[DISCUSSION DRAFT]

113TH CONGRESS
2D SESSION

H. R. _____

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

IN THE HOUSE OF REPRESENTATIVES

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

A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Hospital Improvements for Payment Act of 2014''.

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

TITLE I—HOSPITAL PAYMENT AND QUALITY PROVISIONS

Subtitle A—Payment

SEC. 101. HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

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

(1) On an annual basis, the Centers for Medicare & Medicaid Services (CMS) updates Medicare reimbursement for hospitals through two distinct regulatory proposals—the inpatient prospective payment system (IPPS) and the outpatient prospective payment system (OPPS). The IPPS and the OPPS reimburse Medicare services in very different ways.

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

ment, referred to as diagnosis related groups or DRGs. CMS maintains 751 DRGs for inpatient hospital payment.

(3) The OPPS is focused on current procedural terminology (CPT) codes that are maintained by the American Medical Association (AMA) and HCPCS maintained by CMS. The CPT and HCPCS codes map to Ambulatory Payment Classifications (APCs) for outpatient service reimbursement. CMS maintains 813 APCs for outpatient hospital payment.

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

(5) Some elements of IPPS and OPPS reimbursement are the same, such as making an adjustment for the Medicare wage index. However, there are distinct differences between the two payment systems, the most significant of which are the base reimbursement rates, indirect medical education

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

(6) Arguably, the biggest difference between inpatient and outpatient reimbursement are the discharge add-on payments for IME and DSH. IME and DSH are included in all IPPS payments, where applicable, but they are not included in any OPPS payments. IME and DSH funds per discharge often make up a significant portion of a hospital's Medicare revenue.

(7) There may be as much as a tenfold difference in comparing the base DRG, IME and DSH payment to the sole APC payment.

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

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

(9) The vast discrepancy in reimbursement between the IPPS and OPPS payment systems for ''short stays'' may incentivize hospitals to bill all services on an inpatient basis, even if a procedure is medically appropriate as an outpatient service. Because of these misaligned incentives in the Medicare payment systems, CMS has recognized short inpatient stays as ''errors'' when administering its annual Comprehensive Error Rate Testing (CERT) program. As part of the CERT program, CMS has stated that ''hospital errors are identified more frequently for shorter lengths of stay.'' CMS contracts with several types of auditors and uses the CERT program to target improper payments.

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

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

Medicare beneficiary is treated in a hospital for a minimum of two-midnights, the hospital stay is deemed ''generally reasonable and necessary'' as an inpatient stay. However, if a beneficiary is treated for less than two-midnights (short stays), it is not assumed that the inpatient stay is reasonable and necessary.

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

(13) The Medicare Payment Advisory Commission (MedPAC) has found that observation cases (those with a combination of inpatient status and observation status) increased nearly 60 percent from 2009 to 2012—the period just prior to the implementation by CMS of the two-midnights standard. Some policy experts have connected the increase in observation stays to the unintended consequence of hospitals attempting to avert RAC audits.

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

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

''(t) ESTABLISHMENT OF SITE NEUTRAL HOSPITAL PROSPECTIVE PAYMENT SYSTEM (HPPS).—

''(1) IN GENERAL.—The Secretary shall establish under this subsection a new hospital payment system (in this subsection referred to as the 'HPPS system') for payment for hospital short-term stays for discharges (as defined in paragraph (10)) occurring on or after October 1, 2019. Such system shall be in place of the payment methods under subsection (d) and section 1833(t) for such discharges from subsection (d) hospitals. '

''(2) ESTABLISHMENT OF BASE RATE.—

''(A) IN GENERAL.—In implementing the HPPS system for discharges in fiscal year 2020, the Secretary shall establish by rule a base payment rate (in this subsection referred to as the 'base payment rate') for hospital

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

''(B) BLEND.—

''(i) IN GENERAL.—In computing the base payment rate, the Secretary shall utilize the payment rates established under subsection (u)(2)(B), which reflect—

''(I) a blend of the base operating DRG payment amount used in subsection (o)(7)(D) and an equivalent base operating APC payment amount that would apply under section 1833(t) with respect to overnight hospital outpatient services; and

''(II) the data collected under subsection (u)(4)(A).

''(ii) PROPORTIONALITY FOR BLENDED PAYMENT AMOUNTS.—In implementing clause (i), the Secretary shall apply an appropriate proportionality for the payment amounts described in such clause.

''(C) TREATMENT OF IME AND DSH.—

''(i) INCLUSION OF IME AND DSH IN AGGREGATE.—In computing the base payment rate the Secretary shall take into ac-

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

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

''(D) EXCLUSION OF HOSPITAL SPECIFIC RATES.—In computing the base payment rate the Secretary shall not include any hospital specific rates nor any rates paid for subsection (d) Puerto Rico hospitals under subsection (d)(9). Such base rate shall supersede the payment rates otherwise established under paragraphs (5)(D) and (9) of subsection (d) for sole community hospitals, small rural hospitals, and

subsection (d) Puerto Rico hospitals, as well as any payment rate otherwise established for subsection (d) hospitals which are medicare-dependent, small rural hospitals as defined in clause (iv) of subsection (d)(5)(G) (such as the payment rate described in such subsection, even if otherwise applicable).

''(E) NO SEPARATE LOW-VOLUME PAYMENT ADJUSTMENT.—The Secretary shall not adjust or vary the payment rate for short-term hospital stays based on low-volume hospital payment adjustments (of the type provided under subsection (d)(12)).

''(3) ESTABLISHMENT OF WEIGHT SYSTEM FOR DIFFERENT SERVICES.—The Secretary shall establish for discharges for short-term hospital stays an appropriate weight system which reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups and which may be based upon the weight system established under subsection (d)(4). Such weighting factors shall be reviewed and revised on an annual or other periodic basis as specified by the Secretary.

''(4) APPLICATION OF AREA WAGE ADJUSTMENT.—

''(A) IN GENERAL.—The Secretary shall apply a geographic area wage adjustment to discharges for short-term hospital stays that utilizes the area wage index described in subparagraph (B).

''(B) GEOGRAPHIC AREA WAGE ADJUSTMENT DESCRIBED.—

''(i) IN GENERAL.—Subject to clause (ii), a hospital's geographic area wage index described in this subparagraph is a wage index that is calculated based on the surveys of pay localities for the Employment Cost Index (wages and salaries, private industry workers) published quarterly by the Bureau of Labor Statistics. In calculating an index described in the preceding sentence, the Secretary may not apply to a hospital any wage index floor.

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

is greater than 10 percent (as compared to the wage index utilized under this paragraph or under section 1886(d), as applicable, for such hospital for the prior fiscal year). For purposes of the preceding sentence, the term 'change in the wage index' includes both increases and decreases in such wage index.

''(C) PROHIBITION ON RECLASSIFICATION.—In the case that a hospital is treated as within a pay locality for purposes of the Employment Cost Index described in clause (i), the Secretary may not treat the hospital as though it were within a different pay locality for purposes of this paragraph.

''(D) PUBLICATION.—Not later than October 1, 2018, the Secretary shall make publicly available on the Internet website of the Centers for Medicare & Medicaid Services an estimate of the geographic area wage adjustment that will apply in 2020 to each hospital to which the new payment system under this subsection will apply.

''(5) ANNUAL UPDATING BY A MARKET BASKET INCREASE FACTOR.—

"(A) IN GENERAL.—The base payment rate shall be updated for each fiscal year (beginning in fiscal year 2021) by a market basket increase factor specified by the Secretary that—

"(i) is based on the market basket percentage increase applicable under subsection (b)(3)(B)(iii), the OPD fee schedule increase factor under section 1833(t)(3)(C)(iv), or otherwise; and

"(ii) takes into account the same adjustments that are applicable to such other increase factors, such as those relating to productivity adjustment.

"(B) HOSPITAL-SPECIFIC ADJUSTMENTS.—Such increase factor shall also be subject to adjustment, for individual hospitals, based on the same adjustments that are applied to the market basket percentage increase applicable under subsection (b)(3)(B)(iii) or section 1833(t)(3)(C), including—

"(i) the adjustment for hospital reporting under subsection (b)(3)(B)(viii), subsection (j)(7), and section 1833(t); and

"(ii) the adjustment for meaningful use of electronic health records under subsection (b)(3)(B)(ix).

"(6) APPLICATION OF HOSPITAL-SPECIFIC PAYMENT ADJUSTMENTS.—

"(A) IN GENERAL.—The payment adjustments described in subparagraph (B) shall apply to payment for short-term hospital stays under this subsection in the same manner as they apply to payment under subsection (d).

"(B) PAYMENT ADJUSTMENTS DESCRIBED.—The payment adjustments described in this subparagraph are the following:

"(i) Payment adjustment under the hospital value-based purchasing program under subsection (o).

"(ii) Payment adjustment for hospital acquired conditions under subsection (p).

"(iii) Payment adjustment under the hospital readmission reduction program under subsection (q).

"(iv) Such other hospital-specific payment adjustments as are made to payment under subsection (d) and section 1833(t) as the Secretary may specify.

''(7) OFFSETS.—

''(A) OFFSET FROM IPPS PAYMENTS.—For fiscal year 2020, the Secretary shall reduce each of the standardized amounts otherwise computed under subsection (d)(3)(A) by such percentage as represents the Secretary's estimate (represented as a percentage) of payments under this subsection for short-term hospital stays in that fiscal year to total payments under subsection (d) for discharges in that fiscal year.

''(B) OFFSET FROM OPPS PAYMENTS.—For 2020, the Secretary shall reduce each of the standardized amounts otherwise computed under section 1833(t) by such percentage as represents the Secretary's estimate (represented as a percentage) of payments under this subsection for overnight outpatient observation stays in that year to total payments under section 1833(t) for discharges in that year.

''(8) TREATMENT OF OUTPATIENT OBSERVATION STAYS AS INPATIENT HOSPITAL SERVICES UNDER PART A.—

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

partment services for which payment is made under this subsection shall be treated as the provision of inpatient hospital services for purposes of the following:

''(i) HI PAYMENT.—Payment from the Federal Hospital Insurance Trust Fund (under section 1817) instead of under the Federal Supplementary Medical Insurance Trust Fund (under section 1841), including for purposes of computing premiums under sections 1818(d) and 1839.

''(ii) APPLICATION OF PART A DEDUCTIBLE AND COST-SHARING.—Application of deductibles and coinsurance under section 1813 instead of under section 1833, including with respect to medicare supplemental policies under section 1882 and medicare cost-sharing under title XIX, but not for purposes of applying a limitation on days of coverage of inpatient hospital services under section 1812.

''(iii) APPLICATION OF POST-HOSPITAL PROVISIONS.—Application of spell of illness (under section 1861(a)) with respect

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

''(B) CONSTRUCTION FOR OTHER OUTPATIENT HOSPITAL SERVICES .—Nothing in subparagraph (A) shall be construed to affect the payment or treatment under this title of hospital outpatient department services that are not short-term hospital stays.

''(9) LIMITATION.—There shall be no administrative or judicial review under section 1878 or otherwise of determinations in carrying out this subsection.

''(10) DEFINITIONS.—In this subsection and subsection (u):

''(A) SHORT-TERM HOSPITAL STAY.—The term 'short-term hospital stay' means—

''(i) an inpatient short-term hospital discharge (as defined in subparagraph (B)); or

''(ii) overnight hospital outpatient services (as defined in subparagraph (C)).

''(B) INPATIENT SHORT-TERM HOSPITAL DISCHARGE.—

''(i) IN GENERAL.—Subject to clauses (iii) and (iv), the term 'inpatient short-

term hospital discharge' means a discharge from a subsection (d) hospital that—

"(I) subject to clause (ii), has actual length of less than 3 days;

"(II) is classified to an MS–DRG that subject to clause (ii), has a national average length of stay that, based on the most recent data available as of the date of the enactment of this subsection, is less than 3 days; and

"(III) is classified to an MS–DRG that is among the most highly ranked of such discharges (such as within the highest 50) among diagnosis-related groups for which payment under this section has been denied for reasons of medical necessity by recovery audit contractors.

