I

117TH CONGRESS
2D SESSION

H. R. 6400

To amend titles XVIII and XIX of the Social Security Act to provide for enhanced payments to rural health care providers under the Medicare and Medicaid programs, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 13, 2022

Mr. GRAVES of Missouri (for himself and Mr. HUFFMAN) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and the Budget, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To amend titles XVIII and XIX of the Social Security Act to provide for enhanced payments to rural health care providers under the Medicare and Medicaid programs, 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 ''Save America's Rural Hospitals Act''.

(b) FINDINGS.—Congress finds the following:

(1) More than 60,000,000 individuals in rural areas of the United States rely on rural hospitals and other providers as critical access points to health care.

(2) Access to health care is essential to communities that Americans living in rural areas call home.

(3) Americans living in rural areas are older, poorer, and sicker than Americans living in urban areas.

(4) Between January 2010 and January 1, 2021, 137 rural hospitals closed in the United States, according to the University of North Carolina's Cecil G. Sheps Center for Health Services Research, and the rate of these closures is increasing.

(5) Four hundred and fifty-three hospitals are operating at margins similar to those that have closed over the past decade. Of those, 216 are considered most vulnerable to closure.

(6) Rural Medicare beneficiaries already face a number of challenges when trying to access health care services close to home, including the weather, geography, and cultural, social, and language barriers.

(7) Approximately sixty percent of all primary care health professional shortage areas are located in rural areas.

(8) Seniors living in rural areas are forced to travel significant distances for care.

(9) On average, trauma victims in rural areas must travel twice as far as victims in urban areas to the closest hospital, and, as a result, 60 percent of trauma deaths occur in rural areas, even though only 20 percent of Americans live in rural areas.

(10) With the 453 hospitals on the brink of closure, millions of Americans living in rural areas are on the brink of losing access to the closest emergency room.

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

TITLE I—RURAL PROVIDER PAYMENT STABILIZATION

Subtitle A—Rural Hospitals

SEC. 101. ELIMINATING MEDICARE SEQUESTRATION FOR RURAL HOSPITALS.

(a) IN GENERAL.—Section 256(d)(7) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 906(d)(7)) is amended by adding at the end the following:

"(D) RURAL HOSPITALS.—Payments under part A or part B of title XVIII of the Social Security Act with respect to items and services furnished by a critical access hospital (as defined in section 1861(mm)(1) of such Act), a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act), a Medicare-dependent, small rural hospital (as defined in sec-

tion 1886(d)(5)(G)(iv) of such Act), or a subsection (d) hospital located in a rural area (as defined in section 1886(d)(2)(D) of such Act).''.

(b) APPLICABILITY.—The amendment made by this section applies with respect to orders of sequestration effective on or after the date that is 60 days after the date of the enactment of this Act.

SEC. 102. REVERSING CUTS TO REIMBURSEMENT OF BAD DEBT FOR CRITICAL ACCESS HOSPITALS (CAHS) AND RURAL HOSPITALS.

(a) RURAL HOSPITALS.—Section 1861(v)(1)(T)(v) of the Social Security Act (42 U.S.C. 1395x(v)(1)(T)(v)) is amended by inserting before the period the following: ''or, in the case of a hospital located in a rural area, by 15 percent of such amount otherwise allowable''.

(b) CAHS.—Section 1861(v)(1)(W)(ii) of the Social Security Act (42 U.S.C. 1395x(v)(1)(W)(ii)) is amended by inserting after ''or (V)'' the following: '', a critical access hospital''.

(c) APPLICABILITY.—The amendments made by this section apply with respect to cost reporting periods beginning more than 60 days after the date of the enactment of this Act.

SEC. 103. EXTENDING PAYMENT LEVELS FOR LOW-VOLUME HOSPITALS AND MEDICARE-DEPENDENT HOSPITALS (MDHS).

(a) EXTENSION OF INCREASED PAYMENTS FOR MDHS.—

(1) EXTENSION OF PAYMENT METHODOLOGY.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(A) in clause (i), by striking ", and before October 1, 2022"; and

(B) in clause (ii)(II), by striking ", and before October 1, 2022".

(2) CONFORMING AMENDMENTS.—

(A) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(i) in the matter preceding clause (i), by striking ", and before October 1, 2022"; and

(ii) in clause (iv), by striking "through fiscal year 2022" and inserting "or a subsequent fiscal year".

(B) EXTENDING THE PERIOD DURING WHICH HOSPITALS CAN DECLINE RECLASSIFICATION AS URBAN.—Section 13501(e)(2) of

the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking ''fiscal year 2000 through fiscal year 2022'' and inserting ''a subsequent fiscal year''.

