



House Action Reports

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Permanent "Doc Fix"

This Fact Sheet deals with HR 2 , Medicare Access and CHIP Reauthorization Act, which the House will consider on Thursday, March 26.

The measure repeals the sustainable growth rate (SGR) used to determine Medicare payment rates for physicians, and provides for a transition to a new dual system intended to reward quality of care that would begin in 2019. It extends funding for the Children's Health Insurance Program (CHIP) and community health centers for two years, as well dozens of other Medicare related health programs. The measure's cost would be partially offset through a combination of increased payments from Medicare beneficiaries, including means-testing of high-income beneficiaries, and payment adjustments to various Medicare providers. Absent congressional action on the SGR, Medicare physicians face a 21% payment cut on April 1 when the latest "doc fix" expires.

The White House has signaled support for the bill, which represents an agreement reached by House Republican and Democratic leaders and is expected to garner widespread support. Some Republicans, however, oppose the bill because it increases the deficit by \$141 billion over ten years, while some Democrats have expressed concern that it extends CHIP for only two years and restricts the use of community health center funds for abortions.

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Section I

Background & Summary

The 1997 Balanced Budget Act (PL 105-33) implemented the current system used to determine reimbursements under Medicare Part B. This system sets an overall target for federal spending under Medicare Part B, which allows for reimbursements to physicians to be adjusted, upward or downward, to meet the target. Since the system was created, reimbursement rates have been cut just once, by 4.8% in 2002. Congress has prevented any further cuts by enacting 17 "doc fix" bills to block the required cuts and often to instead provide an increase — which has acted to build up the size of the cumulative cut needed to hit the sustainable growth rate (SGR) target for Medicare spending.

Doc fix measures have become routine in recent years, often attached to other essential legislation. The most recent temporary adjustment, set to last for one year, was enacted in March 2014 (PL 113-93). Absent congressional action, a reduction of roughly 21% in the Medicare reimbursement rate for physician services is currently set to occur on April 1.

Replacement & Offsets

Lawmakers have long sought to modernize the formula for determining Medicare reimbursements and permanently replace the SGR in order to ensure predictable payments to doctors and access to health care for Medicare patients, and to move away from a system that simply rewards the quantity of Medicare services rather than the quality of care. They also want to end the pattern of constant doc fix patches and threats that the physician payment cuts will occur, which injects uncertainty into the health care system. During the 113th Congress, lawmakers from both parties in both chambers worked together on the issue, and in February 2014 they released a merged, bipartisan agreement.

However, members were unable to come up with a bipartisan package of offsets to pay for the cost of replacing the SGR with the new proposed payment system. The House in early March 2014 by a 238-181 vote passed a permanent SGR overhaul, but it was offset with a five-year delay of the "individual mandate" under the 2010 health care overhaul (PL 111-148 , PL 111-152) — which congressional Democrats and President Barack Obama opposed. As a consequence, that bill was never considered by the then-Democratic controlled Senate, and the one-year patch was enacted a few weeks later.

Recent Action

This year, House Republican and Democratic leaders again began discussions seeking a way to replace the SGR, and eventually settled on a broad compromise package that not only replaced the SGR but also achieved separate goals held by each party — funding extensions of the Children's Health Insurance Program (CHIP) and community health centers sought by Democrats, and some structural changes to Medicare sought by Republicans, such as means-testing under which higher-income beneficiaries pay higher premiums.

Under the agreement, however, only about a third of its cost is offset, which has prompted opposition from outside conservative groups and from GOP conservatives concerned about the deficit. But House Speaker John A. Boehner, R-Ohio, has expressed his support for the measure, arguing that the agreement's means-testing and other changes in Medicare will likely produce much greater savings, and more than offset the bill's cost, in future years beyond the 10-year budget window.

Some liberal Democrats, meanwhile, oppose the means-testing and other provisions that would require Medicare beneficiaries to pay more, while some Senate Democrats want a longer funding extension for the CHIP program and have expressed concern about language that would restrict the use of community health center funding for abortions (House Minority Leader Nancy Pelosi, D-Calif., supports the measure and notes that the abortion restriction is temporary, similar to that placed on all federal appropriations).

The White House on Wednesday announced its support for the bill, saying in a statement of administration policy that it would "advance the Administration's goal of moving the Nation's health care delivery system toward one that achieves better care, smarter spending, and healthier people through the expansion of new health care payment models, which could contribute to slowing long-term health care cost growth."

The Rules Committee has recommended a rule which, upon adoption, automatically modifies the bill to make minor changes and technical corrections.

Summary of HR 2

This bill formally repeals the sustainable growth rate (SGR) used to determine Medicare payment rates for physicians, and it provides for a transition to a new dual system intended to reward quality of care that would begin its initial stages in 2019.

It also extends funding for the Children's Health Insurance Program (CHIP) and for community health centers for an additional two years, as well as dozens of other Medicare and other health programs.

The measure's cost would be partially offset through a combination of increased contributions from Medicare beneficiaries, including higher premiums for higher-income beneficiaries, and payment adjustments to certain types of Medicare providers.

The Congressional Budget Office (CBO) estimates the 10-year cost of the bill at \$214 billion, with offsets totaling about \$73 billion — which would increase deficits by \$141 billion.

SGR Replacement

The bill replaces the SGR with a new reimbursement system under which physicians could choose to participate under one of two methods: a Merit-Based Incentive Payment system under which doctors could get higher reimbursements based on better overall performance, or a group-oriented Alternative Payment Model system under which doctors would move away from traditional fee-for-service payments.

It provides for a 10-year transition period under which current Medicare reimbursement rates would gradually rise each year until 2020 and then remain stable for five years while the two new programs are more fully implemented.

Replacement of the SGR and transition to a new system would cost nearly \$175 billion over 10 years.

CHIP & Other Health Care Extenders

The measure extends funding for CHIP for an additional two years, providing a total of \$19.3 billion for the program for FY 2016 and \$20.4 billion for the program for FY 2017. The program helps cover children whose families do not qualify for Medicaid.

It also extends funding for community health centers for an additional two years, through FY 2017, providing \$3.6 billion each year, as well as numerous other health care programs that would otherwise soon expire.

