 1886(q)(5)(E) of the Social Security Act (42 U.S.C.  
6 1395ww(q)(5)(E)). The Commission shall submit to Con-  
7 gress a report on such study in its report to Congress in  
8 June 2016.

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

14 “(v) CONSIDERATION OF EXCLUSION  
15 OF NONCOMPLIANT PATIENT CASES BASED  
16 ON V CODES.—In promulgating regulations  
17 to carry out this subsection for the applica-  
18 ble period with respect to fiscal year 2017,  
19 the Secretary shall consider the use of V  
20 codes for potential exclusions of cases in  
21 order to address the issue of noncompliant  
22 patients.”.

23 (e) REMOVAL OF CERTAIN READMISSIONS.—Section  
24 1886(q)(5)(E) of the Social Security Act (42 U.S.C.  
25 1395ww(q)(5)(E)) is amended by adding at the end the

1 following: “For discharges occurring on or after October  
2 1, 2015, such term does not include an admission that  
3 is classified within one or more of the following: trans-  
4 plants, burns, trauma, psychosis, or substance abuse.”.

5 **SEC. 218. (CAMP) CANCER EXEMPTION FOR CERTAIN**  
6 **QUALIFYING HOSPITALS.**

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

9 (1) in subparagraph (B)(v)—

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

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

14 (C) by adding after subclause (III) and be-  
15 fore the flush matter following subclause (III)  
16 the following new subclause:

17 “(IV) a hospital (not described in a previous  
18 subclause) that meets the requirements of subpara-  
19 graph (F) for the 12-month cost reporting period in-  
20 volved and has an application approved consistent  
21 with subparagraph (G);”;

22 (2) in subparagraph (E), by inserting “and sub-  
23 paragraph (F)” after “subparagraph (B)(v)”; and

24 (3) by adding at the end the following new sub-  
25 paragraphs:

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

4           “(i) For the most recent cost reporting period  
5 for which appropriate cost report data are available  
6 (as determined by the Secretary), at least 50 percent  
7 of the hospital’s total discharges have a principal  
8 **【finding】** of neoplastic disease (as defined in sub-  
9 paragraph (E)).

10          “(ii) The hospital has, for at least 12 years,  
11 served as a comprehensive cancer center designated  
12 as such by the National Cancer Institute of the Na-  
13 tional Institutes of Health.

14          “(iii) The hospital has its own unique CMS  
15 Certification Number issued by the Secretary as of  
16 the date of the enactment of this subparagraph.

17          “(iv) The hospital, as of the date of the enact-  
18 ment of this subparagraph, is licensed or registered  
19 with its appropriate state regulatory agency as hav-  
20 ing not more than 100 inpatient beds.

21          “(v) The hospital is accredited by the American  
22 College of Surgeons as serving as a comprehensive  
23 cancer center designated by the National Cancer In-  
24 stitute of the National Institutes of Health.

1 “(G)(i) Any hospital seeking to be classified as a hos-  
2 pital under subparagraph (B)(v)(IV) must file an applica-  
3 tion seeking such classification (in such form and manner  
4 as the Secretary may specify) not later than 90 days after  
5 the date of the enactment of this subparagraph.

6 “(ii) The Secretary shall make a determination on  
7 such an application not later than 60 days after the date  
8 it is filed. The Secretary shall approve the application if  
9 the application is submitted consistent with clause (i) and  
10 establishes (as determined by the Secretary) that the hos-  
11 pital meets the requirements for classification under sub-  
12 paragraph (B)(v)(IV). Approval of such an application  
13 shall take effect for cost reporting periods beginning after  
14 the date of such approval.”.

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

17 Section 1874A of the Social Security Act (42 U.S.C.  
18 1395kk-1) is amended by adding at the end the following  
19 new subsection:

20 “(h) **LIMITATION ON RECOUPMENT IN CASE OF MAC**  
21 **TRANSITION.—**

22 “(1) **IN GENERAL.—**In the case that a medicare  
23 administrative contractor makes a payment under  
24 subsection (a)(4)(B) to a medicare-dependent, small  
25 rural hospital (as defined in section 1886(d)(5)(G))

1 and a different medicare administrative contractor  
2 subsequently determines that such payment was an  
3 overpayment, the different medicare administrative  
4 contractor may not, in an attempt to recoup such  
5 overpayment from such hospital, make a recoupment  
6 from such hospital in an amount that is greater  
7 than 25 percent of the amount by which such hos-  
8 pital was overpaid by the medicare administrative  
9 contractor that made such payment to such hospital.

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

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

16 “(B) with respect to which the recoupment  
17 described in paragraph (1) that is in excess of  
18 the amount permitted under such paragraph  
19 has not, on a date that is before the date of the  
20 enactment of this subsection, been made by the  
21 different medicare administrative contractor de-  
22 scribed in such paragraph.”.