(b) EXTENSION OF INCREASED PAYMENTS FOR LOW-VOLUME HOSPITALS.—Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

(1) in subparagraph (B)—

(A) in the header, by inserting ''for fiscal years 2005 through 2010'' after ''increase''; and

(B) in the matter preceding clause (i), by striking ''and for discharges occurring in fiscal year 2023 and subsequent fiscal years'';

(2) in subparagraph (C)(i)—

(A) in the matter preceding subclause (I), by striking ''through 2022'' and inserting ''and each subsequent fiscal year'';

(B) in subclause (II), by adding at the end ''and'';

(C) in subclause (III)—

(i) by striking ''fiscal years 2019 through 2022'' and inserting ''fiscal year 2019 and each subsequent fiscal year''; and

(ii) by striking ''; and'' and inserting a period; and

(D) by striking subclause (IV); and

(3) in subparagraph (D)—

(A) by amending the heading to read as follows: ''APPLICABLE PERCENTAGE INCREASE AFTER FISCAL YEAR 2010'';

(B) in the matter preceding clause (i), by striking ''in fiscal years 2011 through 2022'' and inserting ''in fiscal year 2011 or a subsequent fiscal year''; and

(C) in clause (ii), by striking ''each of fiscal years 2019 through 2022'' and inserting ''fiscal year 2019 and each subsequent fiscal year''.

SEC. 104. REINSTATING REVISED DIAGNOSIS-RELATED GROUP PAYMENTS FOR MDHS AND SOLE COMMUNITY HOSPITALS (SCHS).

(a) PAYMENTS FOR MDHS AND SCHS FOR VALUE-BASED INCENTIVE PROGRAMS.—Section 1886(o)(7)(D)(ii)(I) of the Social Security Act (42 U.S.C. 1395ww(o)(7)(D)(ii)(I)) is amended by inserting ''and after fiscal year 2021'' after ''2013''.

(b) PAYMENTS FOR MDHS AND SCHS UNDER HOSPITAL READMISSIONS REDUCTION PROGRAM.—Section

1886(q)(2)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(q)(2)(B)(i)) is amended by inserting ''and after fiscal year 2021'' after ''2013''.

SEC. 105. REINSTATING HOLD HARMLESS TREATMENT FOR HOSPITAL OUTPATIENT SERVICES FOR SCHS.

Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(1) in the heading, by striking ''**TEMPORARY**'' and inserting ''**PERMANENT**'';

(2) in subclause (II)—

(A) in the first sentence, by inserting ''and on or after January 1, 2022,'' after ''January 1, 2013,''; and

(B) in the second sentence, by inserting '', and during or after 2022'' after ''or 2012''; and

(3) in subclause (III), in the first sentence, by inserting ''and on or after January 1, 2022,'' after ''January 1, 2013,''.

Subtitle B—Other Rural Providers

SEC. 111. MAKING PERMANENT INCREASED MEDICARE PAYMENTS FOR GROUND AMBULANCE SERVICES IN RURAL AREAS.

Section 1834(l)(13) of the Social Security Act (42 U.S.C. 1395m(l)(13)) is amended—

(1) in the paragraph heading, by striking ''**TEMPORARY INCREASE**'' and inserting ''**INCREASE**''; and

(2) in subparagraph (A)—

(A) in the matter preceding clause (i), by striking '', and before January 1, 2023''; and

(B) in clause (i), by striking '', and before January 1, 2023''.

SEC. 112. EXTENDING MEDICAID PRIMARY CARE PAYMENTS.

(a) IN GENERAL.—Section 1902(a)(13)(C) of the Social Security Act (42 U.S.C. 1396a(a)(13)(C)) is amended by inserting after ''2014'' the following: ''(or, in the case of primary care services furnished by a physician located in a rural area, as defined in section 1886(d)(2)(D), furnished in any year)''.

(b) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by this section applies to services furnished in a year beginning on or after the date of the enactment of this Act.

(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services

determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendment made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 113. MAKING PERMANENT MEDICARE TELEHEALTH SERVICE ENHANCEMENTS FOR FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

Paragraph (8) of section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended—

(1) in the paragraph heading, be striking ''DURING EMERGENCY PERIOD'';

(2) in the matter preceding subparagraph (A), by striking ''During the emergency period described

in section 1135(g)(1)(B)'' and inserting ''Beginning on the first day of the emergency period described in section 1135(g)(1)(B)'';

(3) in subparagraph (A)(ii), by striking ''determined under subparagraph (B)'' and inserting ''determined, for services furnished during the emergency period described in section 1135(g)(1)(B), under subparagraph (B) and, for services furnished after such period, as an amount equal to the amount that such center or clinic would have been paid under this title had such service been furnished without the use of a telecommunications system''; and

(4) in subparagraph (B)—

(A) by striking ''PAYMENT RULE'' and all that follows through ''The Secretary shall'' and inserting ''PAYMENT RULE.—The Secretary shall''; and

(B) by redesignating clause (ii) as subparagraph (C) and moving such subparagraph as so redesignated 2 ems to the left.

