Issue Brief

FEDERAL ISSUE BRIEF • APRIL 16, 2015

KEY POINTS

- averts a 21.2 percent Medicare physician fee schedule cut
- paid for by reductions in hospital and post-acute care providers
- Medicare-dependent hospital program extension
- delaying of RAC enforcement of the 2-midnight rule

President Signs H.R. 2, the Medicare Access and CHIP Reauthorization Act

The Senate has passed the House's version of the physician sustainable growth rate payment legislation – H.R. 2. The bill will now go to the President who has already signaled that he will sign the bill. This bill is cited as the "Medicare Access and CHIP Reauthorization Act of 2015."

In addition to repealing and replacing the SGR, the bill also includes a number of other Medicare "extender" provisions and funding for a two-year extension of the Children's Health Insurance Program. A copy of the bill as passed by the House and sent to the Senate is at: https://www.congress.gov/bill/114th-congress/house-bill/2/text?format=xml.

Below is a brief section-by-section summary.

TITLE I — SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION

SEC. 101. Repealing the sustainable growth rate and improving Medicare payment for physicians' services

This section repeals the SGR. It provides "stable updates" for five years and ensures no changes are made to the current payment system for four years. In 2019, it establishes an incentive payment program that will focus the fee-for-service system on providing value and quality. The incentive payment program, referred to as the Merit-Based Incentive Payment System, consolidates the three existing incentive programs, continuing the focus on quality, resource use, and meaningful electronic health record use. Further, this section provides financial incentive(s) for professionals to participate in tests of alternative payment models.

(a) Rate updates

The update for January through June 2015 will be 0.0 percent, and for July through December 2015 it will be 0.5 percent. For 2016 through 2019 it will be 0.0 percent.

The rates in 2019 will be frozen through 2025, while providing professionals with the opportunity to receive additional payment adjustments through the MIPS. In 2026 and subsequent years, professionals participating in APMs that meet certain criteria will receive annual updates of 0.75 percent, while all other professionals will receive annual updates of 0.25 percent.

4712 Country Club Drive
Jefferson City, MO 65109

P.O. Box 60
Jefferson City, MO 65102

573/893-3700
www.mhanet.com

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COMMENT

Congress says that the repeal and replacement of the SGR is a permanent fix to the Medicare physician payment system. The term permanent may be too broad. The update values over the past few years and those prescribed over the next 10 years are, to say the least, low.

Therefore, it should be expected that given these very constrained increases, the physician community will be back seeking additional payment increases as inflation and other cost increases cramp physician incomes.

(b) Consolidation of certain current law performance programs with new merit-based incentive payment system

The payment implications associated with current law incentive program penalties are sunset at the end of 2018, including the 2 percent penalty for failure to report physician quality reporting system quality measures and the 3 percent (increasing to 5 percent in 2019) penalty for failure to meet electronic health record meaningful use requirements. The money from penalties that would have been assessed will now remain in the physician fee schedule.

(c) Merit-Based Incentive Payment System

Payments to professionals will be adjusted based on performance in the MIPS starting in 2019. The MIPS will utilize four categories – quality, resource use, clinical practice improvement and meaningful EHR use.

The Secretary is to develop a methodology for assessing the total performance of each MIPS eligible professional according to the performance standards and the applicable measures and activities and determine a composite assessment (composite performance score) for each such professional for each performance period. As incentive, the Secretary will treat those eligible professionals who fail to report on an applicable measure or activity that is required as achieving the lowest potential score applicable.

In weighting the performance categories to determine the composite performance score, 30 percent of the initial score will be based on performance on the quality measure; outcome measures will be encouraged, as feasible. The weight for the resource use category also will be 30 percent initially, and the clinical practice category will receive a weight of 15 percent. The meaningful use of certified EHR technology will receive a 25 percent weight. These weights will change over time. For example, should the percentage of meaningful EHR users exceed 75 percent, the Secretary could reduce the weight for that category, but not below 15 percent, with the other weights increased.

The MIPS adjustment factor (positive or negative) will be 4 percent in 2019, 5 percent in 2020, 7 percent in 2021, and 9 percent in 2022 and in subsequent years; each professional's MIPS adjustment factor will be between 0 percent and +/– (adjustment factor) percent, reflecting his or her composite score between 0 and 100 on a sliding scale.

The estimated aggregate increase in payments for additional MIPS adjustments for exceptional performance is to be $500 million for each year from 2019 through 2024, subject to the restriction that the additional adjustment cannot exceed 10 percent for an eligible professional in a year. Thus, the aggregate increase in payments may be less than $500 million if this restriction is applied.

The Secretary will establish a process under which an MIPS-eligible

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professional could seek an informal review of the calculation of the individual's MIPS program incentive payment. The results of such a review will not be taken into account for purposes of determining the MIPS adjustment factor and payments with respect to a year (other than with respect to the calculation of the eligible professional's MIPS program incentive payment for such year).

There will be no administrative or judicial review of the following:

- The methodology used to determine the amount of the MIPS adjustment factors, including for exceptional performance,
- the establishment of the performance standards and the performance period,
- the identification of performance category measures and activities and information made public or posted on the Physician Compare Internet website of CMS, or
- the methodology developed and used to calculate performance scores and the calculation of such scores, including the weighting of measures and activities under such methodology.

COMMENT

The MIPS program is exceeding complex. The legislative language constitutes some 65 pages of the 262 page bill.