It makes permanent the Qualifying Individual (QI) program that helps low-income senior pay their Medicare premiums, as well as the Transitional Medical Assistance (TMA) program under which individuals receiving Medicaid may continue to receive benefits as they transition to employment.

Medicare-Related Offsets & Other Provisions

The measure partially offsets the cost of the deal by requiring roughly 2% of Medicare beneficiaries, who have incomes above \$133,500 (\$267,000 for couples) to pay higher Medicare premiums (so-called means testing) starting in 2018 (which would save \$34.3 billion through FY 2025). And starting in 2020, it prohibits new private Medigap policies from providing "first-dollar" coverage of Medicare costs, thereby requiring beneficiaries to pay Medicare's monthly \$147 deductible.

It also allows the Treasury Department, as a means of collecting unpaid taxes, to levy up to 100% of certain federal payments made to Medicare providers; phases in a 3.2 percentage-point adjustment for hospitals that was scheduled to occur in FY 2018; delays until FY 2018 scheduled reductions in payments to hospitals that treat unusually large numbers of patients with little or no health insurance; replaces the market basket update for post-acute providers in 2018 with a 1% update for long-term care hospitals skilled nursing facilities, inpatient rehabilitation facilities, home health providers and hospice providers; requires bidders under Medicare's durable medical equipment competitive acquisition program to obtain surety bonds for their bids; and requires a range of new Medicare anti-fraud efforts — including by eliminating Social Security numbers from Medicare cards.

Finally, the bill includes non-health related provisions that extend federal payments to rural, western counties to help make up for declining revenues from timber sales.

CBO Cost Estimate

The Congressional Budget Office (CBO) estimates that the bill would increase net direct spending by about \$145 billion over 10 years and net revenues by about \$4 billion, resulting in a \$141 billion increase in federal budget deficits over that same period. The measure waives pay-as-you-go rules that would otherwise apply.

Second-Decade Estimates

CBO also examined the effects of the bill on deficits during the decade after 2025, but noted that "considerable uncertainty" did not make a precise estimate possible. CBO said it expects the bill to raise federal costs relative to current law during the second decade after 2025. While the budgetary effects of some provisions of the bill that would generate savings would increase rapidly in the second decade, CBO notes, they would be growing from a much smaller starting point in 2025 than the budgetary effects of the provisions generating additional costs.

Section II

SGR Replacement

This section describes the provisions of HR 2 , the Medicare Access and CHIP Reauthorization Act, that repeal the sustainable growth rate (SGR) currently used to determine Medicare payment rates for physicians and that replace it with a new system.

The bill formally repeals the existing SGR and it provides for a transition to a new dual system intended to reward quality of care that would begin its initial stages in 2019. Under the new system, physicians could choose to participate under one of two reimbursement methods: a Merit-Based Incentive Payment system under which doctors could get higher reimbursements based on better overall performance, or a group-oriented Alternative Payment Model system under which doctors would move away from traditional fee-for-service payments.

The Congressional Budget Office estimates that the bill's SGR replacement provisions would increase direct spending, relative to the current-law baseline, by about \$175 billion over the 10-year period.

Transition & Increases

The measure provides for a five-year transition period, after which doctors (and other medical professionals who perform similar services) would move into either the Merit-Based Incentive Payment System or the Alternative Payment Model. Regular payments under the respective systems, however, would not begin for 10 years.

Under the current system, reimbursements are provided on the basis of a fee schedule that specifies a payment rate for each type of covered service. The bill extends through June 2015 the current Medicare physician reimbursement rates that were set by last year's doc fix (PL 113-93), and for the remainder of the year (July through December) it increases those rates by 0.5%. Beginning Jan. 1, 2016, rates would be further increased by 0.5% for each year through 2019.

Starting in 2020, payment rates would remain stable through 2025 until the two new separate systems fully take effect in 2026. During that second five-year period, providers would also be eligible for payment incentives through the Merit-Based Incentive Payment System, or to participate in tests of alternative payment models.

Dual Systems

Starting in 2019, providers would have to choose between the Merit-Based and Alternative Payment systems, and the amounts subsequently paid to individual providers would be subject to adjustment through the chosen system.

Within the Merit-Based system, payments to individual providers would be subject to positive or negative adjustments based on performance — but with the increases and decreases in aggregate offsetting one another so there is no overall net increase in payments. In the Alternative Model system, meanwhile, providers would be required to move away from traditional fee-for-service Medicare payments into alternative payment models. Through 2024, providers would receive an annual bonus lump sum of 5% of the amount of payments they received the prior year if they achieved specified targets in moving away from fee-for-service.

Beginning in 2026, payment rates for doctors under each system would automatically be increased each year, increasing by 0.25% per year for the Merit-Based Incentive Payment System and by 0.75% for the Alternative Payment Model.

MedPAC Studies

The bill requires the Medicare Payment Advisory Commission (MedPAC) to submit reports to Congress in 2019 evaluating the impact that the payment updates made between 2015 and 2019 have on beneficiary access and quality of care, with recommendations regarding further updates.

It requires MedPAC to submit reports to Congress in 2017 and 2021 that assess the relationship between spending on services furnished by providers under Medicare Part B (physician services) and total expenditures under Medicare Parts A (hospital services), B and D (prescription drugs). These reports must recognize the role that providers have in directing care and utilization by evaluating their impact on total program spending, including under the Merit-Based Incentive Payment System program.

Merit-Based Incentive Payment System

The Health and Human Services Department (HHS) would be responsible for developing the performance standards for the Merit-Based Incentive Payment system — under which doctors participating in the system would receive a composite quality performance score that would be used to determine whether the doctor receives an annual increase or decrease in Medicare reimbursement rates.

Under the measure, doctors who receive performance scores at or above an annual performance threshold set by HHS would receive zero or positive increases, with higher-scoring professionals receiving greater increases. Professionals below the threshold would see their reimbursement rates reduced — but they would know what composite score they must achieve to avoid penalties at the beginning of each performance period (see Payment Adjustments, below).

Doctors could also receive a bonus increase for exceptional performance, but a provider's payment adjustment in one year would have no impact on their payment adjustment in future years. The measure appropriates \$500 million each year for 2019 through 2024 from the Federal Supplementary Medical Insurance Trust Fund for the bonus increases.