SEC. 114. CREATION OF REPORTING REQUIREMENTS FOR PROVIDER-BASED RURAL HEALTH CLINICS.

(a) IN GENERAL.—Not later than two years after the date of the enactment of this Act, the Secretary of Health

and Human Services (in this section referred to as the ''Secretary'') shall, taking into account the recommendations made pursuant to subsection (b), implement a voluntary Medicare provider-based rural health clinic quality reporting program, in accordance with this section, under which—

(1) provider-based rural health clinics established on or after January 1, 2021, may voluntarily comply with reporting requirements described in subsection (b)(2); and

(2) payments under title XVIII to such clinics complying with such requirements are provided in accordance with subsection (d).

(b) CONSULTATION.—Not later than one year after the date of the enactment of this Act, the Secretary, acting through the Administrator for Centers for Medicare & Medicaid Services, the Federal Office of Rural Health Policy, and the Agency for Healthcare Research and Quality, shall consult with relevant stakeholders—

(1) to review rural health clinic data collection processes and quality measurers identified for rural health clinics by the National Quality Forum and other national quality-monitoring systems; and

(2) to make recommendations to the Secretary for voluntary reporting requirements for the Sec-

retary to implement under the eligible professional Merit-based Incentive Payment System under section 1848(q) of the Social Security Act (42 U.S.C. 1395w–4) for provider-based rural health clinics established on or after January 1, 2021.

(c) COLLABORATION.—In implementing the voluntary Medicare provider-based rural health clinic quality reporting program, the Secretary shall consult with a diverse group of rural health clinic stakeholders, which shall include—

(1) the National Quality Forum, or such other standard-setting organizations specified by the Secretary;

(2) relevant State and local public agencies, including State offices of rural health;

(3) established provider-based rural health clinics, including those in the application process;

(4) small rural hospitals with 50 beds or less;

(5) organizations representing provider-based rural health clinics; and

(6) organizations representing rural health care.

(d) CONDITIONS.—Under the voluntary Medicare provider-based rural health clinic quality reporting program the Secretary shall provide that in the case of a provider-based rural health clinic described in subsection

(a)(1) that voluntarily complies with the reporting requirements described in subsection (b)(2), with respect to a year—

(1) reimbursement rates under title XVIII of the Social Security Act for rural health services furnished by such clinic during such year shall be consistent with reimbursement rates under such title for such services furnished by a provider-based rural health clinic established before December 31, 2020; and

(2) the provisions of section 1833(f)(3) of such Act (42 U.S.C. 1395l(f)(3)) shall not apply with respect to such clinic and such year.

(e) GRANTS FOR TECHNICAL ASSISTANCE.—

(1) IN GENERAL.—Section 1820(g)(3) of the Social Security Act (42 U.S.C. 1395i–4(g)(3)) is amended—

(A) in subparagraph (A)—

(i) by striking ''Balanced Budget Act of 1997 and'' and inserting ''Balanced Budget Act of 1997,''; and

(ii) by inserting before the period at the end the following: '', and to provide to such small rural hospitals that participate in the voluntary Medicare provider-based

rural health clinic quality reporting program established pursuant to section 114 of the Save America's Rural Hospitals Act technical assistance necessary to so participate in such program''; and

(B) in subparagraph (E)—

(i) by striking ''and to participate in delivery system reforms'' and inserting '', to participate in delivery system reforms''; and

(ii) by inserting before the period at the end the following: '', and in the case of small rural hospitals that participate in the voluntary Medicare provider-based rural health clinic quality reporting program established pursuant to section 114 of the Save America's Rural Hospitals Act, for technical assistance necessary to so participate in such program''.

(2) FUNDING.—In addition to amounts otherwise made available for grants under section 1820(g)(3) of the Social Security Act, there is appropriated to the Secretary of Health and Human Services, out of any monies in the Treasury not otherwise appropriated, $15,000,000 for the period of

fiscal years 2022 through 2026 to provide grants under such section to small rural hospitals that participate in the voluntary Medicare provider-based rural health clinic quality reporting program established pursuant to this section for technical assistance necessary to so participate in such program.

TITLE II—RURAL MEDICARE BENEFICIARY EQUITY

SEC. 201. EQUALIZING BENEFICIARY COPAYMENTS FOR SERVICES FURNISHED BY CAHS.

