WAYS AND MEANS

The Helping Hospitals Improve Patient Care Act of 2016 (H.R. 5273)

Section-by-Section
(updated to reflect the Amendment in the Nature of a Substitute)

Section 1. Short Title

Section 101. Development of Medicare Study for HCPCS Version of MS-DRG Codes for Similar Hospital Services
Section 101 requires the Secretary to translate inpatient hospital codes (International Classification of Disease) to outpatient hospital (Healthcare Common Procedure Classification System) codes for 10 surgical procedures. This "crosswalk" is required to be completed no later than January 1, 2018.

Section 102. Establishing Beneficiary Equity in the Medicare Hospital Readmission Program
Section 102 requires the Secretary to implement a transitional risk adjustment methodology to serve as a proxy of socio-economic status for the Hospital Readmissions Reduction Program, including the clarification that the calculation should only apply to a hospital's Medicare population (per the amendment in the nature of a substitute). In addition to the transitional adjustment, the section clarifies that the Secretary is able to permanently use a more refined methodology following the analysis required by the *Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014*. The section also requires a study by the Medicare Payment Advisory Commission (MedPAC), and allows for an analysis of "V-codes" and an exploration of potential exclusions.

Section 103. Five-Year Extension of the Rural Community Hospital Demonstration Program
Section 103 requires the Secretary to extend the current-law Rural Community Hospital Demonstration for an additional 5 years.

Section 104. Regulatory Relief for LTCHs
Section 104 provides regulatory relief for Long-Term Care Hospitals (LTCH) by allowing

LTCHs to qualify for a "mid-build" exception to the current law moratorium on bed expansion. The section is offset by a reduction to LTCH outlier payments, requiring a higher threshold for LTCH discharges to qualify for outlier payments.

Section 105. Savings from IPPS MACRA Pay-For Through Not Applying Documentation and Coding Adjustments

Section 105 reduces the payment update that was included in the bipartisan *Medicare and CHIP Reauthorization Act (MACRA) of 2015.* Specifically, the update of 0.5 percent for fiscal year 2018, is changed to an update of 0.4590.

Section 201. Continuing Medicare Payment Under HOPD Prospective Payment System for Services Furnished by Off-Campus Outpatient Department of Providers Mid-Build

Section 201 provides for an exception to section 603 of the *Bipartisan Budget Act of 2015 (BBA '15)* for those hospital outpatient departments (HOPDs) that were defined as "mid-build" prior to November 2, 2015. "Mid-build" is defined as a provider that had a binding written agreement with an outside, unrelated, party for the actual construction of the HOPD. To qualify as "mid-build," each HOPD will be required to submit a certification from the provider's Chief Executive Officer/Chief Operating Officer that the HOPD meets the definition of mid-build prior to 60 days after the date of enactment (per the amendment in the nature of a substitute). Further, each mid-build HOPD will be required to submit an attestation that it meets the requirements of being provider-based (42 Code of Federal Regulations 413.65) by December 31, 2016 or if later, 60 days after the date of enactment (per the amendment in the nature of a substitute). In addition, the section also requires the Secretary to audit the accuracy of these attestations. HOPDs that meet all of above requirements will receive the full HOPD payment rate beginning January 1, 2018 instead of the lower physician fee schedule or ambulatory surgical center payments required under the *BBA '15*. Finally, those off-campus HOPDs that submitted a voluntary attestation prior to December 2, 2015 will receive the full HOPD payment rate beginning January 1, 2017.

Section 202. Treatment of Cancer Hospitals in Off-Campus Outpatient Department of a Provider Policy

Section 202 provides that Prospective Payment System (PPS)-exempt cancer hospitals are not included in the payment changes made under section 603 of the *BBA '15*. This ensures that these facilities' payments continue under their existing separate system, as opposed to the inpatient and outpatient PPS systems. The section also requires cancer HOPDs to attest (described above) and requires the Secretary to audit the accuracy of the attestation. Section 202 also includes a payment reduction to the target payment-to-cost ratio that is used to calculate the additional payments that PPS-exempt cancer hospitals receive.

Section 203. Treatment of Eligible Professionals in Ambulatory Surgical Centers in Determining Meaningful Use and MIPS

Section 203 excludes physicians who furnish substantially all of their Medicare services

at ambulatory surgical centers (ASC) from the penalties under the Electronic Health Records (EHR) Incentives Program and subsequent program under the Merit-Based Incentive Payment System (MIPS). This exclusion ends three years after the Secretary of the Department of Health and Human Services, in consultation with stakeholders, determines that EHRs are available at the ASC setting.

Section 301. Delay in Authority to Terminate Contracts for Medicare Advantage Plans Failing to Achieve Minimum Quality Ratings

Section 301 delays for three years the authority to terminate Medicare Advantage (MA) contracts based solely on plans failing to achieve minimum quality ratings under the Medicare Advantage STARS rating system. The delay would not prevent CMS from terminating plans for the other ten performance categories considered in the Past Cycle Performance Review at anytime.

Section 302. Requirement for Enrollment Data Reporting for Medicare

Section 302 requires the Secretary to publish Medicare enrollment data by Congressional District, zip code, and state on an annual basis. This data includes MA, Part D, and fee-for-service enrollment data. This legislation also requires the Secretary to release this comprehensive enrollment report for the Medicare program by May 1, but no later than June 1, of each calendar year for the prior year.

Section 303. Updating the Welcome to Medicare Package

Section 303 requires the Secretary to revise the pre-Medicare eligibility enrollment notification to include, in a simplified manner, the available options for receiving benefits under the Medicare program, including through the original Medicare fee-for-service program, MA, and Part D. The section also requires the Secretary to reach out to stakeholders on their recommendations on what such notice would include.