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

''(iii) EXPANSION AUTHORITY.—Beginning with fiscal year 2017, the Secretary by regulation may expand those discharges from subsection (d) hospitals that are inpatient short-term hospital short-term discharges for purposes of this subsection.

''(iv) TEMPORARY EXCLUSION OF MEDICARE DEPENDENT HOSPITALS AND SOLE COMMUNITY HOSPITALS.—The term 'inpatient short-term hospital discharge' does not include, for fiscal years 2016 through 2019, a discharge from a medicare-dependent, small rural hospital (as defined in subsection (d)(5)(G)) or from a sole community hospital.

''(C) OVERNIGHT OUTPATIENT HOSPITAL SERVICES.—The term 'overnight outpatient hospital services' means hospital outpatient services in a subsection (d) hospital with an observation stay of more than 24 hours.

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

payments for outpatient and inpatient hospital services under sections 1833(t) and 1886(d) of the Social Security Act in order to transition to one unified hospital prospective payment system.''.

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

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

''(1) ALTERNATIVE PAYMENT RATE FOR INPATIENT SHORT-TERM HOSPITAL STAYS.—In the case of inpatient short-term hospital discharges (as defined in subsection (t)(10)(B)) occurring in a fiscal year (beginning with fiscal year 2016 and ending with fiscal year 2019), the payment rate under this section shall be, instead of the payment rate under subsection (d), the payment rate specified by the Secretary under paragraph (2) for that fiscal year.

''(2) PAYMENT RATE FOR INPATIENT SHORT-TERM HOSPITAL DISCHARGES BASED ON INPATIENT SHORT-TERM PAYMENT POOL FOR FISCAL YEARS 2016 THROUGH 2019.—

"(A) INPATIENT SHORT-TERM PAYMENT POOL.—

"(i) ESTABLISHMENT.—The Secretary shall establish by regulation an inpatient short-term payment pool (in this subsection referred to as an 'inpatient short-term payment pool') for inpatient short-term hospital discharges in a fiscal year (beginning with fiscal year 2016 and ending with fiscal year 2019).

"(ii) INITIAL AMOUNT IN THE POOL.—The amount in the inpatient short-term payment pool for fiscal year 2016 is an amount equal to not less than **[**X**]** and not greater than **[**Y**]** percent of the payments made under subsection (d) for all discharges in fiscal year 2014. Such percent is set in a manner so as to result in a reduction in payments under this section equivalent to **[**Z**]** percent. .

"(iii) AMOUNT IN POOL IN SUBSEQUENT YEARS.—With respect to each of fiscal years 2017 through 2019, the amount in the inpatient short-term payment pool for such fiscal year is an

amount equal to not less than [X] and not greater than [Y] percent of the payments made under subsection (d) for all discharges in the fiscal year that is two years prior to such fiscal year. Such percent is set in a manner so as to result in a reduction in payments under this section equivalent to [Z] percent.

''(B) PAYMENT RATES.—

''(i) IN GENERAL.—For each fiscal year to which subparagraph (A) applies the Secretary shall compute an inpatient short-term adjustment factor to the base operating DRG payment amount (as defined in clause (ii)) that would otherwise apply with respect to inpatient short-term hospital discharges occurring in such fiscal year. Such factor shall be computed in a manner so that the total of the payments under this subsection is estimated to equal the inpatient short-term payment pool amount under subparagraph (A) for such fiscal year. Insofar as the Secretary determines that the aggregate amount of such payments with respect to discharges in a fiscal

year is less or greater than the inpatient short-term payment pool for such fiscal year, the Secretary shall decrease or increase, respectively, the amount in such payment pool for the succeeding fiscal year by the amount of such excess or deficit, respectively.

''(ii) BASE OPERATING DRG PAYMENT AMOUNT.—In this paragraph, the term 'base operating DRG payment amount' means the base operating DRG payment amount (as defined in subsection (o)(7)(D)). Nothing in this subparagraph shall be construed as interfering with the aggregate payment adjustments under subparagraphs (B) and (F) of subsection (d)(5) that are attributable to inpatient short-term hospital stays (and, with respect to such subparagraph (F), paid directly with respect to individual discharges).

''(3) NO IMPACT ON DGME PAYMENTS.—Nothing in this subsection shall be construed as affecting the payment to hospitals under subsection (h) and

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

''(4) DUAL SUBMISSION OF CLAIMS; CROSSWALK OF ICD–10 CODES, CPT CODES, AND HCPCS; CROSSWALK OF DRGS AND APCS.—

''(A) DUAL SUBMISSION OF CLAIMS FOR INPATIENT SHORT-TERM HOSPITAL DISCHARGES AND OVERNIGHT OUTPATIENT HOSPITAL SERVICES DURING 2016.—

''(i) IN GENERAL.—For short-term hospital stays in a subsection (d) hospital occurring during fiscal year 2016, the hospital shall submit information necessary to process a claim for such a stay as an inpatient hospital discharge under subsection (d) and as hospital outpatient hospital services under section 1833(t).

''(ii) AUDITING BY RACS; PAYMENT REDUCTION FOR FAILURE TO SUBMIT INFORMATION.—Recovery audit contractors may audit discharges and services described in clause (i) for the sole purpose of ensuring claims are submitted in accordance with such clause. If a recovery audit contractor determines that information is

not submitted for a such discharge or services in accordance with such clause—

"(I) payment for the discharge or services shall be reduced by 10 percent; and

"(II) the contractor shall be awarded the amount of such reduction.

"(iii) NO CHANGE IN PAYMENT RATES AS A RESULT OF DUAL SUBMISSION REQUIREMENT.—Nothing in this subparagraph (other than clause (ii)) shall be construed as changing the payment rate for inpatient hospital services. All hospital outpatient services described in clause (i) for which claims are submitted in accordance with such clause shall be reimbursed in the amount of zero dollars.

"(B) ICD10–TO–CPT–TO–HCPCS CROSSWALK.—

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

section as 'crosswalks') to link the relevant ICD–10 inpatient codes to relevant CPT and HCPCS outpatient codes, and vice versa, in order to permit comparisons of inpatient hospital services, for which payment is made under subsection (d) and hospital outpatient department services, for which payment is made under section 1833(t).

''(ii) CONSULTATION REQUIRED.—In developing under clause (i) the general equivalency maps described in such clause, the Secretary shall consult with the Medicare Payment Advisory Commission and the Inspector General of the Department of Health and Human Services.

''(iii) CODE TERMINOLOGY.— In this subparagraph, the terms 'ICD–10 codes' and 'CPT and HCPCS codes' include procedure as well as diagnostic codes.

''(iv) DEVELOPMENT THROUGH NOTICE AND COMMENT RULEMAKING.—In carrying out clause (i) and in accordance with this subparagraph, the Secretary shall develop a proposed ICD10–to–CPT–to–

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

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

''(vi) PUBLICATION OF FINAL CROSSWALK.—Taking into consideration comments received on the proposed crosswalk, the Secretary shall publish a final ICD10–to–CPT–to–HCPCS crosswalk under clause (i) and shall post such crosswalk on the Internet Website of the Centers for Medicare & Medicaid Services.

''(vii) UPDATING.—The Secretary shall update such crosswalk on an annual basis.

''(C) DRG–TO–APC CROSSWALK.—

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

the Secretary shall, using the ICD10–to–CPT–to–HCPCS crosswalks so developed, develop crosswalks between diagnosis-related group (DRG) codes for inpatient hospital services and Ambulatory Payment Class (APC) codes for outpatient hospital services.

''(ii) APPLICATION OF SAME PROCESSES.—The provisions of clauses (iv) through (vii) of subparagraph (B) shall apply to the development of the crosswalks under clause (i) in the same manner as they apply to the development of the crosswalks under subparagraph (B)(i).''.

(d) CONTINUATION OF CERTAIN MEDICAL REVIEW ACTIVITIES.—

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

(A) in subsection (a), by striking ''through the first 6 months of fiscal year 2015'' and inserting ''through fiscal year 2015''; and

(B) in subsection (b), by striking ''through March 31, 2015'' and inserting ''through September 30, 2015''.

(2) FURTHER EXTENSION OF MORATORIUM TO INPATIENT SHORT-TERM HOSPITAL DISCHARGES THROUGH TRANSITION.—The Secretary of Health and Human Services shall not permit recovery audit contractors under section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) to conduct audits with respect to inpatient short-term hospital discharges (as defined in paragraph (2) of section 1886(t) of such Act, as added by subsection (a)) occurring during fiscal years 2016 through 2019 except as required under paragraph (3)(C)(ii) of such section.

(e) FUNDING.—For purposes of carrying out this section and section 102 (including the amendments made by such sections), the Secretary of Health and Human Services shall provide for the transfer to the Centers for Medicare & Medicaid Services Program Management Account, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appro-

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

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

Section 1886(d) of the Social Security Act is amended by adding at the end the following new paragraph:

"(14) PER DIEM PAYMENT SYSTEM FOR UNUSUALLY SHORT LENGTH OF STAY (LOS) DISCHARGES.—

"(A) IN GENERAL.—Not later October 1, 2015, the Secretary shall establish a short LOS policy with respect to payment for unusually short LOS discharges (as defined in subparagraph (D)) in the amount determined under this paragraph. Such payment shall be instead of the payment that would otherwise have been made for such discharge under this subsection.

"(B) PER DIEM RATE DETERMINATION.—Under the short LOS policy under this paragraph the payment rate for a short LOS discharge classified within a diagnosis-related group shall be computed as follows:

"(i) The Secretary shall first compute for each fiscal year 80 percent of the applicable payment rate otherwise applicable

with respect to discharges so classified, before the application of any payment adjustments and without regard to this paragraph. The Secretary shall compute such rate based upon data available for the most recent fiscal year.

''(ii) Based upon the amount computed under clause (i) for discharges so classified, the Secretary shall compute a per diem payment rate.

''(iii) The Secretary shall, after the application of clause (ii), adjust the per diem rate so computed, in a budget neutral manner, so that the per diem payment rate for the first 2 days in any discharge is greater than the payment rate for subsequent days.

''(iv) The payment rate for the specific discharge involved shall be based on the per diem rate for the days involved in such discharge and then shall be subject to an area wage adjustment, an adjustment for indirect medical education costs, an adjustment for disproportionate share hospitals, and similar adjustments in the same

manner as such adjustments would otherwise apply to a payment rate under subsection (d).

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

''(D) UNUSUALLY SHORT LOS DISCHARGE DEFINED.—In this paragraph, the term 'unusually short LOS discharge' means, with respect to a discharge that is classified within a diagnosis-related group, a discharge from inpatient hospital services from a subsection (d) hospital if—

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

''(ii) the length of stay for the discharge is significantly shorter (as determined by the Secretary using a metric such as standard deviation) from the median length of stay for discharges classified within such group.''.

SEC. 103. REPEAL OF THE TWO MIDNIGHTS PAYMENT REDUCTION.

(a) FINDINGS ON THE CMS TWO-MIDNIGHT PAYMENT REDUCTION.—Congress finds the following:

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

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

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

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

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

(1) the payment rates that would have been applied under such systems for fiscal year 2014 if subsection (b) had applied with respect to items and services furnished during such fiscal year 2014, exceeds

(2) the payment rates actually applied under such systems for such fiscal year 2014 without application of subsection (b) (and taking into account the 0.2 percent reduction described in such subsection).

Subtitle B—Audits

SEC. 104. MONITORING PERFORMANCE OF THE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM.

(a) FINDINGS ON THE LACK OF PUBLIC AVAILABILITY OF STATISTICS REGARDING THE RECOVERY AUDIT PROGRAM.—Congress finds the following:

(1) The Subcommittee on Health of the Committee on Ways and Means of the House of Representatives held a hearing on May 20, 2014, that

examined a number issues that have surrounded the relationship between Recovery Audit Contractors, the Medicare appeals process, and Medicare providers.

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

(3) These witnesses used different methodologies from which to derive the statistics to best support their respective points of view.

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

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

''(j) RAC COMPARE WEBSITE.—

''(1) IN GENERAL.—No later than October 1, 2015, the Secretary shall establish a RAC Compare Website (in this subsection referred to as the 'RAC website').