(a) IN GENERAL.—Section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by adding at the end the following: ''In the case of outpatient critical access hospital services for which payment is made under section 1834(g), clause (ii) of the first sentence shall be applied by substituting '20 percent of the lesser of the actual charge or the payment basis under this part for such services if the critical access hospital were treated as a hospital' for '20 per centum of the reasonable charges for such items and services'.''.

(b) APPLICABILITY.—The amendment made by this section applies with respect to services furnished during a year that begins more than 60 days after the date of the enactment of this Act.

TITLE III—REGULATORY RELIEF

SEC. 301. ELIMINATING 96-HOUR PHYSICIAN CERTIFICATION REQUIREMENT WITH RESPECT TO INPATIENT CAH SERVICES.

(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)(E), by striking ''; and'' and inserting a period; and

(3) by striking paragraph (8).

(b) APPLICABILITY.—The amendments made by this section apply with respect to services furnished during a year that begins more than 60 days after the date of the enactment of this Act.

SEC. 302. REBASING SUPERVISION REQUIREMENTS.

(a) THERAPEUTIC HOSPITAL OUTPATIENT SERVICES.—

(1) SUPERVISION REQUIREMENTS.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

''(ee) PHYSICIAN SUPERVISION REQUIREMENTS FOR THERAPEUTIC HOSPITAL OUTPATIENT SERVICES.—

''(1) GENERAL SUPERVISION FOR THERAPEUTIC SERVICES.—Except as may be provided under paragraph (2), insofar as the Secretary requires the supervision by a physician or a non-physician practitioner for payment for therapeutic hospital outpatient services (as defined in paragraph (5)(A)) furnished under this part, such requirement shall be met if such services are furnished under the general supervision (as defined in paragraph (5)(B)) of the physician or non-physician practitioner, as the case may be.

''(2) EXCEPTIONS PROCESS FOR HIGH-RISK OR COMPLEX MEDICAL SERVICES REQUIRING A DIRECT LEVEL OF SUPERVISION.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, the Secretary shall establish a process for the designation of therapeutic hospital outpatient services furnished under this part that, by reason of complexity or high risk, require—

''(i) direct supervision (as defined in paragraph (5)(C)) for the entire service; or

''(ii) direct supervision during the initiation of the service followed by general

supervision for the remainder of the service.

"(B) CONSULTATION WITH CLINICAL EXPERTS.—

"(i) IN GENERAL.—Under the process established under subparagraph (A), before the designation of any therapeutic hospital outpatient service for which direct supervision may be required under this part, the Secretary shall consult with a panel of outside experts described in clause (ii) to advise the Secretary with respect to each such designation.

"(ii) ADVISORY PANEL ON SUPERVISION OF THERAPEUTIC HOSPITAL OUTPATIENT SERVICES.—For purposes of clause (i), a panel of outside experts described in this clause is a panel appointed by the Secretary, based on nominations submitted by hospital, rural health, and medical organizations representing physicians, non-physician practitioners, and hospital administrators, as the case may be, that meets the following requirements:

"(I) COMPOSITION.—The panel shall be composed of at least 15 physicians and non-physician practitioners who furnish therapeutic hospital outpatient services for which payment is made under this part and who collectively represent the medical specialties that furnish such services, and of 4 hospital administrators of hospitals located in rural areas (as defined in section 1886(d)(2)(D)) or critical access hospitals.

"(II) PRACTICAL EXPERIENCE REQUIRED FOR PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS.—During the 12-month period preceding appointment to the panel by the Secretary, each physician or non-physician practitioner described in subclause (I) shall have furnished therapeutic hospital outpatient services for which payment was made under this part.

"(III) MINIMUM RURAL REPRESENTATION REQUIREMENT FOR

PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS.—Not less than 50 percent of the membership of the panel that is comprised of physicians and non-physician practitioners shall be physicians or non-physician practitioners described in subclause (I) who practice in rural areas (as defined in section 1886(d)(2)(D)) or who furnish such services in critical access hospitals.

''(iii) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. 2 App.), other than section 14 of such Act, shall apply to the panel of outside experts appointed by the Secretary under clause (ii).

''(C) SPECIAL RULE FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—Insofar as a therapeutic outpatient hospital service that is an outpatient critical access hospital service is designated as requiring direct supervision under the process established under subparagraph (A), the Secretary shall deem the critical access hospital furnishing that service

as having met the requirement for direct supervision for that service if, when furnishing such service, the critical access hospital meets the standard for personnel required as a condition of participation under section 485.618(d) of title 42, Code of Federal Regulations (as in effect on the date of the enactment of this subsection).