The new system would consolidate Medicare's three current quality performance incentive programs, ending the penalties under those programs and sunsetting certain current-law value-based payments after 2018.

Eligible Professionals

To participate in the Merit-Based system, doctors would have to treat a certain number of Medicare patients, provide a certain number of Medicare services and bill a certain amount of allowable charges, with a low-volume threshold measurement to be set by HHS. Providers who treat few Medicare patients or who receive a significant portion of their revenues from eligible alternative payment models would be excluded from the Merit-Based system.

Initially, only the following medical professionals would be eligible to participate in the merit-based system: medical doctors or osteopaths, dental surgeons and dental physicians, podiatrists, optometric physicians, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists. Beginning in 2021, other professionals paid under the physician fee schedule could be included in the Merit-Based system, provided there are viable performance metrics available. Any new Medicare-enrolled providers would not be treated an eligible professional under the system until the subsequent year.

To help implement the new system, the measure provides for the transfer of \$80 million each year from FY 2015 through FY 2019 from the Supplementary Medical Insurance Trust Fund to the Centers for Medicare & Medicaid Program Management Account.

Performance Scores & Measures

HHS would be required to use four performance categories in determining a doctor's composite performance score: quality of care, resource use, clinical practice improvement activities and meaningful use of certified electronic health records technology.

Providers would be assessed only on the categories and activities that apply to them, and scoring weights could be adjusted as necessary. Providers also would have the flexibility to participate in the system in a way that best fits their practice environment, including the use of electronic health records, the use of qualified clinical data registries maintained by physician specialty organizations and the option to be assessed as a group, as a virtual group, or with an affiliated hospital or facility.

Generally, providers would receive a composite performance score of 0 to 100 based on their performance in each of the four performance categories. After the first two years, 30% would be based on quality of care, 30% on resource used, 15% on clinical practice improvement activities, and 25% on meaningful use of electronic health records. As an incentive to improve performance, providers would receive credit for improvement from one year to the next in the determination of their quality and resource use performance category score. They also could receive credit for improvement in clinical practice improvement activities.

The measure requires HHS in establishing performance standards to consider historical performance standards, improvement, and the opportunity for continued improvement. HHS would also establish the performance period for each year, and a provider's payment adjustment in one year would have no impact on their payment adjustment in a future year. HHS could use global measures and population-based measures in determining performance standards and must consider how to apply the standards to doctors not involved in face-to-face contact with patients.

Quality Performance Measures

HHS each year must establish a list of quality of care measures, from which doctors would choose to be assessed. Medical professional organizations and other stakeholders each year could identify and submit suggestions for quality measures to be included on HHS's list.

The bill requires that measures used for the quality of care performance category be published annually in the final measures list. The final list should address clinical care, safety, care coordination, patient and caregiver experience and population health and

prevention. Before including a new measure in the list, HHS would be required to submit the measure for publication in an applicable specialty-appropriate peer-reviewed journal, including the method HHS used to develop and select the measure.

Resource Use Performance Measures

In establishing resource use measures, HHS must incorporate measures used in its current Value-Based Modifier program and enhance the methodology CMS is currently developing to identify resources associated with specific care episodes — including through public input and an additional process that directly engages professionals. The additional process would allow professionals to report their specific role in treating the beneficiary (i.e., as primary care or specialist) and the type of treatment provided (such as for chronic conditions or acute episodes).

According to the Energy and Commerce Committee, this process would address concerns that algorithms and patient attribution rules fail to accurately link the cost of services to a professional. Resource use measurements also would reflect additional research and recommendations on how to improve risk adjustment methodologies to ensure that providers are not penalized for serving sicker or more costly patients.

Clinical Practice Improvement Activities

For performance measures of clinical practice improvement activities, HHS must include measures of expanded practice access (such as same-day appointments for urgent needs and after-hours access to clinician advice), population management (such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry), and care coordination (such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth). HHS also must consider beneficiary engagement (such as the establishment of care plans for individuals with complex care needs) and patient safety and practice assessment (such as through use of clinical or surgical checklists).

Providers in practice at a patient-centered medical home or comparable specialty practice would be given the highest potential score with respect to a performance period. In establishing these activities, HHS must give consideration to the circumstances of small practices of 15 or fewer professionals and practices located in rural areas and in areas with shortages of health professionals.

Electronic Health Records Use

The bill provides that current Meaningful Use of Electronic Health Records requirements, demonstrated by use of a certified system, would continue to apply in order to receive credit in this category. To prevent duplicative reporting, providers who report quality measures through certified electronic health records systems for the Merit-Based Incentive Payment system quality category are deemed to meet the meaningful use clinical quality measure component.

Role of Professional Organizations

The bill allows eligible professional organizations and other relevant stakeholders to identify and submit quality measures to be considered for selection and to identify and submit updates to the measures already on the list. Measures could be submitted regardless of whether the measures were previously published in a proposed rule or endorsed by a consensus-based entity that holds a contract with CMS. However, any measure selected for inclusion in the list that is not endorsed by a consensus-based entity must be evidence-based.

Payment Adjustments

Under the measure, each provider's composite performance score would be compared to a performance threshold that is equal to the mean or median of the composite scores for all providers in the new merit-based system during the prior performance period, so that professionals would know what composite score they must achieve to obtain incentive payments and avoid penalties for the upcoming performance period.

Payment adjustments would follow a linear distribution. Professionals with scores above the threshold would receive positive payment adjustments, and those with scores below the threshold would receive negative payment adjustments.

Negative & Zero Adjustments

The bill caps negative payment adjustments at 4% in 2019, 5% in 2020, 7% in 2021, and 9% in 2022. Providers whose composite score falls between 0 and one-fourth of the threshold would receive the maximum possible negative payment adjustment for the year, while those with scores closer to the threshold would receive proportionally smaller negative adjustments.

The negative payment adjustments would fund positive payment adjustments to providers with scores above the threshold; providers with a score at the threshold would receive no adjustment.

Positive Adjustments

Providers whose scores are above the threshold would receive positive payment adjustments. Those with higher scores would receive proportionally larger incentive payments, up to a maximum of three times the annual cap for negative adjustments.