''(2) CONTENT.—The Secretary shall publicly report on the RAC website at least the following information for each RAC contractor:

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

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

''(i) the total number paid;

''(ii) the number denied (within the meaning of paragraph (4)) by the recovery audit contractor; and

''(iii) the total number of denied claims overturned on appeal by an administrative law judge or the departmental appeals board.

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

"(3) CMS PAYMENT SYSTEM DEFINED.—In this subsection, the term 'CMS payment system' means each of the following payment systems:

"(A) INPATIENT HOSPITAL SERVICES.—Inpatient hospital payment systems under each of the following:

"(i) IPPS.—Section 1886(d).

"(ii) CAH.—Section 1814(l).

"(iii) PPS-EXEMPT.—Section 1886(b).

"(iv) PUERTO RICO HOSPITALS.—Section 1886(d)(9).

"(B) OUTPATIENT HOSPITAL SERVICES.—Outpatient hospital payment systems under each of the following:

"(i) IN GENERAL.—Section 1833(t).

"(ii) CAH.—Section 1834(g).

"(C) PFS.—The physician fee schedule under section 1848.

"(D) DMEPOS.—Payment systems for durable medical equipment and for prosthetics, orthotics, and supplies treating each as a separate payment system under each of the following:

"(i) Section 1834(a).

''(ii) Section 1834(h).

''(iii) Section 1847.

''(E) ESRD.—The payment system for end-stage renal disease services under section 1881.

''(F) ASC.—The payment system for ambulatory surgical centers under section 1833(i).

''(G) CLINICAL LABORATORIES.—The payment system for clinical diagnostic laboratory services under section 1833(h).

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

''(I) SNF.—The payment system for skilled nursing facility services under section 1888.

''(J) IRF.—The payment system for inpatient rehabilitation facility services under section 1886(j).

''(K) IPF.—The payment system for inpatient psychiatric facility services under section 1886(s).

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

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

''(4) CLAIM DENIALS BY RACS.—In this subsection, a claim shall be treated as denied by a recovery audit contractor if the claim is fully or partially reversed by the contractor, except that those claims that are dismissed or remanded shall not be considered as claim denials.''.

SEC. 105. IMPROVEMENTS TO THE RAC PROGRAM.

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

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

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

(b) PERIOD FOR DISCUSSION.—

(1) IN GENERAL.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) is amended by adding at the end the following new paragraph:

''(10) PERIOD FOR DISCUSSION BEFORE INITIATING COLLECTION.—The contract with a recovery

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

''(A) allow the provider or supplier a period of at least 30 days for discussion with the contractor before the contractor transmits the claim to a medicare administrative contractor for adjustment or recoupment; and

''(B) confirm with the provider or supplier a request for such discussion within 3 business days of the date of such request.''.

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

(c) LIMITS ON ADRS.—

(1) IN GENERAL.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) is further amended by adding at the end the following new paragraph:

''(11) LIMITS ON ADDITIONAL DOCUMENTATION REQUESTS (ADRS).—The contract with a recovery audit contractor under this subsection shall include the establishment of limits for additional documentation requests. Such limits shall—

''(A) vary by payment system; and

''(B) be adjusted in accordance with the denial rate for the provider of services or supplier involved so that a provider or supplier with a low denial rate has a lower limit and a provider or supplier with a high denial rate has a higher limit.''.

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

(d) PREVENTING DUPLICATIVE AUDITS.—

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

''(f) PREVENTING DUPLICATIVE AUDITS.—The Secretary shall require that all entities with a contract to conduct pre- and post-payment review of claims under this title submit a record of such review to the recovery audit data warehouse (or successor system) that is managed by the Centers for Medicare & Medicaid Services.''.

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

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

Subtitle C—Appeals

SEC. 106. RETROSPECTIVE HOSPITAL SOLUTIONS TO ADDRESS PROBLEMS IN THE MEDICARE APPEALS PROCESS.

(a) FINDINGS.—Congress finds the following:

(1) At the beginning of 2014, the Administration temporarily suspended the assignment of new requests for Medicare appeals at the Administrative Law Judge level.

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

(3) On Friday, August 29, 2014, the Centers for Medicare & Medicaid Services established the ''Hospital Appeals Settlement for Fee-for-Service Denials Based on Patient Status Reviews for Admission Prior to October 1, 2013''. In this settlement process the Centers failed to—

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

(B) make interest payments on settled claims;

(C) count settled claims at full reimbursement levels for purposes of calculating a hospital's direct graduate medical education reimbursement; and

(D) consider settlement as the final resolution of the claim.

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

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

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

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

(5) The Centers has historically denied Medicare providers the full ability to rebill services rendered and, in most instances, the Centers has used a ''timely filing requirement'' threshold of one year after a service is rendered before rebilling is permitted. Representative Adrian Smith has introduced H.R. 2329 in the 113th Congress to afford hospitals the ability to rebill certain services.

(b) VOLUNTARY SETTLEMENT PROCESS FOR MEDICAL MS-DRGS.—Section 1869(b)(1) of the Social Security Act (42 U.S.C. 1395ff(b)(1)) is amended by adding at the end the following new subparagraph:

''(H) VOLUNTARY SETTLEMENT PROCESS FOR MEDICAL MS-DRGS.—

''(i) IN GENERAL.—The Secretary shall establish by regulation a voluntary settlement process consistent with this subparagraph under which, in the case of a request for a hearing by an administrative law judge relating to a denial of a claim for services occurring beginning on July 1, 2007, and ending on September 30, 2013, for payment under section 1886(d) for inpatient hospital services furnished by a subsection (d) hospital and classified as a medical MS–DRG as not being reasonable and necessary, the appellant is provided an opportunity to accept a settlement offered with respect to such claim under terms and conditions, including a settlement rate, specified in the regulation. Such process may be based on the process for hospital appeals settlement for fee-for-service deni-

als based on patient status reviews. Under such process a hospital may elect, with respect to an individual medical MS–DRG, to use such process or not use such process (and continue an appeal with respect to such MS–DRG).

''(ii) INELIGIBLE CLAIMS.—Such process shall not apply to a claim for which—

''(I) an appeal has been requested with the Departmental Appeals Board; or

''(II) a request for a hearing before an administrative law judge has not been filed.

''(iii) SETTLEMENT RATE CONSIDERATIONS.—The Secretary shall establish the settlement rate under such process using an analysis of empirical data and other factors. Such rate shall take into account an appropriate factor to reflect the interest on denied claims for the average amount of time that appeals of such claims have been pending at the administrative law judge

level. Such analysis shall consider at least—

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

"(II) information maintained by other government agencies, including the Office of the Inspector General of the Department of Health and Human Services and the Medicare Payment Advisory Commission.

"(iv) DEADLINE AND CONTENTS OF PROPOSED REGULATION.—The Secretary shall provide for the publication of a proposed regulation to carry out this subparagraph not later than 90 days after the date of the enactment of this subparagraph. Such publication shall include the proposed settlement rate as well as the analysis and factors described in clause (iv).

"(v) NOTICE AND OFFER.—

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

retary shall provide to the appellant notice of the settlement offer, with instructions for how to accept the offer.

''(II) ACCEPTANCE.—Under such process the appellant shall be provided 60 days after the date of such notice to accept the offer.

''(III) ACKNOWLEDGMENT OF RECEIPT OF REQUEST TO ACCEPT.—Such process the Secretary shall provide a receipt for such a notice to accept the offer.

''(vi) TERMS OF ACCEPTANCE.—Under such process the appellant may accept the offer on an individual discharge basis and acceptance of the offer shall be considered final resolution of the claim such that—

''(I) the appellant may not seek further appeal or review of the claim nor seek any other administrative or judicial review of the claim; and

''(II) the Secretary may not subject the claim to further audit, including through the Comprehensive Error

Rate Testing program, except in the case of suspected fraud or misrepresentation of facts.

''(vii) TREATMENT OF SETTLEMENT.—The Secretary shall treat a settlement of a claim for inpatient hospital services under this subparagraph, as payment of the claim for purposes of applying cost reporting principles, such as in calculating the percentage of expenditures under part A for inpatient hospital services for purposes of calculating a hospital's part A percentage in applying section 1886(h) (relating to payment for costs of graduate medical education).

''(viii) PROCESS FOR ADJUSTMENT OF RAC CONTINGENCY FEES.—In carrying out the settlement process under this subparagraph and the process referred to in the last sentence of clause (i), the Secretary shall establish a separate settlement process for the contingency fees of recovery audit contractors under section 1893(h). Under such process the Secretary shall adjust the contingency fees of such contrac-

tors through an offset against future contingency fees, through a requirement that such contractors repay payments associated with a reduced contingency fee based on a reduced settlement reimbursement, or otherwise.''.

(c) REBILLING OPTION FOR SURGICAL MS-DRGS.—

(1) IN GENERAL.—Subject to paragraph (4), the Secretary of Health and Human Services shall allow, with regard to any rebilling limitation, subsection (d) hospitals the opportunity to rebill under section 1834(t) of the Social Security Act (42 U.S.C. 1395m(t)) for inpatient hospital services classified as surgical MS-DRGs that have been denied as not reasonable and necessary and that are pending at the administrative law judge level, for items and services furnished during the period beginning on July 1, 2007 and ending on September 30, 2013. Such opportunity shall be available to hospitals only if the rebilling is submitted not later than 6 months after the date of the notice under paragraph (2).

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

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

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

(A) any contingency fee initially paid out to recovery audit contractors shall not be subject to adjustment or repayment; and

(B) any beneficiary cost-sharing obligations shall not be subject to adjustment.

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

(4) EXCEPTION.—Any hospital that elects to participate in the ''Hospitals Appeals Settlement for Fee-for-Service Denials Based on Patient Status Reviews for Admission Prior to October 1, 2013'' program is not eligible for any rebilling of previously denied surgical discharges under paragraph (1) regarding patient status.

SEC. 107. RETROSPECTIVE NON-HOSPITAL SOLUTIONS TO ADDRESS PROBLEMS IN THE MEDICARE APPEALS PROCESS.

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

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

''(I) EXPEDITING DECISIONS ON PART B CLAIMS TO REDUCE ALJ BACKLOG.—Not later than 60 days after the date of the enactment of this subparagraph, the Secretary shall establish (and make publicly available the details of) a voluntary process under which, in the case of a request for a hearing by an administrative law judge filed on or after such date of enactment (or filed before such date of enactment but pending as of such date) with respect to a claim for services under part B, the appellant is provided an opportunity to resolve the claim through extrapolation of the results of a review decision on a statistically valid sample of claims for the same or similar services. Under such process—

''(i) the Secretary shall use a statistician or an individual with comparable training in constructing the sample and extrapolating the review results;

''(ii) in the case of such a request for a hearing filed before such date of enactment but pending as of such date—

''(I) not later than 90 days after the date of the enactment of this subparagraph, the Secretary shall provide notice of the process, with instructions for how to elect the process; and

''(II) the appellant is provided 60 days from the date of such notice to use such process with respect to such claim;

''(iii) in the case of such a request for a hearing filed on or after such date of enactment, not later than 90 days after the date of the enactment of this subparagraph, the Secretary shall take such measures as are necessary to ensure that the filing process under this subsection provides for notice of the availability of the process established under this subparagraph; and

''(iv) of all appellants that are eligible to use the process under this subparagraph and that elect to use such process, the Secretary shall give priority to appellants with respect to a request for a hearing filed be-

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

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

''(J) AUTHORIZING VOLUNTARY SETTLEMENT PROCESS FOR PART B CLAIMS.—

''(i) IN GENERAL.—The Secretary may establish a voluntary settlement process under which, in the case of a request for a hearing by an administrative law judge filed on or before the date of the enactment of this subparagraph with respect to a claim for items and services under part B, the appellant is provided an opportunity to accept a settlement offered with respect to claims for the same or similar services.

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

under such subparagraph need not apply and the settlement amount shall be based on the extent to which the appeals for claims for the same or similar services furnished by the provider of services or supplier involved have been determined favorably to such provider or supplier.''.

SEC. 108. PROSPECTIVE SOLUTIONS TO ADDRESS PROBLEMS IN THE MEDICARE APPEALS PROCESS.