''(D) CONSIDERATION OF COMPLIANCE BURDENS.—Under the process established under subparagraph (A), the Secretary shall take into account the impact on hospitals and critical access hospitals in complying with requirements for direct supervision in the furnishing of therapeutic hospital outpatient services, including hospital resources, availability of hospital-privileged physicians, specialty physicians, and non-physician practitioners, and administrative burdens.

''(E) REQUIREMENT FOR NOTICE AND COMMENT RULEMAKING.—Under the process established under subparagraph (A), the Secretary shall only designate therapeutic hospital outpatient services requiring direct supervision under this part through proposed and final

rulemaking that provides for public notice and opportunity for comment.

''(F) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as authorizing the Secretary to apply or require any level of supervision other than general or direct supervision with respect to the furnishing of therapeutic hospital outpatient services.

''(3) INITIAL LIST OF DESIGNATED SERVICES.—The Secretary shall include in the proposed and final regulation for payment for hospital outpatient services for 2022 under this part a list of initial therapeutic hospital outpatient services, if any, designated under the process established under paragraph (2)(A) as requiring direct supervision under this part.

''(4) DIRECT SUPERVISION BY NON-PHYSICIAN PRACTITIONERS FOR CERTAIN HOSPITAL OUTPATIENT SERVICES PERMITTED.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, a non-physician practitioner may directly supervise the furnishing of—

''(i) therapeutic hospital outpatient services under this part, including cardiac

rehabilitation services (under section 1861(eee)(1)), intensive cardiac rehabilitation services (under section 1861(eee)(4)), and pulmonary rehabilitation services (under section 1861(fff)(1)); and

''(ii) those hospital outpatient diagnostic services (described in section 1861(s)(2)(C)) that require direct supervision under the fee schedule established under section 1848.

''(B) REQUIREMENTS.—Subparagraph (A) shall apply insofar as the non-physician practitioner involved meets the following requirements:

''(i) SCOPE OF PRACTICE.—The non-physician practitioner is acting within the scope of practice under State law applicable to the practitioner.

''(ii) ADDITIONAL REQUIREMENTS.—The non-physician practitioner meets such requirements as the Secretary may specify.

''(5) DEFINITIONS.—In this subsection:

''(A) THERAPEUTIC HOSPITAL OUTPATIENT SERVICES.—The term 'therapeutic hospital outpatient services' means hospital

services described in section 1861(s)(2)(B) furnished by a hospital or critical access hospital and includes—

"(i) cardiac rehabilitation services and intensive cardiac rehabilitation services (as defined in paragraphs (1) and (4), respectively, of section 1861(eee)); and

"(ii) pulmonary rehabilitation services (as defined in section 1861(fff)(1)).

"(B) GENERAL SUPERVISION.—

"(i) OVERALL DIRECTION AND CONTROL OF PHYSICIAN.—Subject to clause (ii), with respect to the furnishing of therapeutic hospital outpatient services for which payment may be made under this part, the term 'general supervision' means such services that are furnished under the overall direction and control of a physician or non-physician practitioner, as the case may be.

"(ii) PRESENCE NOT REQUIRED.—For purposes of clause (i), the presence of a physician or non-physician practitioner is not required during the performance of the procedure involved.

"(C) DIRECT SUPERVISION.—

"(i) PROVISION OF ASSISTANCE AND DIRECTION.—Subject to clause (ii), with respect to the furnishing of therapeutic hospital outpatient services for which payment may be made under this part, the term 'direct supervision' means that a physician or non-physician practitioner, as the case may be, is immediately available (including by telephone or other means) to furnish assistance and direction throughout the furnishing of such services. Such term includes, with respect to the furnishing of a therapeutic hospital outpatient service for which payment may be made under this part, direct supervision during the initiation of the service followed by general supervision for the remainder of the service (as described in paragraph (2)(A)(ii)).

"(ii) PRESENCE IN ROOM NOT REQUIRED.—For purposes of clause (i), a physician or non-physician practitioner, as the case may be, is not required to be present in the room during the perform-

ance of the procedure involved or within any other physical boundary as long as the physician or non-physician practitioner, as the case may be, is immediately available.

''(D) NON-PHYSICIAN PRACTITIONER DEFINED.—The term 'non-physician practitioner' means an individual who—

''(i) is a physician assistant, a nurse practitioner, a clinical nurse specialist, a clinical social worker, a clinical psychologist, a certified nurse midwife, or a certified registered nurse anesthetist, and includes such other practitioners as the Secretary may specify; and

''(ii) with respect to the furnishing of therapeutic outpatient hospital services, meets the requirements of paragraph (4)(B).''.

(2) CONFORMING AMENDMENT.—Section 1861(eee)(2)(B) of the Social Security Act (42 U.S.C. 1395x(eee)(2)(B)) is amended by inserting '', and a non-physician practitioner (as defined in section 1833(cc)(5)(D)) may supervise the furnishing of such items and services in the hospital'' after ''in the case of items and services furnished under such

a program in a hospital, such availability shall be presumed''.