The bill also provides for an additional performance threshold for exceptional performance, which would allow some professionals to receive incentive payments even if all professionals score above the initial threshold. Specifically, providers with scores above that additional performance threshold would receive an additional incentive payment — although the total of these additional payments would be capped at \$500 million per year from 2019 through 2024. Additional incentive payments would be allocated according to a linear distribution, with better performers receiving larger payments.

Other Provisions

The measure directs HHS to enter into contracts with appropriate entities to offer guidance and assistance to doctors in the Merit-Based Incentive Payment System who are in practices of 15 or fewer providers and medically underserved or rural areas. It provides for the transfer of \$20 million each year for FY 2016 through 2020 from the Federal Supplementary Medical Insurance Trust Fund for this effort.

It establishes a system under which providers would receive confidential feedback at least quarterly on their performance in the quality and resource use categories, likely through a web-based portal. Providers also would receive confidential feedback on performance through qualified clinical data registries.

GAO Evaluation

The bill directs the Government Accountability Office (GAO) to evaluate the Merit-Based system and issue a report in 2021, including an assessment of the professional types, practice sizes, practice geography and patient mix that are receiving payment increases and reductions under the system. Within another 18 months, GAO must compare the similarities and differences in the use of quality measures under the original Medicare fee-for-service program under parts A and B, the Medicare Advantage program under part C, selected state Medicaid programs and private payer arrangements

In addition, GAO must report by 2017 on whether entities that pool financial risk for physician practices, such as independent risk managers, can play a role in supporting physician practices in assuming financial risk for the treatment of patients, particularly for

small physician practices. By the beginning of FY 2022, GAO must examine the transition of professionals in rural areas, health professional shortage areas or medically underserved areas to an alternative payment model.

Alternative Payment Model

Under the Alternative Payment Model system for making Medicare payments, doctors would be encouraged to move away from the traditional fee-for-service and toward group-oriented alternative payment mechanisms in which they bear some financial risk — such as a single payment for bundled services for a patient. Payments for patient-centered medical homes where patient health is monitored and care is coordinated would also be provided through this system.

To encourage alternative payment models, the bill provides Medicare bonuses for doctors who get a significant portion of their Medicare revenue through such payment mechanisms. Specifically, doctors who choose to operate within the system who in 2019 received 25% of their total Medicare revenue from an alternative payment mechanism would be rewarded in 2020 with a 5% bonus of the total Medicare amounts they received in 2019. To continue receiving the 5% bonus, providers would have to receive an increasing share of their Medicare revenue through such alternative payment mechanisms each year, with the bonus eventually rising to 75% for 2023 (for payment of the bonus in 2024).

The measure provides two tracks for professionals to qualify for the bonus. Under the first, a significant percentage of a provider's Medicare revenue must have been generated through an alternative payment model that has incorporated Medicare. Under the other, in addition to receiving revenue from Medicare and other traditional health payers (such as Medicaid), a significant percentage of the provider's revenue must have been generated through an alternative payment model. The second option would make it possible for providers to qualify for the bonus, even if alternative payment models that include Medicare have not been established in their area.

Agency Requirements

Under the measure, HHS would be encouraged to test alternative payment models relevant to specialty professionals, professionals in small practices and those that align with private and state-based payer initiatives. Providers who meet the criteria for alternative payment models would be excluded from the Merit-Based system assessment and most electronic health records meaningful use requirements.

HHS also would be required to identify potential fraud vulnerabilities in alternative payment models.

Technical Advisory Committee

The measure creates an 11-member Payment Model Technical Advisory Committee to establish criteria for physician-focused payment models no later than Nov. 1, 2016. On an ongoing basis, individuals and stakeholder entities could submit proposals to the committee for creating such models.

CMS would be required to provide a detailed response to committee-recommended alternative payment models.

Development of Classification Codes

In order to classify similar patients into care episode groups and patient condition groups, HHS must develop classification codes for the groups using stakeholder input. In order to facilitate the attribution of patients and episodes to one or more physicians or applicable practitioners furnishing items and services, HHS would develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a provider with a patient.

HHS would use the patient relationship, care episode and patient condition codes to evaluate and measure the resources used to treat patients.

Quality Measure Development

The bill requires HHS to develop and publish a plan for the development of quality measures, taking into account stakeholder input and how measures from the private sector and integrated delivery systems could be utilized in the Medicare program. The plan, which must be finalized by May 1, 2016, must prioritize outcome measures, patient experience measures, care coordination measures and measures of appropriate use of services.

Through the plan, HHS also would consider gaps in quality measurement and applicability of measures across health care settings. HHS would contract with entities (such as physician organizations) to develop priority measures and focus on measures that can be reported through an electronic health record.

By May 1, 2017, and annually thereafter, HHS must report to Congress on its progress in developing quality measures. The report must include descriptions of the number of measures developed (including the name and type of each measure); descriptions of the measures under development (including an estimated timeline for completion); and quality areas being considered for future measure development.

The measure provides \$15 million annually for 2015 through 2019 for professional quality measure development by HHS, with those funds to remain available through FY 2022.

Chronic Care

The measure requires HHS to establish new codes for chronic care management services, and to begin paying for such services that are furnished on or after Jan. 1, 2015. This provision is intended to encourage care coordination and the use of medical homes for individuals who receive chronic care.

Under the measure, payments for chronic care management would not require, as a condition of payment, that the individual first visit a physician for an annual wellness or initial preventive examination.

At least one payment code for care management services must be established for professionals treating chronic care payments. In order to prevent duplicative payments, only one professional or group practice could receive payment for those provided services to an individual during a specified period.

Data Collection & Other Provisions

The measure also includes a number of data collection and administrative provisions.

The bill directs HHS to make publicly available on the Physician Compare website information on the number of Medicare services furnished by doctors and on the payments made for those services. The information would emphasize the services a provider most commonly furnishes and would be searchable by the provider's name, location and services furnished. Performance composite score for providers under the Merit-Based system would also be included on the Physician Compare site.

Expand Use of Claims Data

The measure permits qualified entities that currently receive Medicare data for public reporting purposes to provide or sell non-public Medicare analyses and claims data to physicians, other professionals, providers, medical societies and hospital associations to assist them in their quality improvement activities or in developing alternative payment models. Any data or analyses must be de-identified, though the provider accessing the data or analysis could receive identifiable information on the services furnished to his or her patient.