(a) DATA COLLECTION REQUIREMENTS.—

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

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

''(A) medicare administrative contractors with respect to requests filed for reconsideration of claims pursuant to a contract under section 1874A;

''(B) administrative law judges with respect to requests filed for hearings under this section of determinations made for claims; and

''(C) the Departmental Appeals Board of the Department of Health and Human Services

with respect to requests for reviews of decisions on hearings filed under this section;

in the same manner as such provisions apply with respect to qualified independent contractors to carry out the purposes of this section.''.

(2) CONFORMING AMENDMENT.—Section 1869(e)(4)(A) of the Social Security Act (42 U.S.C. 1395ff(e)(4)(A)) is amended, in the second sentence, by inserting '', medicare administrative contractors, administrative law judges, and the Departmental Appeals Board of the Department of Health and Human Services'' after ''qualified independent contractors''.

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

''(j) COMPREHENSIVE ELECTRONIC SYSTEM FOR MANAGING APPEALS.—

''(1) IN GENERAL.—Not later than July 1, 2015, the Secretary shall implement an electronic system for managing appeals of determinations provided for under this section. Such system shall—

''(A) contain basic information (such as the payment system under this title and total allowed charges) on each claim for which an appeal has been filed under this section, with respect to each level of appeal;

''(B) enable information to be extracted from the claims processing system for each payment system, with respect to claims that are subject to such appeals;

''(C) enable the appellant involved to submit clinical documentation and other information in support of the appeal involved directly to the applicable contractor;

''(D) contain information in support of the effort to uphold the decision the appellant seeks to overturn and enable the Secretary (and relevant contractors) to share information for the claim through subsequent levels of appeal; and

''(E) contain information and other features that the Secretary determines appropriate.

''(2) AVAILABILITY OF INFORMATION.—For purposes of carrying out this subsection, each applicable contractor under this section shall make available to the Secretary such information as needed by

the Secretary to establish and maintain the electronic system under paragraph (1).''.

(c) PUBLIC INFORMATION ON PENDING APPEALS AND DETERMINATIONS.—Section 1869 of the Social Security Act is further amended by adding at the end the following new subsection:

''(k) POSTING OF INFORMATION ON PENDING APPEALS AND DETERMINATIONS.—

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

''(2) UPDATING AT LEAST BI-ANNUALLY.—The Secretary shall update such information not less frequently than bi-annually.

''(3) INFORMATION TO BE INCLUDED.—Such information, with respect to claims for which a request for such an appeal was filed, shall include at each level of appeal under this section, as applicable, at least the following information:

''(A) The total number of such claims and total charges allowed with respect to such claims.

''(B) Of such total number and total allowed charges—

''(i) such number and charges with respect items and services for which payment is sought under part A; and

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

''(C) The number of such claims with respect to items and services described in clauses (i) and (ii) of subparagraph (B), presented by type of provider of services or supplier and by payment system under the respective part and by item or service or category of such items and services.

''(D) In applying subparagraph (C) in the case of durable medical equipment, prosthetics, orthotics, and supplies for which amounts are payable under section 1834(a), information described in such subparagraph with respect to type of provider of services or supplier and payment system presented in a manner that sepa-

rates durable medical equipment from prosthetics, orthotics, and supplies.

''(E) The most frequent reason for the initial determination under this section denying payment under this title, presented by type of provider of services or supplier, as applicable and by payment system and presented, to the extent feasible, by item or service or category of such items and services.

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

''(G) The number and percentage of such claims described in subparagraph (A) for which a determination is made under this section in favor of the appellant at each level of appeal, presented in a manner that separates favorable determinations from partially favorable determinations.

"(H) The number of determinations under this section by administrative law judges with respect to claims that had a hearing as compared to the number of determinations under this section by administrative law judges that were made on the record.

"(4) INCLUSION OF ANALYSIS OF VARIATIONS IN INITIAL COVERAGE DETERMINATIONS.—

"(A) IN GENERAL.—Such information also shall include an analysis of the extent to which initial determinations made under this section by medicare administrative contractors pursuant to contracts under section 1874A (including with respect to payment and coverage determinations under part B for durable medical equipment) vary significantly by contractor region for the same or similar services. Such analysis shall include initial determinations based on local coverage decisions made under this section.

"(B) CONSULTATION WITH MEDICARE ADMINISTRATIVE CONTRACTORS.—In conducting the analysis under subparagraph (A), the Secretary shall consult with medicare administrative contractors to determine if standardization

or other improvements are appropriate to generate more consistent initial determinations under this section.''.

(d) TREATMENT OF CERTAIN DOCUMENTATION CREATED BY ORTHOTISTS AND PROSTHETISTS.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

''(j) TREATMENT OF CERTAIN DOCUMENTATION CREATED BY ORTHOTISTS AND PROSTHETISTS.—

''(1) IN GENERAL.—For purposes of determining under this title the reasonableness and medical necessity of prosthetic devices and orthotics and prosthetics, documentation created by orthotists and prosthetists relating to the need for such devices, orthotics, and prosthetics shall be considered part of the medical record.

''(2) DOCUMENTATION ON MEDICAL NECESSITY FOR LOWER LIMB PROSTHETIC DEVICES.—The Secretary shall make public the elements that need to be documented in the medical record from the evaluation of the need for a lower limb prosthetic device to establish that it is reasonable and necessary under this title. Such elements shall be established in consultation with stakeholders and shall be made

public no later than 90 days after the date of the enactment of this subsection.''.

Subtitle D—Quality and Transparency

SEC. 109. HOSPITAL ASSESSMENT DATA.

(a) IN GENERAL.—Section 1899B of the Social Security Act (42 U.S.C. 1395lll) is amended—

(1) by redesignating subsections (j), (k), (l), and (m) as subsections (k), (l), (m), and (n), respectively; and

(2) by inserting after subsection (i) the following new subsection:

''(j) ASSESSMENT DATA REQUIREMENTS FOR INPATIENT HOSPITALS, PPS-EXEMPT CANCER HOSPITALS, AND CRITICAL ACCESS HOSPITALS.—

''(1) IN GENERAL.—Not later than October 1, 2018, the Secretary shall require subsection (d) hospitals, hospitals described in section 1886(d)(1)(B)(v), and critical access hospitals, under the applicable reporting provisions, to report to the Secretary standardized patient assessment data with respect to inpatient hospital services furnished by such a hospital or critical access hospital to individuals who are entitled to benefits under part A. Under the applicable reporting provisions, each

such hospital and critical access hospital shall collect and submit such data, with respect to items and services furnished to such an individual admitted to such hospital or critical access hospital, upon discharge of such individual. Such standardized patient assessment data shall be with respect to the following categories:

''(A) Medical conditions and co-morbidities, such as diabetes, congestive heart failure, and pressure ulcers.

''(B) Functional status, such as mobility and self care, before discharge from a hospital provider.

''(C) Cognitive function, such as ability to express ideas and to understand, and mental status, such as depression and dementia.

''(D) Living situation and access to family caregivers and other caregivers at home.

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

''(2) APPLICABLE REPORTING PROVISION DEFINED.—For purposes of this subsection, the term 'applicable reporting provision'means—

''(A) for subsection (d) hospitals (as defined in section 1886(d)(1)(B)), section 1886(b)(3)(B)(viii);

''(B) for critical access hospitals (as described in section 1820(c)(2)(B)), section 1814(l)(5); and

''(C) for a hospital described in section 1886(d)(1)(B)(v), section 1866(k).''.

(b) PAYMENT CONSEQUENCES UNDER THE APPLICABLE REPORTING PROVISIONS.—

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

''(XII) Effective for payments beginning with fiscal year 2019, in addition to data otherwise required to be submitted on measures selected under this clause, the Secretary shall require to be submitted the standardized patient assessment data required under section 1899B(j)(1). To the extent such standardized data are duplicative of any other data required

to be reported under this clause, the submission of such standardized data shall be required under this clause in lieu of the submission of such other data.''.

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

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

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

''(5)(A) For cost reporting periods beginning in fiscal year 2019 or a subsequent fiscal year, in the case of a critical access hospital that does not submit to the Secretary, in accordance with subparagraph (B), standardized patient assessment data required under section 1899B(j) with respect to such a fiscal year, paragraph (1) shall be applied to such critical access hospital for such fiscal year by reducing the percent described in such paragraph, after application of paragraph (4), by 2 percentage points. Such reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the pay-

ment amount under this subsection for a subsequent fiscal year.

''(B) A critical access hospital shall submit to the Secretary, in a manner and within the timeframes prescribed by the Secretary, standardized patient assessment data required under section 1899B(j)(1). To the extent such standardized data are duplicative of any other data required to be reported under this subsection, the submission of such standardized data shall be required under this subsection in lieu of the submission of such other data.''.

(3) PPS-EXEMPT CANCER HOSPITALS.—

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

(i) by striking paragraph (2) and inserting the following:

''(2) SUBMISSION OF DATA.—

''(A) IN GENERAL.—

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

ity measures specified under paragraph (3).

''(ii) STANDARDIZED PATIENT ASSESSMENT DATA.—For fiscal year 2019 and each subsequent fiscal year, in addition to such data on quality measures, each hospital described in such section shall submit to the Secretary standardized patient assessment data required under section 1899B(j)(1). To the extent such standardized data are duplicative of any other data required to be reported under this subsection, the submission of such standardized data shall be required under this subsection in lieu of the submission of such other data.

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

(ii) in paragraph (4), by striking ''paragraph (4)'' and inserting ''paragraph (2)(A)(i)''; and

(iii) by adding at the end the following new paragraph:

''(5) REDUCTION FOR FAILURE TO REPORT STANDARDIZED PATIENT ASSESSMENT DATA.—For fiscal year 2019 or a subsequent fiscal year, in the case of a hospital described in section 1886(d)(1)(B)(v) that does not submit to the Secretary, in accordance with subparagraphs (A)(ii) and (B) of paragraph (2), standardized patient assessment data required under section 1899B(j)(1) with respect to such fiscal year, the applicable percentage increase under subparagraph (B)(ii) of section 1886(b)(3) otherwise applicable to such hospital for purposes of subparagraph (E) of such section for such fiscal year shall be reduced by 2 percentage points. Such reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under section 1886(b) for a subsequent fiscal year.''.

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

SEC. 110. COST INFORMATION ON HOSPITAL PAYMENTS.

(a) REPORTING OF CERTAIN HOSPITAL PAYMENT DATA.—

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

(A) in subsection (a)(1)—

(i) in subparagraph (V), by striking ''and'' at the end;

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

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

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

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

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

(II) by redesignating such subparagraph as subparagraph (X); and

(III) by striking the period at the end and inserting '', and''; and

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

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

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

''(j) REPORTING OF CERTAIN HOSPITAL PAYMENT DATA.—

''(1) IN GENERAL.—A subsection (d) hospital (as defined in section 1886(d)(1)(B)) shall submit to the Secretary data on the actual amounts collected by the hospital from uninsured and insured patients over the preceding 2 years for each of the procedures described in paragraph (2).

''(2) PROCEDURES DESCRIBED.—The procedures described in this paragraph are the 50 most common diagnosis-related groups and ambulatory payment classification groups for which payment is made under this title, as determined by the Secretary based on claims data, in both the inpatient and outpatient settings.

''(3) TRANSPARENCY.—

''(A) IN GENERAL.—In order to be beneficial to consumers, the reporting of data under

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

''(B) PUBLIC AVAILABILITY OF INFORMATION.—The Secretary shall post data submitted under paragraph (1) on a publicly accessible and searchable Internet website in a form and manner that—

''(i) allows for meaningful comparisons of hospital collections and related policies by zip code; and

''(ii) is readily understandable by a typical consumer.

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

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to contracts entered into, or renewed, on or after the date of the enactment of this Act.

(b) INCLUSION OF INFORMATION ON CHARITY CARE FURNISHED BY HOSPITALS IN MEDPAC'S ANNUAL REPORT.—Each annual report submitted to Congress after the date of the enactment of this Act by the Medicare Payment Advisory Commission under section 1805 of the So-

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

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.