(b) PROHIBITION ON RETROACTIVE ENFORCEMENT OF REVISED INTERPRETATION.—

(1) REPEAL OF REGULATORY CLARIFICATION.—The restatement and clarification under the final rulemaking changes to the Medicare hospital outpatient prospective payment system and calendar year 2009 payment rates (published in the Federal Register on November 18, 2008, 73 Fed. Reg. 68702 through 68704) with respect to requirements for direct supervision by physicians for therapeutic hospital outpatient services (as defined in paragraph (3)) for purposes of payment for such services under the Medicare program shall have no force or effect in law.

(2) HOLD HARMLESS.—A hospital or critical access hospital that furnishes therapeutic hospital outpatient services during the period beginning on January 1, 2001, and ending on the later of December 31, 2021, or the date on which the final regulation promulgated by the Secretary of Health and Human Services to carry out this section takes effect, for which a claim for payment is made under part B of title XVIII of the Social Security Act shall

not be subject to any civil or criminal action or penalty under Federal law for failure to meet supervision requirements under the regulation described in paragraph (1), under program manuals, or otherwise.

(3) THERAPEUTIC HOSPITAL OUTPATIENT SERVICES DEFINED.—In this subsection, the term ''therapeutic hospital outpatient services'' means medical and other health services furnished by a hospital or critical access hospital that are—

(A) hospital services described in subsection (s)(2)(B) of section 1861 of the Social Security Act (42 U.S.C. 1395x);

(B) cardiac rehabilitation services or intensive cardiac rehabilitation services (as defined in paragraphs (1) and (4), respectively, of subsection (eee) of such section); or

(C) pulmonary rehabilitation services (as defined in subsection (fff)(1) of such section).

SEC. 303. REFORMING PRACTICES OF RECOVERY AUDIT CONTRACTORS UNDER MEDICARE.

(a) ELIMINATION OF CONTINGENCY FEE PAYMENT SYSTEM.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) is amended—

(1) in paragraph (1), by inserting ", for recovery activities conducted during a fiscal year before fiscal year 2022" after "Under the contracts"; and

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

"(11) PAYMENT FOR RECOVERY ACTIVITIES PERFORMED AFTER FISCAL YEAR 2021.—

"(A) IN GENERAL.—Under the contracts, subject to paragraphs (B) and (C), payment shall be made to recovery audit contractors for recovery activities conducted during fiscal year 2022 and each fiscal year thereafter in the same manner, and from the same amounts, as payment is made to eligible entities under contracts entered into for recovery activities conducted during fiscal year 2021 under subsection (a).

"(B) PROHIBITION ON INCENTIVE PAYMENTS.—Under the contracts, payment made to a recovery audit contractor for recovery activities conducted during fiscal year 2022 or any fiscal year thereafter may not include any incentive payments.

"(C) PERFORMANCE ACCOUNTABILITY.—

''(i) IN GENERAL.—Under the contracts, payment made to a recovery audit contractor for recovery activities conducted during fiscal year 2022 or any fiscal year thereafter shall, in the case that the contractor has a complex audit denial overturn rate at the end of such fiscal year (as calculated under the methodology described in clause (iv)) that is 0.1 or greater, be reduced in an amount determined in accordance with clause (ii).

''(ii) PAYMENT REDUCTIONS.—

''(I) SLIDING SCALE OF AMOUNT OF REDUCTIONS.—The Secretary shall establish, for purposes of determining the amount of a reduction in payment to a recovery audit contractor under clause (i) for recovery activities conducted during fiscal year, a linear sliding scale of payment reductions for recovery audit contractors for such fiscal year. Under such linear sliding scale, the amount of such a reduction in payment to a recovery audit contractor for a fiscal

year shall be calculated in a manner that provides for such reduction to be greater than the reduction for such fiscal year for recovery audit contractors that have complex audit denial overturn rates at the end of such fiscal year (as calculated under the methodology described in clause (iv)) that are lower than the complex audit denial overturn rate of the contractor at the end of such fiscal year (as so calculated).

''(II) MANNER OF COLLECTING REDUCTION.—The Secretary may assess and collect the reductions in payment to recovery audit contractors under clause (i) in such manner as the Secretary may specify (such as by reducing the amount paid to the contractor for recovery activities conducted during a fiscal year or by assessing the reduction as a separate penalty payment to be paid to the Secretary by the contractor with respect to each complex audit denial

issued by the contractor that is overturned on appeal).

