Division C: Increasing Choice, Access, and Quality in Health Care for Americans	
TITLE XV: Provisions Relating to Medicare Part A	
Sec. 15001. Development of Medicare study for HCPCS versions of MS-DRG codes for similar hospital services.	• 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.
Sec.15002. Establishing beneficiary equity in the Medicare hospital readmissions program.	• 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 proxy should only apply to a hospital's Medicare population. • 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.
Sec. 15003. Five-year extension of the rural community hospital demonstration program.	• Requires the Secretary to extend the current-law Rural Community Hospital Demonstration for an additional 5 years.
Sec. 15004. Regulatory relief for LTCHs.	• Provides regulatory relief for Long-Term Care Hospitals (LTCHs) 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 LTCHs outlier payments, requiring a higher threshold for LTCHs discharges to qualify for outlier payments.
Sec. 15005. Savings from IPPS MACRA pay-for through not applying documentation and coding adjustments.	• 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 0.4588.
Sec. 15006. Extension of certain LTCH Medicare payment rules	• Makes a modification to the *Bipartisan Budget Act of 2013 (BBA '13)*. *BBA '13* prohibited the Secretary from enforcing the LTCH 25-percent rule (no more than 25-percent of a LTCH's admissions can come from the same inpatient acute hospital) through June 30, 2016. This section extends the prohibition for an additional 12-months from October 1, 2016 through October 1, 2017.

Sec 15007. Application of rules on the calculation of hospital length of stay to all LTCHs.	• Makes a modification to the *Bipartisan Budget Act of 2013 (BBA '13)*. *BBA '13* carved-out Medicare Advantage (MA) and site neutral discharges from the calculation of the 25-day average length of stay requirement for all LTCHs operating under the Medicare program prior to December 26, 2013. This section affords the same relief to any LTCH that takes advantage of the current law moratorium exception.
Sec. 15008. Change in Medicare classification for certain hospitals.	• Codifies changes, in statute, that the Centers for Medicare and Medicaid Services (CMS) has already made to its regulations for certain applicable LTCHs who were exempted from the inpatient prospective payment system established in the *Tax Equity and Fiscal Responsibility Act of 1982*.
Sec. 15009. Temporary extension to the application of the Medicare LTCH site neutral provisions for certain spinal cord specialty hospitals.	• Provides for a temporary exception of the LTCH site neutral criteria for certain hospitals that treat patients nationwide with brain and spinal cord injuries for fiscal years 2018 and 2019.
Sec. 15010. Temporary extension to the application of the Medicare LTCH site neutral provision for certain discharges with severe wounds.	• Provides for a temporary exception of the LTCH site neutral criteria for payments for hospitalizations for severe wounds for all grandfathered LTCHs for fiscal year 2018.
Subtitle B Provisions to Medicare Part B	
Sec. 16001. Continuing Medicare payment under HOPD prospective payment system for services furnished by mid-build off-campus outpatient departments of providers.	• 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.
Sec. 16002. Treatment of cancer hospitals in off-campus outpatient departments of providers.	• 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.
Sec.16003. Treatment of eligible professionals in ambulatory surgical centers for meaningful use and MIPS.	• 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.
Sec. 16004. Continuing Access to Hospitals Act of 2016.	• Prohibits the Secretary from enforcing the "direct supervision" regulations under 42 Code of Federal Regulations (CFR) 410.27 for calendar year 2016. 42 CFR 410.27 requires that services and supplies, furnished in Critical Access Hospitals (CAHs), that assist clinicians in the treatment of patients must be provided with "direct supervision." Direct supervision, as defined by 42 CFR 410.32, means that a physician or non-physician practitioner must be immediately available to furnish assistance and direction throughout the performance of a procedure.
Sec. 16005. Delay of implementation of Medicare fee schedule adjustments for wheelchair accessories and seating systems when used in conjunction	• Delays the application of competitive bid pricing used with CRT accessories used with Group 3 power wheelchairs for six months to be compliant with Congressional understanding of the *Medicare Improvements for Patients and Providers Act (MIPPA) of 2008* provision prohibiting such application of competitive bidding through a simple date change.