(a) IN GENERAL.—Section 1877(i) of the Social Security Act (42 U.S.C. 1395nn(i)) is amended—

(1) in paragraph (1)(A)—

(A) in the matter preceding clause (i), by striking ''had'';

(B) in clause (i), by inserting ''had'' before ''physician ownership''; and

(C) by amending clause (ii) to read as follows:

''(ii) either—

''(I) had a provider agreement under section 1866 in effect on such date; or

"(II) was under construction on such date."; and

(2) in paragraph (3)—

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

"(E) APPLICABLE HOSPITAL.—In this paragraph, the term 'applicable hospital' means a hospital that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries."; and

(B) in subparagraph (F)(iii), by striking "subparagraph (E)(iii)" and inserting "subparagraph (E)".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective as if included in the enactment of subsection (i) of section 1877 of the Social Security Act (42 U.S.C. 1395nn).

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.

(a) IN GENERAL.—Section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) is amended by adding at the end the following new clause:

"(iv) APPLICATION OF BUDGET NEUTRALITY RELATING TO FLOOR ON WAGE AREA INDEX IN NON-RURAL AREAS.—

"(I) APPLICATION ON A STATE-SPECIFIC BASIS BEGINNING IN FISCAL YEAR 2016.—Subject to subclause (II), in the case of discharges occurring on or after October 1, 2015, for purposes of applying section 4410(b) of the Balanced Budget Act of 1997, the Secretary shall administer such section 4410(b) and paragraph (e) of section 412.64 of title 42, Code of Federal Regulations, as if paragraph (e)(4)(ii) of such section 412.64 had never applied and by using the methodology promulgated in the Federal

Register on August 19, 2008 (73 Fed. Reg. 48570) (applied as if such methodology had been fully implemented for fiscal year 2011 using a 100 percent State-specific adjustment to the area wage index).

"(II) CONSTRUCTION.—Nothing in subclause (I) shall be construed as preventing the Secretary, for discharges occurring on or after October 1, 2015, from modifying the regulations under such section 412.64 in carrying out the budget neutrality requirements of such section 4410(b).".

(b) CONFORMING AMENDMENT TERMINATING APPLICATION OF BUDGET NEUTRALITY ON A NATIONWIDE BASIS.—Section 3141 of the Patient Protection and Affordable Care Act (42 U.S.C. 1395ww note) is amended by inserting "and before October 1, 2015," after "2010,".

SEC. 203. H.R. 4418 – (RYAN) EXPANDING THE AVAILABILITY OF MEDICARE DATA ACT.

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

(1) ADDITIONAL ANALYSES.—

(A) IN GENERAL.—Subject to subparagraph (B), to the extent consistent with applicable information, privacy, security, and disclosure laws (including paragraph (3)), notwithstanding paragraph (4)(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of paragraph (4)(D) of such section, beginning July 1, 2015, a qualified entity may use the combined data described in paragraph (4)(B)(iii) of such section received by such entity under such section, and information derived from the evaluation described in such paragraph (4)(D), to conduct additional non-public analyses (as determined appropriate by the Secretary) and provide or sell such analyses to authorized users for non-public use (including for the purposes of assisting providers of services and suppliers to develop and participate in quality and patient care improvement activities, including developing new models of care).

(B) LIMITATIONS WITH RESPECT TO ANALYSES.—

(i) EMPLOYERS.—Any analyses provided or sold under subparagraph (A) to

an employer described in paragraph (9)(A)(iii) may only be used by such employer for purposes of providing health insurance to employees and retirees of the employer.

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

(2) ACCESS TO CERTAIN DATA.—

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

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

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

(ii) subject to subparagraph (C), provide Medicare claims data to authorized users described in clauses (i), (ii), and (v), of paragraph (9)(A) for non-public use, including for the purposes described in subparagraph (B).

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

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

(3) PROTECTION OF INFORMATION.—

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

shall not contain information that individually identifies a patient.

(B) INFORMATION ON PATIENTS OF THE PROVIDER OF SERVICES OR SUPPLIER.—To the extent consistent with applicable information, privacy, security, and disclosure laws, an analysis or data that is provided or sold to a provider of services or supplier under paragraph (1) or (2) may contain information that individually identifies a patient of such provider or supplier, including with respect to items and services furnished to the patient by other providers of services or suppliers.

(C) PROHIBITION ON USING ANALYSES OR DATA FOR MARKETING PURPOSES.—An authorized user shall not use an analysis or data provided or sold under paragraph (1) or (2) for marketing purposes.

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

the data and, as determined appropriate by the Secretary, any prohibitions on using such data to link to other individually identifiable sources of information. If the authorized user is not a covered entity under the rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, the agreement shall identify the relevant regulations, as determined by the Secretary, that the user shall comply with as if it were acting in the capacity of such a covered entity.

(5) NO REDISCLOSURE OF ANALYSES OR DATA.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an authorized user that is provided or sold an analysis or data under paragraph (1) or (2) shall not redisclose or make public such analysis or data or any analysis using such data.

(B) PERMITTED REDISCLOSURE.—A provider of services or supplier that is provided or sold an analysis or data under paragraph (1) or (2) may, as determined by the Secretary, redisclose such analysis or data for the purposes of performance improvement and care coordination

activities but shall not make public such analysis or data or any analysis using such data.

(6) OPPORTUNITY FOR PROVIDERS OF SERVICES AND SUPPLIERS TO REVIEW.—Prior to a qualified entity providing or selling an analysis to an authorized user under paragraph (1), to the extent that such analysis would individually identify a provider of services or supplier who is not being provided or sold such analysis, such qualified entity shall provide such provider or supplier with the opportunity to appeal and correct errors in the manner described in section 1874(e)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(C)(ii)).

(7) ASSESSMENT FOR A BREACH.—

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

(i) an agreement between the Secretary and a qualified entity; and

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

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

(i) in the case of an agreement described in subparagraph (A)(i), for whom the Secretary provided data on to the qualified entity under paragraph (2); and

(ii) in the case of an agreement described in subparagraph (A)(ii), for whom the qualified entity provided data on to the authorized user under paragraph (2).

(C) DEPOSIT OF AMOUNTS COLLECTED.—Any amounts collected pursuant to this paragraph shall be deposited in Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

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

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

(B) a description of the topics and purposes of such analyses;

(C) information on the entities who received the data under paragraph (2), the uses of the data, and the total amount of fees received for providing, selling, or sharing the data; and

(D) other information determined appropriate by the Secretary.

(9) DEFINITIONS.—In this subsection and subsection (b):

(A) AUTHORIZED USER.—The term ''authorized user'' means the following:

(i) A provider of services.

(ii) A supplier.

(iii) An employer (as defined in section 3(5) of the Employee Retirement Insurance Security Act of 1974).

(iv) A health insurance issuer (as defined in section 2791 of the Public Health Service Act).

(v) A medical society or hospital association.

(vi) Any entity not described in clauses (i) through (v) that is approved by the Secretary (other than an employer or health insurance issuer not described in clauses (iii) and (iv), respectively, as determined by the Secretary).

(B) PROVIDER OF SERVICES.—The term ''provider of services'' has the meaning given such term in section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u)).

(C) QUALIFIED ENTITY.—The term ''qualified entity'' has the meaning given such term in section 1874(e)(2) of the Social Security Act (42 U.S.C. 1395kk(e)).

(D) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

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

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

(1) ACCESS.—

(A) IN GENERAL.—To the extent consistent with applicable information, privacy, security, and disclosure laws, beginning July 1, 2015, the Secretary shall, at the request of a qualified clinical data registry under section 1848(m)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(E)), provide the data described in subparagraph (B) (in a form and manner determined to be appropriate) to such qualified clinical data registry for purposes of linking such data with clinical outcomes data and performing risk-adjusted, scientifically valid analyses and research to support quality improvement or patient safety, provided that any public reporting of such analyses or research that identifies a provider of services or supplier shall only be conducted with the opportunity of such provider or supplier to appeal and correct errors in the manner described in subsection (a)(6).

(B) DATA DESCRIBED.—The data described in this subparagraph is—

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

(ii) if the Secretary determines appropriate, claims data under the Medicaid program under title XIX of such Act and the State Children's Health Insurance Program under title XXI of such Act.

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

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

(1) in the subsection heading, by striking ''MEDICARE''; and

(2) in paragraph (3)—

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

2015, if the Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under titles XIX and XXI for assistance provided under such titles for one or more specified geographic areas and time periods requested by a qualified entity.''; and

(B) in the last sentence, by inserting ''or under titles XIX or XXI'' before the period at the end.

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

(1) by inserting '', for periods prior to July 1, 2015,'' after ''deposited''; and

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

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

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

U.S.C. 1395l(t)(9)(A)) is amended by inserting ''and suppliers subject to the prospective payment system (including at least one ambulatory surgical center representative)'' after ''an appropriate selection of representatives of providers''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 205. H.R. 4187 – (ROSKAM) DEVELOPING AN INNOVATIVE STRATEGY FOR ANTIMICROBIAL RESISTANT MICROORGANISMS ACT OF 2014.

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

''(M)(i) Effective for discharges beginning on or after October 1, 2015, the Secretary shall, after notice and opportunity for public comment (in the publications required by subsection (e)(5) for a fiscal year or otherwise), recognize the costs of new antimicrobial drugs under the payment system established under this subsection. The Secretary shall ensure the timeframes specified under section 412.87(b)(2) of title 42, Code of Federal Regulations, as in effect as of the date of the enactment of this subparagraph, are enforced for purposes of this subparagraph.

''(ii) Pursuant to clause (i), the Secretary shall apply section 412.88(a)(2) of title 42, Code of Federal Regulations, with respect to discharges occurring on or after October 1, 2015, as if the additional amount described in such section referenced an amount equal to the lesser of the amount described in clause (i) or (ii) of such section or the amount provided for under section 1847A for drugs and biologicals that are described in section 1842(o)(1)(C).

''(iii) For purposes of this subparagraph, the term 'new antimicrobial drug' means a product that is approved for use, or a product for which an indication is first approved for use, by the Federal Food and Drug Administration on or after January 1, 2014, and that—

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

''(II) is used in facilities that participate in the Antimicrobial Use and Resistance Module of the National Healthcare Safety Network of the Centers for Disease Control and Prevention (or, in the case that

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

SEC. 206. (BUCHANAN) HAND SANITATION DEMONSTRATION PROGRAM.

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

''SEC. 1866F. HAND SANITATION DEMONSTRATION PROGRAM.

''(a) ESTABLISHMENT.—The Secretary shall establish a demonstration program (in this section referred to as 'demonstration program') under which the Secretary shall approve demonstration projects that—

''(1) identify barriers to hand sanitation in eligible hospitals; and

''(2) implement solutions to eliminate those barriers.

''(b) ADMINISTRATION BY CONTRACT.—Except as otherwise provided in this section, the Secretary may administer the demonstration program in accordance with section 1866B.

''(c) DEFINITIONS.—In this section:

''(1) ELIGIBLE HOSPITAL.—The term 'eligible hospital' means any of the following:

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

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

''(C) A hospital that is paid under section 1814(b)(3).

''(D) A hospital that is located in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the Virgin Islands of the United States, or in any other territory or possession of the United States, and that would be a subsection (d) hospital if it were located in one of the 50 States.

''(2) CONGRESSIONAL DISTRICT.—The term 'Congressional district' means a Congressional district in any of the 50 States or in the District of Columbia, Puerto Rico, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, or the Virgin Islands of the United States.

''(d) PARTICIPATION.—

''(1) APPLICATION.—To participate in a demonstration project under this section, an eligible hospital shall submit an application to the Secretary at

such time, in such manner, and containing such information as the Secretary may require.

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

''(3) PRIORITY.—In selecting hospitals under paragraph (2), the Secretary may give priority to eligible hospitals that are in the bottom quartile of performance on measures of hospital acquired conditions.

''(e) DEMONSTRATION PROJECT.—Each eligible hospital selected under subsection (d) shall—

''(1) identify barriers to hand sanitation, which may include—

''(A) ineffective use of soap dispensers or sinks;

''(B) lack of collecting or reporting hand hygiene compliance data accurately or frequently;

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

''(D) absence of emphasis on hand hygiene as part of the safety culture of the eligible hospital;

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

''(F) distractions or other interferences, such as already wearing gloves or having both hands occupied;

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

''(H) forgetting; and

''(2) implement appropriate solutions to eliminate such barriers, which may include—

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

''(B) real-time behavior modification feedback to healthcare workers;

''(C) trained and certified independent observers;

''(D) peer-to-peer coaching;

''(E) just-in-time training; and

''(F) solutions endorsed by the Joint Commission Center for Transforming Healthcare, including Targeted Solutions Tools, robust process improvement, and Six Sigma.