''(iii) TIMING OF DETERMINATIONS OF PAYMENT REDUCTIONS.—The Secretary shall, with respect to a recovery audit contractor, determine not later than six months after the end of a fiscal year—

''(I) whether to reduce payment to the recovery audit contractor under clause (i) for recovery activities conducted during such fiscal year; and

''(II) in the case that the Secretary determines to so reduce payment to the contractor, the amount of such payment reduction.

''(iv) METHODOLOGY FOR CALCULATION OF OVERTURNED COMPLEX AUDIT DENIAL OVERTURN RATE.—

''(I) CALCULATION OF OVERTURN RATE.—The Secretary shall calculate a complex audit denial overturn rate for a recovery audit contractor for a fiscal year by—

''(aa) determining, with respect to the contract entered into

under paragraph (1) by the contractor, the number of complex audit denials issued by the contractor under the contract (including denials issued before such fiscal year and during such fiscal year) that are overturned on appeal; and

''(bb) dividing the number determined under item (aa) by the number of complex audit denials issued by the contractor under such contract (including denials issued before such fiscal year and during such fiscal year).

''(II) FAIRNESS AND TRANSPARENCY.—The Secretary shall calculate the percentage described in subclause (I) in a fair and transparent manner.

''(III) ACCOUNTING FOR SUBSEQUENTLY OVERTURNED APPEALS.—The Secretary shall calculate the percentage described in subclause (I) in a manner that accounts for the likeli-

hood that complex audit denials issued by the contractor for such fiscal year will be overturned on appeal in a subsequent fiscal year.

"(IV) COMPLEX AUDIT DENIAL DEFINED.—In this subparagraph, the term 'complex audit denial' means a denial by a recovery audit contractor of a claim for payment under this title submitted by a hospital, psychiatric hospital, or critical access hospital that is so denied by the contractor after the contractor has—

"(aa) requested that the hospital, psychiatric hospital, or critical access hospital, in order to support such claim for payment, provide supporting medical records to the contractor; and

"(bb) reviewed such medical records in order to determine whether an improper payment has been made to the hospital, psychiatric hospital, or critical access hospital for such claim.

"(V) OVERTURNED ON APPEAL DEFINED.—In this subparagraph, the term 'overturned on appeal' means, with respect to a complex audit denial, a denial that is overturned on appeal at the reconsideration level, the redetermination level, or the administrative law judge hearing level.

"(D) APPLICATION TO EXISTING CONTRACTS.—Not later than 60 days after the date of the enactment of this paragraph, the Secretary shall modify, as necessary, each contract under paragraph (1) that the Secretary entered into prior to such date of enactment in order to ensure that payment with respect to recovery activities conducted under such contract is made in accordance with the requirements described in this paragraph.".

(b) ELIMINATION OF ONE-YEAR TIMELY FILING LIMIT TO REBILL PART B CLAIMS.—

(1) IN GENERAL.—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

"(20) EXCEPTION TO THE ONE-YEAR TIMELY FILING LIMIT FOR CERTAIN REBILLED CLAIMS.—

"(A) IN GENERAL.—In the case of a claim submitted under this part by a hospital (as defined in subparagraph (B)(i)) for hospital services with respect to which there was a previous claim submitted under part A as inpatient hospital services or inpatient critical access hospital services that was denied by a medicare contractor (as defined in subparagraph (B)(ii)) because of a determination that the inpatient admission was not medically reasonable and necessary under section 1862(a)(1)(A), the deadline described in this paragraph is 180 days after the date of the final denial of such claim under part A.

"(B) DEFINITIONS.—In this paragraph:

"(i) HOSPITAL.—The term 'hospital' has the meaning given such term in section 1861(e) and includes a psychiatric hospital (as defined in section 1861(f)) and a critical access hospital (as defined in section 1861(mm)(1)).

"(ii) MEDICARE CONTRACTOR.—The term 'medicare contractor' has the meaning given such term under section 1889(g),

and includes a recovery audit contractor with a contract under section 1893(h).

''(iii) FINAL DENIAL.—The term 'final denial' means—

''(I) in the case that a hospital elects not to appeal a denial described in subparagraph (A) by a medicare contractor, the date of such denial; or

''(II) in the case that a hospital elects to appeal a such a denial, the date on which such appeal is exhausted.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1835(a)(1) of the Social Security Act (42 U.S.C. 1395n(a)(1)) is amended by inserting ''or, in the case of a claim described in section 1842(b)(20), not later than the deadline described in such paragraph'' after ''the date of service''.

(B) Section 1842(b)(3)(B) of the Social Security Act (42 U.S.C. 1395u(b)(3)(B)) is amended in the flush language following clause (ii) by inserting ''or, in the case of a claim described in section 1842(b)(20), not later than

the deadline described in such paragraph'' after ''the date of service''.