Claims data that would be available to qualified entities would also include Medicaid and Children's Health Insurance Program (CHIP) data.

Non-public analyses could also be sold to health insurers and self-insured employers, but only for purposes of providing health insurance to their employees or retirees. Providers identified in such analyses would have an opportunity to review and submit corrections before the information is sold.

To ensure the privacy, security and appropriate use of Medicare claims information, qualified entities must have a data use agreement with the providers and entities to whom they provide data. Providers and entities receiving data and analyses would be prohibited from re-disclosing them or using them for marketing.

The bill requires qualified entities that provide or sell such analyses or data to provide an annual report to HHS which provides an accounting of the analyses provided or sold — including the number of analyses and purchasers, the amount of fees received, and the topics and purposes of the analyses.

Qualified Clinical Data Registries

The measure requires HHS to make data available, for a fee that covers the cost of its preparation, to qualified clinical data registries in order to support quality improvement and patient safety activities. Providers identified in public reports would have an opportunity to review and submit corrections.

Other Provisions

The bill allows providers who opt out of Medicare to automatically renew at the end of each two-year cycle, but it requires regular reporting of opt-out physician characteristics.

It also requires that electronic health records be interoperable by 2018, and prohibits providers from deliberately blocking information sharing with other electronic health record vendor products.

Section III

Health Care Extenders & Other Provisions

This section describes the provisions of HR 2 , the Medicare Access and CHIP Reauthorization Act, that extend the Children's Health Insurance Program, community health centers, and other Medicare reimbursement and health care programs. Most are currently set to expire either on March 31 or later this year.

The Congressional Budget Office (CBO) estimates these extensions would cost at least \$33.7 billion over 10 years.

CHIP

The bill extends funding for the Children's Health Insurance Program (CHIP) for an additional two years, through FY 2017, providing a total of \$19.3 billion for the program for FY 2016 and \$20.4 billion for the program for FY 2017.

The program, which is administered by the states, helps provide health care to children whose families do not qualify for Medicaid; it currently covers more than 8 million children and pregnant women. Funding for the program was last extended through the 2010 health care overhaul law, which also included changes to CHIP eligibility and enrollment. While current funding for CHIP expires at the end of FY 2015, the program itself is authorized through 2019.

The measure extends through September 2017 the authority of states to rely on findings from an "Express Lane" agency to determine whether a child satisfies one or more eligibility criteria for Medicaid or CHIP coverage. Express Lane agencies are designated by the state Medicaid or CHIP agencies as capable of making eligibility determinations. Under the measure, the Health and Human Services (HHS) Department's inspector general must report to Congress on the use by states of the Express Lane option.

The bill also extends for two years funding for the following: the outreach and enrollment program, at \$40 million per year; the childhood obesity demonstration project, at \$10 million per year; and the pediatric quality measures program, at \$20 million per year.

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimate that the CHIP extension would increase outlays by \$7 billion and increase revenues by \$1.4 billion, for a net cost of \$5.6 billion over the 10-year period, relative to CBO's baseline. This baseline assumes certain programs like CHIP would continue beyond the scheduled expiration date and that the cost of CHIP would be partially offset by reductions in spending for other health care programs.

Community Health Centers & Related Programs

The measure extends mandatory funds for community health centers for an additional two years, through FY 2017, providing \$3.6 billion each year.

For decades, HHS has provided support to community-based and patient-directed health centers that serve populations with limited access to health care, with HHS funding for those centers being provided through annual appropriations acts. The 2010 health care overhaul law established the Community Health Center Fund, which provided a total of \$11 billion in mandatory funding for the operation, expansion and construction of community health centers over a five-year period, with increased levels of funding each year.

In 2013, more than 1,302 federally funded health centers located in urban and rural areas across the country served an estimated 22.7 million patients. The vast majority of the 90 million visits to health centers were for primary medical care, according to the Energy and Commerce Committee.

CBO estimates these provisions, including extension of the two programs listed below, would increase direct spending by \$8 billion over 10 years.

Other Programs

The bill also extends for two years, through FY 2017, the following programs:

- **National Health Service Corps (NHSC)** — \$310 million each year for the NHSC program, which helps bring health care professionals to areas where they are most needed by providing scholarships and loan repayment in exchange for a commitment of service in an underserved community.
- **Community-Based Residency Training** — \$60 million each year for the Teaching Health Center Graduate Medical Education Payment Program, which promotes residency training in community-based facilities where residents are trained in family and internal medicine, pediatrics, obstetrics and gynecology, psychiatry and general and pediatric dentistry.

Abortion Limits

The bill subjects funding provided for community health centers, as well as the NHSC and community-based residency, to provisions under the FY 2015 omnibus appropriations law (PL 113-235) that prohibit the use of funds for abortions. (Although many Democrats and pro-abortion rights groups oppose the language, Democratic leaders have argued that it simply maintains existing policy and doesn't further restrict abortion access.)

Other Extenders

The measure extends, and in some cases makes permanent, dozens of Medicare and other health care policies that routinely expire along with the so-called "doc fix."

Permanent Qualified Individual & Transitional Assistance

The measure makes permanent the Qualified Individual (QI) program that helps low-income senior pay their Medicare premiums. Under the program, Medicaid pays the Medicare Part B (doctors services) premium for individuals whose incomes are between 120% and 135% of the poverty level (currently between \$14,124 - \$15,890 a year). CBO estimates that this provision would cost \$14.6 billion over 10 years.

It also makes permanent the Transitional Medical Assistance program, under which individuals receiving Medicaid may continue to receive benefits for a year as they transition to employment. According to CBO, this provision would increase revenues by \$1.7 billion and reduce direct spending by \$1.2 billion over 10 years, for a net deficit reduction of \$2.9 billion over 10 years.

Special-Needs Medicare Advantage Plans

The measure extends for an three-and-a-half years, until Dec. 31, 2018, the availability of Medicare Advantage Plans to individuals with special needs. According to CBO, this extension would cost \$600 million over 10 years.