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

''(g) REPORT TO CONGRESS.—The Secretary shall collect data on the barriers to hand sanitation identified and the effectiveness of each solution implemented, and submit findings in a report to Congress not later than December 31, 2017.

''(h) COSTS.—There shall be transferred to the Secretary, from the Federal Hospital Insurance Trust Fund established under section 1817, such sums as are necessary, not to exceed $100,000,000, to carry out the provisions of this section.''.

(b) REQUIREMENTS FOR HAND WASHING QUALITY MEASURES.—

(1) SELECTION.—Not later than October 1, 2015, the Secretary shall select one or more hand washing quality measures to be used for the quality reporting requirement described in paragraph (2). The Secretary may use information from the demonstration program conducted pursuant to section 1866F of the Social Security Act (as added by subsection (a)) to inform the selection of hand washing quality measures under this paragraph.

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

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

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

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

(4) PUBLIC REPORTING.—Not later than October 1, 2017, the Secretary shall make available to the public the hand washing quality measures selected under paragraph (1).

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.

(a) EXTENSION OF THERAPY SUPERVISION NONENFORCEMENT INSTRUCTION.—The Secretary of Health and Human Services shall, during the extension period, extend the therapy supervision nonenforcement instruction.

(b) DEFINITIONS.—In this section:

(1) THERAPY SUPERVISION NONENFORCEMENT INSTRUCTION.—The term ''therapy supervision nonenforcement instruction'' means the enforcement instruction on supervision requirements for outpatient therapeutic services in critical access and small rural hospitals, as extended for calendar year 2013 by the Centers for Medicare & Medicaid Services (released as of November 1, 2012).

(2) CRITICAL ACCESS HOSPITAL; SMALL RURAL HOSPITAL.—The terms ''critical access hospital'' and ''small rural hospital'' have the meanings given such terms for purposes of the therapy supervision nonenforcement instruction.

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

(c) STUDY AND REPORT ON IMPACT OF FAILURE TO EXTEND THERAPY SUPERVISION NONENFORCEMENT INSTRUCTION.—

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

(2) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on the findings of the study conducted under paragraph (1), including recommendations regarding on whether the therapy supervision nonenforcement instruction should be extended or made permanent.

SEC. 208. H.R. 3991 – (SMITH) CRITICAL ACCESS HOSPITAL RELIEF ACT OF 2014.

(a) IN GENERAL.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended—

(1) in paragraph (6), by adding ''and'' at the end;

(2) in paragraph (7), at the end of subparagraph (D)(ii), by striking ''and'' and inserting a period; and

(3) by striking paragraph (8).

(b) APPLICATION.—The amendments made by subsection (a) shall apply with respect to items and services furnished on or after January 1, 2015.

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

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

(1) by treating a provider as meeting all of the requirements described in paragraph (f)(1) of such section if the provider or a wholly owned subsidiary educational institution of such provider singly or collectively meets all of such requirements;

(2) in the case of a provider that would meet the requirements of paragraph (g)(3) of such section, with respect to a nursing or allied health education program, except that the transfer described in such paragraph of such a program to a wholly owned subsidiary educational institution in order to meet accreditation standards occurred after October 1, 2003, by treating such provider as meeting the requirements of such paragraph (and eligible for payments under such paragraph) with respect to such program; and

(3) by defining the term ''wholly owned subsidiary educational institution'', as referenced in such section, as such term is defined under subsection (b).

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

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

(2) WHOLLY OWNED SUBSIDIARY EDUCATIONAL INSTITUTION.—The term ''wholly owned subsidiary educational institution'' means, with respect to a provider, an educational institution that—

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

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

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

SEC. 210. H.R. 1379 – (SCHOCK) PUERTO RICO HOSPITAL HITECH AMENDMENTS ACT OF 2013.

(a) IN GENERAL.—Subsection (n)(6)(B) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by striking ''subsection (d) hospital'' and inserting ''hospital that is a subsection (d) hospital or a subsection (d) Puerto Rico hospital''.

(b) CONFORMING AMENDMENTS.—

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

(A) in subsection (b)(3)(B)(ix)—

(i) in subclause (I), by striking ''(n)(6)(A)'' and inserting ''(n)(6)(B)''; and

(ii) in subclause (II), by striking ''a subsection (d) hospital'' and inserting ''an eligible hospital''; and

(B) in subsection (n)(4)(A)(iii), by striking ''paragraph (6)(B)'' and inserting ''paragraph (6)(A)''.

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

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

(d) EFFECTIVE DATE.—The amendments made by this section shall apply as if included in the enactment of the American Recovery and Reinvestment Act of 2009 (Public Law 111–3), except that, in order to take into account delays in the implementation of this section, in applying subsections (b)(3)(B)(ix), (n)(2)(E)(ii), and (n)(2)(G)(i) of section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by this section, any reference in such subsections to a particular year shall be treated with respect to a subsection (d) Puerto Rico hospital as a reference to the year that is 2 years after such particular year.

SEC. 211. H.R. 4781 – (JENKINS) MEDICARE ACCESS TO RURAL ANESTHESIOLOGY ACT OF 2014.

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

''Anesthesiologist Services Provided in Certain Rural Hospitals

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

''(2) No payment shall be made under any other provision of this title for physicians' services for which payment is made under this subsection.

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

''(A) any reference in such section to a 'certified registered nurse anesthetist' or 'anesthetist' is

deemed a reference to a 'physician who is an anesthesiologist' or 'anesthesiologist', respectively; and

''(B) any reference to 'January 1, 1988' or '1987' is deemed a reference to such date and year as the Secretary shall specify.''.

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

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

(a) IN GENERAL.—Section 1814(a)(3) of the Social Security Act (42 U.S.C. 1395f(a)(3)) is amended by inserting ''(or, in the case of such inpatient hospital services ordered by a nurse practitioner, clinical nurse specialist, physician assistant (as such terms are defined in section 1861(aa)(5)), or a certified nurse-midwife (as such term is defined in section 1861(gg)) who is privileged and credentialed at the hospital at which such services are to be furnished, the nurse practitioner, clinical nurse specialist, physician assistant, or certified nurse-midwife)'' after ''a physician''.

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

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

SEC. 213. H.R. 3796 – (BLACK) COMPREHENSIVE CARE PAYMENT INNOVATION ACT.

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

''NATIONAL VOLUNTARY PAYMENT BUNDLING

''SEC. 1866G. (a) ESTABLISHMENT AND IMPLEMENTATION.—

''(1) IN GENERAL.—The Secretary shall provide for bundled payments under this section for integrated care furnished by a qualified entity during an episode of care to an applicable beneficiary for applicable conditions involving a hospitalization.

''(2) DEADLINE.—The Secretary shall implement this section not later than January 1, 2015.

''(3) APPLICABLE BENEFICIARY DEFINED.—In this section, the term 'applicable beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B, but not enrolled under part C or in a PACE program under section 1894, and who is admitted to a hospital for an applicable condition.

''(b) QUALIFIED ENTITY AND APPLICATION PROCESS.—

''(1) DEFINITIONS.—In this section:

''(A) IN GENERAL.—The term 'qualified entity' means a qualified applicant that has an application approved by the Secretary to receive bundled payments for furnishing applicable services to applicable individuals under this section.

''(B) QUALIFIED APPLICANT.—The term 'qualified applicant' means a corporation, partnership, or limited liability company, that is authorized in writing by a group of providers of services and suppliers, including at least a hospital, that are otherwise participating under this title to act as their agent for the purpose of receiving and distributing bundled payments on their behalf under this section. A qualified applicant may (but is not required to) be a provider of services or supplier that is otherwise participating under this title.

''(2) APPLICATION.—

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

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

''(i) shall contain such information and assurances as the Secretary may specify, including with respect to the requirements under subsection (c)(1); and

''(ii) shall indicate the applicable conditions with respect to which the group seeks to furnish applicable services during the episode of care involved and the bundled payment methodology under subsection (g) or (h) under which the group would be paid for such services.

''(3) CHOICE AMONG APPLICABLE CONDITIONS.—A qualified entity may select one or more applicable conditions for bundled payments under this section. Nothing in this section shall be construed as requiring, or authorizing the Secretary to require, a qualified entity to select any particular applicable condition under this section.

''(4) EXPEDITED APPLICATION PROCESS FOR QUALIFIED APPLICANTS SUCCESSFULLY PARTICIPATING IN THE CMI BUNDLED PAYMENT DEMONSTRATION.—In the case of any qualified applicant

that the Secretary determines has successfully participated in any of the payment and service delivery models tested by the Center for Medicare and Medicaid Innovation under section 1115A through the Bundled Payments for Care Improvement (BPCI) Initiative, the Secretary shall provide for an expedited application process under this subsection.

''(c) REQUIREMENTS FOR QUALIFIED ENTITIES.—

''(1) REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary shall develop requirements for qualified entities to receive bundled payments for furnishing applicable services for applicable conditions during an episode of care under this section.

''(B) AGREEMENT PERIOD.—Under such requirements, a qualified entity shall agree to receive bundled payments for the furnishing of such services for a 5-year period (each such year in such period referred to in this section as an 'agreement year').

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

practicable, of the beneficiary's inpatient admission for the applicable condition and episode of care involved. Such a notice shall include—

"(i) appropriate notice of bundled payments for the applicable condition for the episode of care involved; and

"(ii) a statement informing the beneficiary of the beneficiary's right to select the providers of services and suppliers furnishing items and services related to the episode of care.

"(D) METHODOLOGY AND MEASURES FOR QUALITY AND EFFICIENCY ARRANGEMENTS.—Insofar as a qualified entity uses or seeks to implement a quality and efficiency arrangement under subsection (i), the qualified entity shall specify in the application to the Secretary in detail the methodology for allocating savings under the arrangement and the specific measures to be used to assess the quality of care under the arrangement.

"(2) PROVISION OF DATA BY SECRETARY.—

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

tion under subsection (b)(2) claims data under parts A and B, including complete claims files, for applicable conditions relating to the providers and suppliers in the group that are sufficiently specific to permit such group to determine whether to submit such application. Such claims data shall also be furnished to a qualified entity monthly during the agreement period described in paragraph (1)(B) of any approved application with respect to an applicable condition.

''(B) QUALITY DATA.—The Secretary shall furnish to a qualified entity data on quality measures with respect to any applicable condition under an approved application during the agreement period for the entity for each episode of care and across the continuum of care.

''(d) APPLICABLE CONDITIONS.—

''(1) INITIAL CONDITIONS.—In this section, the term 'applicable condition' means any of the following procedures furnished as part of inpatient hospital services:

''(A) Hip/Knee joint replacement.

''(B) Lumbar spine fusion.

''(C) Coronary artery bypass graft.

''(D) Heart valve replacement.

''(E) Percutaneous coronary intervention with stent.

''(F) Colon resection.

''(2) DISCRETION TO ADD CONDITIONS.—Such term also includes such additional procedures or conditions as the Secretary may select. In selecting such procedures or conditions, the Secretary may take into consideration the factors described in section 1866D(a)(2)(B).

''(e) APPLICABLE SERVICES; EPISODE OF CARE.—In this section:

''(1) APPLICABLE SERVICES.—The term 'applicable services' means the following items and services:

''(A) Acute care inpatient services.

''(B) Physicians' services delivered in and outside of an acute care hospital setting.

''(C) Outpatient hospital services.

''(D) Post-acute care services, including home health services, skilled nursing services, inpatient rehabilitation services, and inpatient hospital services furnished by a long-term care hospital.

''(E) Other services the Secretary determines appropriate.

''(2) EPISODE OF CARE.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'episode of care' means, with respect to an applicable condition and an applicable beneficiary, the period consisting of—

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

''(ii) the duration of the applicable beneficiary's initial inpatient stay in such hospital for the applicable condition; and

''(iii) the 90 days following the discharge of the applicable beneficiary from such hospital.