(3) APPLICABILITY.—The amendments made by this subsection apply to claims submitted under part B of title XVIII of the Social Security Act for hospital services for which there was a previous claim submitted under part A as inpatient hospital services or inpatient critical access hospital services that was subject to a final denial (as defined in paragraph (20)(B)(iii) of section 1842(b) of such Act (42 U.S.C. 1395u(b))) on or after the date of the enactment of this Act.

(c) MEDICAL DOCUMENTATION CONSIDERED FOR MEDICAL NECESSITY REVIEWS OF CLAIMS FOR INPATIENT HOSPITAL SERVICES.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended by adding at the end the following new sentence: ''A determination under paragraph (1) of whether inpatient hospital services or inpatient critical access hospital services furnished to an individual on or after the date of the enactment of this sentence are reasonable and necessary shall be based solely upon information available to the admitting physician at the time of the inpatient admission of the individual for such inpatient services, as documented in the medical record.''.

TITLE IV—FUTURE OF RURAL HEALTH CARE

SEC. 401. MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM GRANTS.

Section 1820(g) of the Social Security Act (42 U.S.C. 1395i–4(g)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (C), by striking ''and'' at the end;

(B) in subparagraph (D), by striking the period at the end and inserting a semicolon; and

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

''(E) rural emergency hospitals providing support for critical access hospitals to convert to rural emergency hospitals to stabilize hospital emergency services in their communities; and

''(F) supporting certified rural health clinics for maintaining and building business operations, increasing financial indicators, addressing population health, transforming services, and providing linkages and services for behav-

ioral health and substance use disorders responding to public health emergencies.'';

(2) by redesignating paragraphs (3) through (7) as paragraphs (4) through (8), respectively;

(3) after paragraph (2), by inserting the following new paragraph:

''(3) ACTIVITIES TO SUPPORT CARRYING OUT FLEX GRANTS.—The Secretary may award grants or cooperative agreements to entities that submit to the Secretary applications, at such time and in such form and manner and containing such information as the Secretary specifies, for purposes of supporting States and hospitals in carrying out the activities under this subsection by providing technical assistance, data analysis, and evaluation efforts.'';

(4) in paragraph (4), as redesignated—

(A) in subparagraph (A), by inserting ''State Offices of Rural Health on behalf of eligible hospitals'' after ''award grants to'';

(B) by amending subparagraph (C) to read as follows:

''(C) APPLICATION.—The State Office of Rural Health shall submit an application, on behalf of eligible rural hospitals, to the Sec-

retary on or before such date and in such form and manner as the Secretary specifies.'';

(C) by amending subparagraph (D), to read as follows:

''(D) AMOUNT OF GRANT.—A grant to a hospital under this paragraph shall be determined on an equal national distribution so that each hospital receives the same amount of support related to the funds appropriated.'';

(D) by amending subparagraph (E), to read as follows:

''(E) USE OF FUNDS.—State Offices of Rural Health and eligible hospitals may use the funds received through a grant under this paragraph for the purchase of computer software and hardware; the education and training of hospital staff on billing, operational, quality improvement and related value-focused efforts; and other delivery system reform programs determined appropriate by the Secretary.''; and

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

''(9) RURAL HEALTH TRANSFORMATION GRANTS.—

''(A) GRANTS.—The Secretary may award 5-year grants to State Offices of Rural Health and to eligible rural health care providers (as defined in subparagraph (E)) on the transition to new models, including rural emergency hospitals, extended stay clinics, freestanding emergency departments, rural health clinics, and integration of behavioral, oral health services, telehealth and other transformational models relevant to rural providers as such providers evolve to better meet community needs and the changing health care environment.

''(B) APPLICATION.—An applicable rural health care provider, in partnership with the State Office of Rural Health in the State in which the rural health care provider seeking a grant under this paragraph is located, shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

''(C) ADDITIONAL REQUIREMENTS.—The Secretary may not award a grant under this paragraph to an eligible rural health care provider unless—

''(i) local organizations or the State in which the hospital is located provides support (either direct or in kind); and there are letters of support from key State payers such as Medicaid and private insurance; and

''(ii) the applicant describes in detail how the transition of the health care provider or providers will better meet local needs and be sustainable.

''(D) ELIGIBLE RURAL HEALTH CARE PROVIDER DEFINED.—For purposes of this paragraph, the term 'eligible rural health care provider' includes a critical access hospital, a certified rural health clinic, a rural nursing home, skilled nursing facility, emergency care provider, or other entity identified by the Secretary. An eligible rural health care provider may include other entities applying on behalf of a group of providers such as a State Office of Rural Health, a State or local health care authority, a rural health network, or other entity identified by the Secretary.''.

○