with complex rehabilitation technology (CRT) wheelchairs.	
Sec. 16006. Allowing physical therapists to utilize locum tenens arrangements under Medicare.	• Allows physical therapists furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area to use specified locum tenens arrangements for payment purposes in the same manner as such arrangements are used to apply to physicians furnishing substitute physicians services for other physicians.
Sec. 16007. Extension of the transition to new payment rates for durable medical equipment (DME) under the Medicare program.	• Delays the application of competitively bid prices for durable medical equipment (DME) suppliers in non-competitively bid areas (CBAs) retroactively from July 1, 2016 through December 31, 2016.
Sec. 16008. Requirements in determining adjustments using information from competitive bidding programs.	• Requires that the Secretary take into account, when determining adjustments in the use of competitively bid prices in DME the average travel time and cost associated with furnishing items as well as the resulting number of suppliers in the area.
Subtitle C Other Medicare Provisions	
Sec. 17001. Delay in authority to terminate contracts for Medicare Advantage plans failing to achieve minimum quality.	• Delays for three years, the authority to terminate MA contracts based solely on plans failing to achieve minimum quality ratings under the MA 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.
Sec. 17002. Requirement for enrollment data reporting for Medicare.	• 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 section 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.
Sec. 17003. Updating the Welcome to Medicare package.	• 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.
Sec. 17004. No payment for items and services furnished by newly enrolled providers or suppliers within a temporary moratorium area.	• Provides the Secretary with the authority to deny reimbursement for services by providers/suppliers within an area the Secretary has designated as a moratoria area. The authority would apply across the Medicare, Medicaid, and CHIP programs.
Sec. 17005. Preservation of Medicare beneficiary choice under Medicare Advantage.	• Allows, starting in 2019, an MA eligible individual, during the first three months of any year, to change a previous election to receive benefits through the original Medicare fee-for-service program or an MA plan, and to elect coverage under part D. • This continuous open enrollment and disenrollment period during the first three months of any year starting in 2019 shall apply with respect to a prescription drug plan only in the case of an individual who, previous to such change in enrollment, is enrolled in an MA plan. • Prohibits unsolicited marketing or marketing materials from being sent to such an eligible individual during the continuous open enrollment and disenrollment period.
Sec. 17006. Allowing end-stage renal disease beneficiaries to choose a Medicare Advantage plan.	• Allows individuals suffering from end-stage renal disease to enroll in any MA plan for plan years beginning in 2021. • Removes the standard acquisition costs (SACs) for kidneys from the benchmark and bid. SACs would be compensated for by traditional Medicare. Requires CMS to provide a report to Congress by 2023 regarding the impact of the provisions of this section related to spending, enrollment and sufficiency of data under the traditional Medicare and Medicare Advantage programs for ESRD beneficiaries. • Adjusts the CMS-HCC Risk Adjustment Model to improve accuracy by directing the Secretary to take into account the total number of diseases, multiple years of data, and Medicare-Medicaid dual eligibility status. • Directs the Secretary to evaluate the impact of including additional diagnosis codes related to mental health and substance use disorders, chronic kidney disease, and other factors in the ESRD-Risk Adjustment Model. • Requires MedPAC to conduct an evaluation on the impact of these changes to the overall accuracy of the risk scores under the MA program, and the Secretary to submit a report to Congress every three years beginning by December 31, 2018 on revisions to the risk adjustment and ESRD risk adjustment models.

Sec. 17007. Improvements to the assignment of beneficiaries under the Medicare Shared Savings Program.	• Establishes additional requirements for assigning Medicare fee-for-service beneficiaries to accountable care organizations (ACOs) under the Medicare shared savings program. (The program enables ACOs to receive payments for savings stemming from care coordination and management.) • Specifically, the bill requires the basis for assignment to reflect beneficiaries' utilization of not only primary care services provided by ACO physicians, but also those furnished in federally qualified health centers or rural health clinics.
Subtitle D Other Provisions	
Sec. 18001. Exception from group health plan requirements for qualified small employer health reimbursement arrangements.	• Exempts small employers who operate qualified Health Reimbursement Accounts (HRAs) from the penalties imposed by Obamacare through rules relating to "group health plans." • To qualify, an HRA would need to supplement existing health coverage of an employee, and reimbursement payments to any given employee would be capped at $4,950 ($10,000, if an HRA also provides for reimbursements for an employee's family members), indexed for inflation.