''(B) ESTABLISHMENT OF PERIOD BY THE SECRETARY.—The Secretary, as appropriate, may establish a period (other than the period described in subparagraph (A)) for an episode of care under this section based on data analyses.

''(3) DISCHARGING HOSPITAL.—The term 'discharging hospital' means, with respect to applicable

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

''(f) BUNDLED PAYMENT DEVELOPMENT.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall develop bundled payments for qualified entities. A bundled payment shall provide for comprehensive payment for the costs of applicable services furnished to an applicable beneficiary during an episode of care for an applicable condition, including readmissions related to the applicable condition but excluding unrelated readmissions, under either a fee-for-service model with shared savings and losses (under subsection (g)) or under a prospective payment model for advanced qualified entities (under subsection (h)). Bundled payments shall be based on the spending targets computed under paragraph (2).

''(2) COMPUTATION OF SPENDING TARGETS.—

''(A) IN GENERAL.—The Secretary shall compute under this paragraph, for each qualified entity for each applicable condition for an episode of care beginning in an agreement year (beginning with 2015) that is attributable to a discharging hospital, a spending target equal to

the updated amount computed under subparagraph (C) for that entity, episode, and year.

''(B) INITIAL WEIGHTED AVERAGE CALCULATION FOR DISCHARGING HOSPITALS.—

''(i) IN GENERAL.—Using fee-for-service claims data from the base period (as defined in subparagraph (D)), subject to clause (ii), the Secretary shall first calculate a base average spending target for each applicable condition for each discharging hospital equal to a weighted average of spending under parts A and B for all applicable services for such applicable condition associated with initial admissions to such hospital computed as the sum of the following (with respect to such hospital):

''(I) 60 percent of the standardized spending per episode in the most recent year in the base period.

''(II) 30 percent of the standardized spending per episode in the previous year.

''(III) 10 percent of the standardized spending per episode in the second previous year.

''(ii) EXCLUSION OF OUTLIERS AND STANDARDIZATION.—In calculating the amount of the base average spending target for an applicable condition under clause (i) for a discharging hospital, the Secretary shall—

''(I) exclude from the calculation payments for episodes of care for the applicable condition that exceed the 95th percentile of all such spending for such episodes of care and applicable condition, as estimated by the Secretary, based on the most recent data available; and

''(II) standardize the spending made in each year in the base period to each provider of service or supplier to remove the spending adjustments in effect in such year relating to provider or supplier location (such as area wage indices) and provider type (such as indirect medical education

adjustments and disproportionate share hospital adjustments).

''(C) TRENDING THE SPENDING TARGETS BASED ON NATIONAL GROWTH RATES TO AGREEMENT YEAR; PERIODIC REBASING FOR NEW AGREEMENT PERIODS.—

''(i) IN GENERAL.—The Secretary shall update the base average spending targets for all discharging hospitals under subparagraph (B) for each applicable condition and agreement year based on trends in the national fee-for-service claims data for applicable services furnished during an episode of care for an applicable condition from the base period to the agreement year involved. Such update shall not vary by discharging hospital.

''(ii) PERIODIC REBASING FOR NEW AGREEMENT PERIODS.—At the start of each new agreement period, the Secretary shall update the base period and calculate new spending targets under the previous provisions of this paragraph for a discharging hospital and applicable conditions, including providing for adjustments

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

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

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

''(1) FEE-FOR-SERVICE-BASED PAYMENT.—If the payment model under this subsection is selected by a qualified entity, the Secretary shall pay providers of services and suppliers of the entity for applicable services for an applicable condition during an episode of care amounts payable under parts A and B for such services in the same manner as such providers and suppliers would otherwise be paid under such parts (referred to in this subsection as 'fee-for-service payments').

''(2) SHARED SAVINGS AND LOSSES.—

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

ardized average fee-for-service spending per episode of care for a discharging hospital for each applicable condition in each agreement year, the Secretary shall exclude outlier episodes of care described in subsection (f)(2)(B)(ii)(I), as estimated by the Secretary, based on data applicable to payments in the agreement year and shall standardize such spending per episode of care in the manner provided in subsection (f)(2)(B)(ii)(II). For the purpose of identifying outlier episodes of care for each applicable condition, the percentile ranking of each episode of care and applicable condition and the 95th percentile shall be based on payments standardized by adjustments for provider location and provider type of the type described in subsection (f)(2)(B)(ii)(II).

''(B) COMPUTATION OF GROSS SHARED SAVINGS AND SHARED LOSSES FOR EACH APPLICABLE CONDITION FOR EACH DISCHARGING HOSPITAL.—For purposes of applying subparagraph (C), if actual standardized average fee-for-service payments to a qualified entity for all episodes of care for an applicable condition in

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

''(i) less than the applicable spending target under subsection (f)(2)(C) for such condition, year, and hospital, there shall be a gross shared savings for such applicable condition, year, and hospital equal to 60 percent of the difference between such actual average payments and the spending target for such condition, year, and hospital; or

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

''(C) RETROSPECTIVE RECONCILIATION.—

''(i) TOTALING GROSS SHARED SAVINGS AND LOSSES FOR ALL CONDITIONS AND ALL DISCHARGING HOSPITALS FOR A QUALIFIED ENTITY.—At the end of each agreement year for each qualified entity, for purposes of applying clauses (ii) and (iii), the Secretary shall aggregate the gross shared savings and the gross shared

losses under subparagraph (B) of such entity for the year for all applicable conditions and for all discharging hospitals.

''(ii) PAYMENT TO ENTITY OF NET SAVINGS.—Subject to clause (iv) and subsection (j)(3) (relating to quality performance thresholds), if such aggregate gross shared savings exceeds such aggregate gross shared losses for a qualified entity for an agreement year, the Secretary shall pay to the qualified entity a lump sum amount equal to such excess for such year.

''(iii) COLLECTION FROM ENTITY OF NET LOSSES.—Subject to clause (iv), if such aggregate gross shared losses exceeds such aggregate gross shared savings for a qualified entity for an agreement year, the qualified entity shall pay to the Secretary (and the Secretary shall collect from the entity) a lump sum amount equal to such excess for such year.

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

aggregate spending target for that qualified entity for all applicable conditions and all discharging hospitals for that year.

''(h) PROSPECTIVE BUNDLED PAYMENT MODEL FOR ADVANCED QUALIFIED ENTITIES.—

''(1) IN GENERAL.—Subject to approval by the Secretary, if the payment model under this subsection is selected, a qualified entity may elect to receive a prospective bundled payment for each episode of care for each applicable condition and discharging hospital in the agreement year equal to the spending target for such episode, year, and hospital under subsection (f)(2) and the provisions of subsection (g) do not apply. Such spending target shall be adjusted, in the same manner described in subsection (g)(2)(B), in order to take into account outlier episodes of care and standardized adjustments for provider location and provider type of the type described in subsection (f)(2)(B)(ii)(II).

''(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting a qualified entity that receives bundled payments under this subsection from participating in an accountable care organization under section 1899.

''(3) RELATIONSHIP TO BPCI.—The Secretary may not terminate the Bundled Payments for Care Improvement initiative conducted pursuant to section 1115A until the prospective bundled payment model is implemented under this subsection.

''(i) QUALITY AND EFFICIENCY ARRANGEMENTS.—

''(1) IN GENERAL.—Subject to subsection (c)(1)(D) (relating to application requirements for notice of quality and efficiency arrangements and their structure) and subsection (j)(3) (relating to minimum quality performance thresholds), qualified entities participating in either the fee-for-service bundled payment model under subsection (g) or the prospective bundled payment model under subsection (h) may enter into quality and efficiency arrangements under which physicians and other health care practitioners work to improve the quality and efficiency of care under this title.

''(2) TYPES OF ARRANGEMENTS.—The arrangements under paragraph (1) shall take into account the utilization of the resources of providers of services and suppliers and may provide for a distribution of a portion of any shared savings (or internal saving, as the case may be) realized under this section to qualifying providers and suppliers.

''(j) QUALITY MEASURES.—

''(1) SELECTION; DEVELOPMENT.—

''(A) SELECTION.—For each applicable condition, the Secretary shall select quality measures related to care provided by providers of services and suppliers through qualified entities to which bundled payments are made under this section. In selecting quality measures, to the extent appropriate and practicable, the Secretary shall choose measures that—

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

''(ii) pertain to the National Quality Strategy's six priorities;

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

''(iv) minimize the incremental data extraction and reporting burden on providers and suppliers.

''(B) DEVELOPMENT OF ELECTRONICALLY SPECIFIED EPISODIC MEASURES.—The Secretary shall develop longitudinal quality and efficiency measures to assess performance of qualified entities with respect to patient outcomes and the care provided for each applicable

condition across the associated episodes of care. Such measures shall be electronically specified for submittal through the use of qualified electronic health records (as defined in section 3000(13) of the Public Health Service Act (42 U.S.C. 300jj(13))).

''(2) REPORTING ON QUALITY MEASURES.—

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

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

''(C) SUBMISSION OF DATA USED IN OTHER PROGRAMS.—Insofar as quality measures established under paragraph (1) are the same as those measures used by the Secretary under other provisions of this title, such as

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

''(3) QUALITY PERFORMANCE THRESHOLDS.—

''(A) ESTABLISHMENT.—For each applicable condition, the Secretary shall establish minimum quality performance thresholds for the measures established under paragraph (1). In the case of a quality and efficiency arrangement, such performance thresholds shall be developed using the quality measures identified by the qualified entity in its application under subsection (c)(1)(D) if approved by the Secretary.

''(B) LOSS OF SHARED SAVINGS PAYMENT AND QUALITY AND EFFICIENCY ARRANGEMENTS FOR FAILURE TO MEET MINIMUM QUALITY PERFORMANCE THRESHOLDS.—If a qualified entity fails to meet the minimum quality performance thresholds established under subparagraph (A) for an agreement year—

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

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

"(C) ADJUSTMENT TO PROCESS MEASURES FOR NEW TECHNOLOGIES AND INNOVATIVE TREATMENTS.—In the case of a qualified entity that furnishes a new technology or innovative item or service (for which payment may be made under this title) to applicable beneficiaries for an applicable condition and episode of care that changes the clinical process of care for such applicable condition and episode of care with respect to such beneficiaries, insofar as such change results in the failure of the qualified entity to meet the minimum quality threshold established under paragraph (1) for one or more applicable clinical process of care measures, the Secretary may provide for such adjustments or exceptions to, or exclusions of, such clinical process of care measure or measures from the overall quality performance thresholds established with respect to such applicable condition and episode of care. Nothing in this subparagraph shall be construed to

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

''(k) WAIVERS.—

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

''(A) With respect to authorizing quality and efficiency arrangements between qualified entities and providers of services and suppliers, section 1877(a) (relating to physician self-referral), paragraphs (1) and (2) of sections 1128A(b) (relating to the gainsharing civil money penalties), and paragraphs (1) and (2) of section 1128B(b) (relating to the anti-kickback statute).

''(B) Section 1128A(a)(5) of the Act (relating to the inducement civil money penalties).

''(C) Section 1861(i) (relating to the 3-day acute hospitalization prerequisite before eligibility for post-hospital extended care services).

''(D) With respect to home health services—

''(i) sections 1814(a)(2)(C) and 1835(a)(2)(A) (relating to the requirement

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

''(ii) limitations on the amount, frequency, and duration on home health services; and

''(iii) prohibitions of free preoperative home safety assessments by home health agencies for patients scheduled to undergo surgery (such as under Advisory Opinion No. 06–01 of the Inspector General of the Department of Health and Human Services).

''(2) AUTHORITY TO MODIFY WAIVERS UNDER CERTAIN CIRCUMSTANCES.—

''(A) IN GENERAL.—In the case of a qualified entity with respect to which one or more waivers under paragraph (1) is in effect, if upon a review of the performance or an audit of the entity the Secretary finds a pattern of deficiencies or harm to applicable beneficiaries, the Secretary may modify or revoke any such waiver at any time as applied to that qualified entity.