Outpatient Therapy Payments

Medicare currently sets annual per-beneficiary payment caps for non-hospital outpatient therapy services, such as physical therapy or speech therapy. Providers can seek an exemption from the cap if the therapy is deemed medically necessary, but that exemption authority expires March 31.

The measure extends the authority to receive cap exemptions through Jan. 1, 2018, and it overhauls the process of medical manual review to help support the integrity of the Medicare program. CBO estimates this provision would cost \$1.9 billion over 10 years.

Medicare Work Geographic Adjustment

Under current law, the Medicare fee schedule is adjusted to reflect the differences in the cost of providing services in different geographic areas, including by providing a payment floor in areas where labor costs are lower than the national average. This adjustment is based on three factors: physician work, practice expense and the cost of medical malpractice insurance. Medicare identifies 89 unique geographic areas.

The measure extends the existing 1.0 floor on the "physician work" cost index until Jan. 1, 2018. CBO estimates this extension would cost \$1.1 billion over 10 years.

Medicare-Dependent Hospital Program

The measure extends the Medicare-Dependent Hospital (MDH) Program through Oct. 1, 2017. The program provides funding for rural hospitals through special Medicare rates resulting from high populations of Medicare patients. A hospital qualifies for the MDH Program if it is located in a rural area, has 100 beds or fewer, is not a "sole community hospital" and has at least 60% of inpatient days or discharges covered by Medicare.

CBO estimates this extension would cost \$400 million over 10 years.

Low-Volume Hospital Program

The measure extends the Low-Volume Hospital Program through Oct. 1, 2017. This program provides additional Medicare funding to hospitals in rural communities that are more than 15 road miles from another comparable hospital and which have fewer than 1,600 Medicare discharges per year.

CBO estimates this extension would cost \$1 billion over 10 years.

Medicare Reasonable Cost Contracts

The measure provides for a transition for certain reasonable cost reimbursement contracts, under which the Centers for Medicare and Medicaid Services (CMS) pay the reasonable costs of Medicare-covered services, less the value of the deductible and coinsurance. Certain plans that no longer meet statutory requirements to operate under Medicare in their service area could move to Medicare Advantage plans, and the bill details a process for making that transition.

According to CBO, these provisions would cost \$300 million over 10 years.

Ambulance Add-Ons

The bill extends current Medicare reimbursement rates for ground ambulance service, including rates for "super-rural" areas, through Jan. 1, 2018. CBO estimates this extension would cost \$400 million over 10 years.

Rural Home Health

The measure extends a 3% add-on to payments made for home health services provided to patients in rural areas through Jan. 1, 2018. CBO estimates that this provision would cost \$200 million over 10 years.

Two-Midnight Rule Reviews

Under the two-midnight rule, surgical procedures, diagnostic tests and certain other treatments are generally appropriate for inpatient hospital admission and payment under higher Medicare Part A (hospital) rates when the physician expects the beneficiary to require a stay that crosses at least two midnights and the beneficiary is admitted to the hospital based upon that expectation. In late 2013, the Centers for Medicare and Medicaid Services (CMS) issued guidance regarding how to select hospital claims to review the validity of admissions that occurred starting Oct. 1, 2013, under that two-midnight rule.

The bill extends through the end of FY 2015 a general prohibition on HHS making decisions regarding the validity of inpatient admissions and Part A payments based on two-midnight rule reviews performed by recovery audit contractors. A current restriction on such patient status reviews ends March 31. Under the measure, HHS could conduct such reviews if there is evidence of systematic gaming, fraud, abuse or delays in the provision of care, and HHS could also continue to perform medical reviews with regard to the two-midnight rule.

CBO estimates this would result in a change in direct spending of less than \$50 million over 10 years.

Special Diabetes Program

The measure extends mandatory funding for diabetes prevention and research programs for American Indians and Alaskan Natives through FY 2017, at the current annual rate of \$150 million. Funding is currently set to expire at the end of FY 2015.

CBO estimates this provision would cost \$600 million over 10 years.

Maternal, Infant, and Early Childhood Home Visiting Programs

The measure extends, through FY 2017, Maternal, Infant, and Early Childhood Home Visiting programs. Those programs facilitate collaboration and partnership at the federal, state and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.

CBO estimates this extension would cost \$700 million over 10 years.

Beneficiary Liability Settlements

The measure extends, through Oct. 1, 2017, the delay of the effective date for Medicaid amendments relating to beneficiary liability settlements and recovery of medical expense claims. CBO estimates this provision would cost \$100 million over 10 years.

Tennessee DSH Allotment

The measure provides Tennessee with an annual Medicaid disproportionate share hospital (DSH) allotment through FY 2025 under the same allocation system as is used for most other states.

Under the DSH program, additional Medicaid funds are provided to hospitals that treat large numbers of low-income and other patients and are not otherwise reimbursed for their services. According to the Energy and Commerce Committee, Hawaii and Tennessee have had different DSH arrangements due to unique past circumstances, but Tennessee now wants parity with other states.

CBO estimates this provision would cost \$500 million over 10 years.

Personal Responsibility Education Program

The measure extends, through FY 2017, the Personal Responsibility Education Program — which provides states, community groups, tribes and tribal organizations with grants to implement evidence-based, or evidence-informed, innovative strategies for teen pregnancy and HIV/STD prevention, youth development and adulthood preparation for young people.

CBO estimates this provision would cost \$100 million over 10 years.

Health Workforce Demonstration Project

The measure extends for an additional two years, at \$85 million per year, the Health Workforce Demonstration Project. The program provides low-income individuals with opportunities for education, training, and career advancement to address health professions workforce needs. CBO estimates this provision would cost \$200 million over 10 years.

Abstinence Education

The bill extends for an additional two years, through FY 2017, abstinence education programs allotted to each state. Mandatory spending for the programs would be increased to \$75 million per year. CBO estimates this provision would cost \$100 million over 10 years.