"(B) TERMINATION OF CERTAIN WAIVERS IN THE CASE OF EXCESS SHARED LOSSES.—

"(i) IN GENERAL.—Subject to the process described in clause (ii), in the case of a qualified entity that has selected the payment model under subsection (g) and has gross shared losses exceeding the cap under subsection (g)(2)(C)(iv) with respect to an applicable condition, the Secretary shall terminate waivers described in paragraphs (1)(C) and (1)(D) with respect to such qualified entity and applicable condition.

"(ii) PRE-TERMINATION NOTICE.—The Secretary shall establish a process whereby a qualified entity is furnished notice of any deficiency that may give rise to a termination of waivers under clause (i) not later than 6 months before the proposed effective date of the termination.

"(l) INDEPENDENT EVALUATION AND REPORTS ON PROGRAM.—

"(1) INDEPENDENT EVALUATION.—The Secretary shall conduct an independent evaluation of the impact of providing bundled payments to quali-

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

"(A) improved health outcomes;

"(B) improved access to care for applicable beneficiaries;

"(C) reduced spending under this title; and

"(D) improvement in performance on quality measures selected under subsection (j)(1)(A).

"(2) REPORTS.—

"(A) INTERIM REPORT.—Not later than March 1, 2018, the Secretary shall submit to Congress a report on the initial results of the independent evaluation conducted under paragraph (1).

"(B) FINAL REPORT.—Not later than March 1, 2020, the Secretary shall submit to Congress a report on the final results of the independent evaluation conducted under paragraph (1) and may include recommendations for the expansion of bundled payment methodologies and applicable conditions under this section as the Secretary determines to be appropriate.

''(C) REPORT ON POLICIES TO ENSURE ACCESS TO NEW MEDICAL TECHNOLOGIES AND INNOVATIVE TREATMENTS UNDER MEDICARE SHARED SAVINGS PROGRAMS AND BUNDLED PAYMENT PROGRAMS.—

''(i) STUDY.—The Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall conduct a study of payment adjustment policies (described in clause (ii)) under this title for new medical technologies and innovative items and services to develop a set of policies to incorporate such adjustments into the following programs:

''(I) The Medicare Shared Savings Program (under section 1899).

''(II) Medicare bundled payment programs (such as those established under section 1866D and this section).

''(III) Shared savings or bundled payment programs tested by the Center for Medicare and Medicaid Innovation under section 1115A or under

other demonstration authority of the Secretary.

''(ii) PAYMENT ADJUSTMENT PROGRAMS DESCRIBED.—For purposes of clause (i), the payment adjustment policies described in this clause for new medical technologies and innovative items and services include the following:

''(I) The new technology add-on payment policy established under subparagraphs (K) and (L) of section 1886(d)(5) under the prospective payment system for inpatient hospital services.

''(II) The pass-through payment policy established under section 1833(t)(6) under the prospective payment system for covered OPD services.

''(III) The New Technology Ambulatory Payment Classification payment policy established by the Secretary through rulemaking for purposes of the prospective payment system for covered OPD services.

''(iii) REPORT.—Not later than one year after the date of the enactment of this section, the Secretary shall submit to Congress a report on the study conducted under clause (i) which shall include recommendations for such legislation and administrative action as the Secretary determines to be appropriate.''.

SEC. 214. (BLACK) TENNESSEE DSH ALLOTMENT FOR FISCAL YEAR 2015 AND SUCCEEDING FISCAL YEARS.

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

''(vi) ALLOTMENT FOR FISCAL YEAR 2015 AND SUCCEEDING FISCAL YEARS.—Notwithstanding any other provision of this subsection, any other provision of law, or the terms of the TennCare Demonstration Project in effect for the State, the DSH allotment for Tennessee for fiscal year 2015, and for each fiscal year thereafter, shall be $53,100,000 for each such fiscal year.''.

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

Section 1833(t)(2)(G) of the Social Security Act (42 U.S.C. 1395l(t)(2)(G)) is amended by striking ''shall'' and all that follows and inserting the following: ''shall—

''(i) create additional groups of covered OPD services that classify separately those procedures that utilize contrast agents from those that do not;

''(ii) create and implement, for services furnished after the date of the enactment of this clause and in a budget neutral manner, additional groups of covered OPD services that classify separately those procedures that utilize a drug (other than contrast agents and diagnostic radiopharmaceuticals) that both—

''(I) has a cost above the drug packaging threshold; and

''(II) functions as a supply when used in a diagnostic test or procedure; from those that do not; and''.

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

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

(1) in subparagraph (V), by striking at the end ''and'';

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

(3) in the second subparagraph (W)—

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

(B) by striking at the end the period and inserting '', and''; and

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

''(Y) in the case of a hospital, to provide to each individual who is entitled to benefits under part A and who the hospital classifies for more than 24 hours as an outpatient under observation status or any other similar status, as the Secretary determines appropriate (or to a person acting on the individual's behalf), not later than 36 hours after the time of such classification of such individual under such status (or, if sooner, upon discharge), an adequate oral and written notification (as defined by the Secretary pursuant to rulemaking and containing such language as the Secretary prescribes consistent with this paragraph) which—

"(i) explains the status of the individual as an outpatient under such observation status or any other such similar status and not as an inpatient of the hospital;

"(ii) explains the reason for the classification of such individual under such status;

"(iii) explains the implications of such status as an outpatient on—

"(I) eligibility for coverage of items and services under this title, including such items and services furnished by the hospital with respect to such individual while under such status and for items and services under this title for a subsequent discharge to a skilled nursing facility or other facility; and

"(II) cost-sharing requirements under this title, including with respect to items and services furnished by the hospital to such individual while under such status and with respect to items and services under this title for a subsequent discharge to a skilled nursing facility or other facility;

''(iv) includes the name and title of the staff of the hospital who provided the oral notification and the date and time of such oral notification;

''(v) includes such additional information as the Secretary deems appropriate; and

''(vi) in the case of the written notification, is—

''(I) signed by such individual (or person acting on the individual's behalf) to acknowledge receipt of such notification;

''(II) written and formatted using language that is clear and easily understandable to Medicare beneficiaries; and

''(III) made available in different languages, as specified by the Secretary.''.

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

SEC. 217. H.R. 4188 – (RENACCI) ESTABLISHING BENEFICIARY EQUITY IN THE HOSPITAL READMISSION PROGRAM ACT.

(a) TRANSITIONAL ADJUSTMENT FOR DUAL ELIGIBLE POPULATION.—Section 1886(q)(4)(C) of the Social

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

''(iii) TRANSITIONAL ADJUSTMENT FOR DUAL ELIGIBLES.—In applying clause (i) for discharges occurring on or after October 1, 2015, and before the initial application of clause (iv), the Secretary shall provide for such risk adjustment as will take into account a hospital's proportion of inpatients who are full-benefit dual eligible individuals (as defined in section 1935(c)(6)) in order to ensure that hospitals that treat the most vulnerable populations are not unfairly penalized by the program under this subsection.''.

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

''(iv) ADJUSTMENTS BASED ON IMPACT REPORTS.—Effective for discharges occurring in fiscal years beginning on or after the date that is 6 months after the date of completion of the reports under section 2(d)(1)(A)(ii) of the IMPACT Act

of 2014, the Secretary shall provide for such risk adjustment as will take into account, based on such report (and, if applicable, the reports submitted under section 2(d)(1)(B)(ii) of such Act), factors relating to disparities in patient status in order to ensure that hospitals that treat the most vulnerable populations are not unfairly penalized by the program under this subsection.''.

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

(d) ADDRESSING ISSUE OF NONCOMPLIANT PATIENTS.—Section 1886(q)(4)(C) of the Social Security Act (42 U.S.C. 1395ww(q)(4)(C)), as amended by subsections (b) and (c), is further amended by adding at the end the following new clause:

''(v) CONSIDERATION OF EXCLUSION OF NONCOMPLIANT PATIENT CASES BASED

ON V CODES.—In promulgating regulations to carry out this subsection for the applicable period with respect to fiscal year 2017, the Secretary shall consider the use of V codes for potential exclusions of cases in order to address the issue of noncompliant patients.''.

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

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

(a) QUALIFICATIONS FOR NEW PPS-EXEMPT CANCER HOSPITALS.—Section 1886(d)(1) of the Social Security Act (42 U.S.C. 1395ww(d)(1)) is amended—

(1) in subparagraph (B)(v)—

(A) by striking ''or'' at the end of subclause (II);

(B) by striking the semicolon at the end of subclause (III) and inserting '', or''; and

(C) by adding after subclause (III) and before the flush matter following subclause (III) the following new subclause:

''(IV) a hospital (not described in a previous subclause) that meets the requirements of subparagraph (F) for the 12-month cost reporting period involved and has an application approved consistent with subparagraph (G);'';

(2) in subparagraph (E), by inserting ''and subparagraph (F)'' after ''subparagraph (B)(v)''; and

(3) by adding at the end the following new subparagraphs:

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

''(i) For the most recent cost reporting period for which appropriate cost report data are available (as determined by the Secretary), at least 50 percent of the hospital's total discharges have a principal finding of neoplastic disease (as defined in subparagraph (E)).

''(ii) The hospital or its predecessor provider entity has, for at least 12 years, served a comprehensive cancer center designated as such by the National Cancer Institute of the National Institutes

of Health. In the previous sentence and in clause (v), the term 'predecessor provider entity' means, with respect to a hospital, an entity situated on or adjacent to the physical campus of the hospital that previously provided cancer-related services substantially similar to the cancer-related services that are being provided by the hospital.

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

''(iv) The hospital, at the time of its application described in subparagraph (G), is licensed or registered with its appropriate state regulatory agency as having at least 90 inpatient beds.

''(v) The hospital or its predecessor provider entity is accredited by the American College of Surgeons as serving as a comprehensive cancer center designated by the National Cancer Institute of the National Institutes of Health.

''(G)(i) Any hospital seeking to be classified as a hospital under subparagraph (B)(v)(IV) must file an application seeking such classification (in such form and manner as the Secretary may specify) not later than 20 months after the date of the enactment of this subparagraph.

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

it is filed. The Secretary shall approve the application if the application is submitted consistent with clause (i) and establishes (as determined by the Secretary) that the hospital meets the requirements for classification under subparagraph (B)(v)(IV). Approval of such an application shall take effect for cost reporting periods beginning after the date of such approval.

''(iii) The requirement of section 412.22(e)(1)(i) of title 42, Code of Federal Regulations (as in effect as of the date of the enactment of this subparagraph, or any successor to such requirement) shall not apply to the qualification of a hospital for classification under subparagraph (B)(v)(IV) pursuant to an application filed under this subparagraph.''.

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

(1) in subparagraph (E), by inserting ''subject to subparagraph (M),'' after ''clause (v) of subsection (d)(1)(B),''; and

(2) by adding at the end the following new subparagraph:

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

other PPS-exempt cancer hospital, the term 'target amount' means an amount that—

''(i) is based on the median target amount (as defined in subparagraph (E)) calculated as of January 31, 2014, for all hospitals described in subclauses (I), (II), and (III) of subsection (d)(1)(B)(v) (as determined by the Secretary); and

''(ii) does not exceed the lowest target amount (as defined in subparagraph (E)) for any hospital described in subclause (I), (II), or (III) of such subsection that is located in such State.''.

(c) OUTPATIENT PAYMENT TARGET AMOUNT FOR NEWLY QUALIFIED HOSPITALS.—Section 1833(t)(18)(B) of the Social Security Act (42 U.S.C. 1395l(t)(18)(B)) is amended by adding at the end the following new sentence: ''With respect to a hospital described under section 1886(d)(1)(B)(v)(IV), the Secretary shall provide such adjustment, if determined appropriate, only after such hospital submits a cost report or other appropriate information as determined by the Secretary.''

SEC. 219. (CAMP) RETROSPECTIVE PAYMENT ADJUSTMENTS DURING A CONTRACTOR CHANGE.

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

''(h) LIMITATION ON RECOUPMENT IN CASE OF MAC TRANSITION.—

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

''(2) EFFECTIVE DATE.—This subsection shall apply with respect to payments made under subsection (a)(4)(B)—

''(A) that are made on or after the date that is seven years before the date of the enactment of this subsection; and

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

enactment of this subsection, been made by the different medicare administrative contractor described in such paragraph.''.