Other Extensions

The measure also extends the following programs:

- **Family-to-Family Information Centers** — Designates \$5 million through FY 2017 for a grant program that provides funding to family-staffed, nonprofit service providers that provide care to special-needs children and their families. (CBO estimate: Change in direct spending of less than \$50 million over 10 years.)
- **Review of Quality & Resource Use Measures** — Provides funding for 2016 and 2017 for the National Quality Forum's review, endorsement and maintenance of quality and resource use measures. It also funds the pre-rulemaking process and measure dissemination and review activities. (CBO estimate: \$100 million over 10 years.)
- **Low-Income Outreach Programs** — Extends through FY 2017, funding for outreach programs that are designed to increase awareness of available benefits for low-income individuals and families. This includes state health insurance programs, area agencies on aging, aging and disability resource centers and the national center for benefits and outreach enrollment. (CBO estimate: \$100 million over 10 years.)

Section IV

Medicare Related Offsets & Other Provisions

This section describes the provisions of HR 2 , Medicare Access and CHIP Reauthorization Act, that modify elements of the Medicare program and produce savings that help to offset the cost of the bill's SGR replacement and other health care extenders, as well as miscellaneous provisions mostly related to Medicare.

Among the major changes, the measure requires higher-income seniors to pay higher Medicare premiums (so-called means testing), restricts the ability of Medigap policies to cover Medicare deductibles, delays reductions in Medicaid payments to hospitals with disproportionate shares of low-income patients, and permits the Treasury Department, as a means of collecting unpaid taxes, to continuously levy up to 100% of certain federal payments made to Medicare providers. It also extends federal payments to rural, western counties to help make up for declining revenues from timber sales.

Offsets

The measure includes numerous provisions that the Congressional Budget Office (CBO) says would produce savings of \$73 billion through 2025, including through increases in revenue and reductions in direct spending. Among those savings provisions are those that would increase costs for Medicare beneficiaries (thereby reducing Medicare costs) and reduce payments to Medicare providers.

Changes for Beneficiaries

For Medicare beneficiaries, the measure includes two major policy changes that would require beneficiaries to pay more — through mean-testing that requires higher-income individuals to pay higher Medicare premiums, and by ending "first-dollar" coverage of Medicare under private Medigap policies. These provisions provide nearly half of the value of all of the offsets.

Means-Testing

Under current law, higher-income individuals and couples are required to pay a greater percentage of their Medicare premiums for Medicare Part A (physician services) and Part D (prescription drugs).

Starting in 2018, the bill increases the percentage of premiums that beneficiaries in two upper income brackets must pay — which bill sponsors estimate will effect roughly 2% of Medicare beneficiaries.

Specifically, it increases from 50% to 65% the percentage of premiums that must be paid by individuals with modified adjusted gross income between \$133,500 and 160,000 (between \$267,000 and \$320,000 for a couple), and increases from 65% to 80% the percentage of premiums to be paid for those with modified adjusted gross income above \$160,000 (\$320,000 for a couple).

It also adjusts the minimum income threshold at which beneficiaries would begin to pay a percentage (35%) of premiums, increasing it from \$80,000 to \$85,000. Under the measure, all income-related thresholds for Medicare premiums would be indexed for inflation beginning in 2020.

CBO estimates this provision would reduce direct spending by \$34.3 billion over the 2018-2025 period.

Medigap

Starting in 2020, the bill prohibits new private Medigap policies from providing "first-dollar" coverage of Medicare costs.

Medigap plans are private plans purchased by Medicare beneficiaries that pay for costs not otherwise covered by Medicare, such as Medicare co-pays and deductibles.

Under the measure, Medigap policies for new Medicare beneficiaries beginning in 2020 could no longer cover the Part B deductible (currently \$147 a month), meaning that the beneficiary would have to pay that deductible. Limiting the ability of Medigap policies to cover monthly deductibles is expected to reduce beneficiaries visits to medical facilities for unnecessary services.

CBO estimates this provision would reduce direct spending by \$400 million over 10 years.

Changes for Providers

The bill includes several provisions that would reduce Medicare payments to certain providers, thereby reducing Medicare expenses. Just over half the bill's offsets come from such policy changes.

Market Basket Update

The bill replaces the market basket update for post-acute providers in 2018 with a 1% update for long-term care hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health providers, and hospice providers. The market basket index reflects changes over time in the prices of an appropriate mix of goods and services included in covered services of these facilities and providers, subject to certain adjustments.

CBO estimates this provision would reduce direct spending by \$15.4 billion over the 2018-2025 period.

Adjustments for Hospitals

The bill phases in a 3.2 percentage-point adjustment for hospitals that was scheduled to occur in FY 2018.

The fiscal cliff law enacted at the beginning of 2013 (PL 112-240) required CMS to retrospectively recoup \$11 billion in Medicare overpayments to hospitals, and hospitals are scheduled to receive a one-time 3.2 percentage point payment increase in FY 2018 to offset this. The bill instead provides for hospital payment increases of 0.5 percentage points per year over six years, beginning in FY 2018 and ending in FY 2023.

CBO estimates this provision would reduce direct spending by \$15.1 billion over the 2018-2025 period.

Medicaid Disproportionate Share Hospital Allotments

The measure delays until FY 2018 scheduled reductions in payments to hospitals that treat unusually large numbers of patients with little or no health insurance, while extending the reductions through FY 2025.

Disproportionate Share Hospital (DSH) adjustment payments provide additional funding to hospitals that serve a significantly disproportionate number of low-income patients. States receive an annual DSH allotment to cover the costs of DSH hospitals that provide care to low-income patients that are not paid by other sources — such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP) or other health insurance. The allotment is calculated through a statutory formula and includes requirements to ensure that the DSH payments to individual DSH hospitals are not higher than actual uncompensated costs. The 2010 health care overhaul modified DSH payments, reducing the rates as health insurance subsidies and state exchanges became available starting in 2014, with the expectation more people would have health coverage because of the 2010 law.

Time-shifting with DSH allotments has previously been used as an offset in major budget and health care legislation, including in the Dec. 2013 Ryan-Murray bipartisan budget agreement (PL 113-67). Last year's doc fix (PL 113-93) postponed scheduled reductions by an additional year, to FY 2017, and extended the reductions by four years, to FY 2024.

CBO estimates this provision would reduce direct spending by \$4.1 billion over the 2016-2025 period.

Levy Authority

The measure permits the Treasury Department, as a means of collecting unpaid taxes, to continuously levy up to 100% of certain federal payments made to Medicare providers, up from the current maximum of 30%.

The change would be effective for levies issued beginning 180 days after enactment. An increase in levy authority to 30% was previously used as an offset to the tax law enacted at the end of the 113th Congress (PL 113-295).

CBO estimates that this provision would increase revenues by \$600 million over 10 years.

Other Provisions

CBO estimates that the following miscellaneous provisions, related to Medicare and payments to rural counties, would cost a total of \$2 billion over 10 years.

Medical Equipment Bidding

The bill requires that companies submitting bids under Medicare's durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding process meet the appropriate licensing requirements for the state where the bidding will occur, and that they obtain a bid surety bond that they could forfeit if they decline to accept the eventual contracted price. A similar measure (HR 284) passed the House by voice vote under suspension of the rules earlier this month.

The measure is intended to provide accountability in the bidding process and ensure more reliable and equitable pricing for durable medical equipment, thereby improving Medicare beneficiaries' access to that equipment.

CBO estimates that these provisions would have a budget impact of less than \$50 million over 10 years.

Licensing and Bond Requirements

Specifically, the bill requires companies that wish to submit bids in a geographic area under Medicare's DMEPOS competitive acquisition program to meet the applicable state licensing requirements for the state where they will be bidding.

Such companies would also have to obtain a bid surety bond of between \$50,000 and \$100,000 from a bonding agency for each competitive acquisition area in which it submits a bid. To discourage companies from submitting artificially low bids, that bond would be forfeited to the federal government if the company placed a bid that is below the eventual contract price (the single payment amount) for the area and the company declines to accept the contract.

Under the measure, this requirement to post a bid surety bond must go into effect with durable medical equipment bidding competitions that occur no later than Jan. 1, 2019.

GAO Study

The bill requires the Government Accountability Office (GAO) to evaluate the impact of the bid surety bond requirement on participation by small suppliers of durable medical equipment in the competitive bidding program, and to make recommendations for changes that would ensure robust participation by legitimate small suppliers in the program.

Fraud in Medicare

The measure requires HHS to undertake a range of anti-fraud efforts, including ensuring that Social Security numbers are not displayed on Medicare cards. It also attempts to reduce wrongful or improper Medicare payments, requires improved prescriber identity information under Medicare Part D, removes duplicative Medicare Secondary Payer reporting requirements, and eliminates civil money penalties for inducements to physicians to limit services that are not medically necessary.

These provisions are similar to the Protecting Integrity in Medicare Act (HR 1021), which was approved by the Ways and Means Committee last month.

CBO estimates these provisions would have a budget impact of less than \$50 million over 10 years.

Social Security Cards

The bill requires HHS to establish a cost-effective process for removing Social Security numbers from Medicare cards that involves the least amount of disruption to Medicare beneficiaries and health care providers, such as a process that provides such beneficiaries with access to assistance through a toll-free telephone number and provides outreach to providers. It provides for the transfer of a total of \$245 million from the Federal Hospital Insurance Trust Fund to implement the requirement, effective four years after enactment.

Wrongful Payments

The measure directs HHS to establish procedures that will ensure that Medicare payments are not made for incarcerated individuals, individuals who are not lawfully present in the United States, or deceased individuals. Within 18 months of enactment, the HHS inspector general must report to Congress on these activities.

In order to reduce improper payments, the bill requires each Medicare administrative contractor to establish an improper payment outreach and education program under which the contractor would give providers the information on their most frequent and expensive payment errors over the last quarter, as well as specific instructions regarding how to correct or avoid such errors in the future. The administrative contractors must give priority to items or services that have the highest rate or greatest dollar amount of improper payment.

Pharmacy Claims

The measure requires valid prescriber national provider identifiers on Medicare Part D pharmacy claims beginning with the 2016 plan year. HHS would establish procedures to ensure that, in the case that a claim is denied for reasons of prescriber identity, the individual is properly informed at the point of service of the reason for the denial.

Other Provisions

The measure also does the following:

- Requires HHS to consider the use of Medicare beneficiary smart cards.
- Eliminates the use of civil money penalties as inducements to physicians to limit services that are not medically necessary.
- Modifies the face-to-face encounter documentation requirement with respect to the Medicare durable medical equipment program.

- Requires HHS to recommend ways to encourage more individuals to report fraud and abuse in the Medicare program.
- Provides Medicare beneficiaries with an option to receive notices electronically beginning 2016.
- Requires HHS to consider a plan for including, in the annual report of the Comprehensive Error Rate Testing program, data on services paid under the Medicare physician fee schedule where the fee schedule amount is in excess of \$250 dollars and where the error rate is in excess of 20%.
- Directs HHS to implement a process for the medical review of spinal manipulation treatment by certain chiropractors under Medicare, focusing on chiropractors whose pattern of billing is aberrant and who have previously had a major portion of their claims denied.
- Requires HHS to issue a report recommending how a permanent physician-hospital gainsharing program can best be established, and requires GAO to report on barriers to expanded use of telemedicine and remote patient monitoring.

Global Surgical Packages

The bill blocks CMS from implementing a Nov. 2014 rule that would eliminate bundled payments for surgical services that span 10- and 90-day periods.

Instead, beginning no later than 2017, it requires CMS to periodically collect information on the services that surgeons furnish during these global periods and to use that information to ensure that the bundled payment amounts for surgical services are accurate.

The measure directs HHS to transfer \$2 million from the Federal Supplemental Medical Insurance Trust Fund to the CMS Program Management Account for FY 2015 for collection of the data. HHS would be authorized to delay 5% of payment for services with a 10- and 90-day global periods to incentivize reporting of information. HHS could cease the collection of information from surgeons once the needed information can be obtained through other mechanisms, such as clinical data registries and electronic medical records.

CBO estimates these provision would cost \$1.5 billion over 10 years.

Secure Rural Schools

The bill extends for two years, through FY 2015, the Secure Rural Schools and Community Self-Determination Act.

Under the act, payments are made to states to be used for roads and schools in counties where national forests are located, but where timber harvests on those federal lands — and the associated receipts to counties associated with timber harvests — have declined.

The measure provides for a reduction in FY 2014 payments to account for payments received earlier. Payments for FY 2014 must be made within 45 days.

CBO estimates these provisions would cost \$500 million over 10 years.