(d) Improving quality reporting for composite scores (refer to bill)

(e) Promoting alternative payment models

This bill also will establish pathways for implementing new payment models that might eventually replace the traditional fee-for-service-based payment.

The term APM will be defined to mean any of the following.

- a model under the Center for Medicaid and Medicare Innovation (other than a health care innovation award)
- a Medicare shared savings program accountable care organization
- a demonstration under Section 1866C of the Social Security Act
- a demonstration required by federal law

The term "eligible alternative payment entity" will mean an entity that (1) participates in an APM that requires participants to use certified EHR technology and provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in the MIPS program, and (2) bears financial risk for monetary losses under the APM that are in excess of a nominal amount, or is a medical home expanded under Section 1115(c) of the SSA.

A qualifying APM participant will mean the following.

- For 2019 and 2020, an eligible professional for whom the Secretary determines that at least 25 percent of payments for Medicare-covered professional services furnished by a professional during the most recent period for which data are available (which could be less than a year) were attributable to services furnished to Medicare beneficiaries through an entity eligible for participation in an eligible APM.
- For 2021 and 2022, an eligible professional who meets either of the following criteria.
    - Medicare payment threshold. At least 50 percent of Medicare

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payments for covered professional services during the most recent period for which data are available were furnished to Medicare beneficiaries through an eligible APM; or
    - Combination all-payer and Medicare payment threshold. Satisfies conditions on (1) the amount of Medicare payments made under qualified APMs and (2) payments made by other payers under arrangements in which quality measures, EHR technology, and other conditions apply.
- For 2023 and in subsequent years, an eligible professional as described above, but meeting a criteria of 75 percent for (a) and a similarly higher condition for (b).

A partial qualifying APM participant will be defined as an eligible professional who would fail to meet the appropriate revenue threshold to achieve a bonus payment under the qualified APM program but had achieved a lower threshold. The Secretary will select one of the following low-volume threshold measurements to determine the above exclusion for the performance period.

- A minimum number of Medicare beneficiaries who are treated by the eligible professional;
- a minimum number of items and services furnished by the professional; or
- a minimum amount of allowed charges billed by the professional.

In each case, the minimum number will be determined by the Secretary.

To advise and evaluate the development of alternative payment models, the bill establishes an ad hoc committee to be known as the Physician-Focused Payment Models Technical Advisory Committee.

In the case of covered professional services furnished by an eligible professional during a year that is in the period beginning with 2019 and ending with 2024 and for which the professional is a qualifying APM participant with respect to such year, in addition to the amount of payment that will otherwise be made for such covered professional services under this part for such year, there also shall be paid to such professional an amount equal to 5 percent of the estimated aggregate payment amounts for such covered professional services under this part for the preceding year. For purposes of the previous sentence, the payment amount for the preceding year may be an estimation for the full preceding year based on a period of such preceding year that is less than the full year.

The incentive payment will be made in a lump sum on an annual basis, as soon as practicable. These incentive payments will not be taken into account for purposes of determining actual expenditures under an alternative payment model or for purposes of determining or rebasing any benchmarks used under the APM.

(f) Collaborating with the physician, practitioner, and other stakeholder communities to improve resource use measurement

The bill requires the development of (1) care episode and patient condition groups and classification codes, (2) patient relationship categories and codes to facilitate the attribution of patients and episodes to physicians or applicable practitioners, (3) expanded claims to gather more information for resource use measurement, and (4) a methodology for resource use analysis.

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SEC. 102. Priorities and funding for measure development.

The Secretary is required to develop and publish a plan for the development of quality measures for use in the MIPS and in APMs, taking into account how measures from the private sector and integrated delivery systems could be utilized in the Medicare program. Not later than Jan. 1, 2016, the Secretary shall develop, and post on CMS' website, a draft plan for the development of quality measures. The plan, which must be finalized by May 1, 2016, will prioritize outcome measures, patient experience measures, care coordination measures, and measures of appropriate use of services, and consider gaps in quality measurement and applicability of measures across health care settings.

SEC. 103. Encouraging care management for individuals with chronic care needs.

In order to encourage the management of care for individuals with chronic conditions, at least one payment code for care management services will be established for professionals treating such individuals. In order to prevent duplicative payments, only one professional or group practice will receive payment for these services provided to an individual during a specified period. Payment for these codes will be budget-neutral within the physician fee schedule. Finally, payments for chronic care management will not require that an annual wellness visit or an initial preventive physician examination be furnished as a condition of payment.

SEC. 104. Empowering beneficiary choices through continued access to information on physicians' services.

On an annual basis (beginning with 2015), the Secretary shall make publicly available, in an easily understandable format, information with respect to physicians and, as appropriate, other eligible professionals on items and services furnished to Medicare beneficiaries under title XVIII of the Social Security Act. The Secretary is required to publish utilization and payment data for physicians and professionals, as appropriate. With emphasis on the services a professional most commonly furnishes, such information **will include the number of services furnished and submitted charges and payments** for such services and will be searchable by at least the eligible professional's name, location, and services furnished. The Secretary will integrate this information on the Physician Compare website starting in 2016.

SEC. 105. Expanding availability of Medicare data.

Consistent with relevant privacy and security laws, entities that currently receive Medicare data for public reporting purposes (qualified entities, "QEs") will be permitted, beginning July 1, 2016, to provide or sell non-public 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 APMs. Any data or analyses must be de-identified, though the provider accessing the data or analysis can receive identifiable information on the services furnished to his or her patient.

The Secretary is required to make data available, for a fee that covers the cost of preparing the data, to requesting qualified clinical data registries to support quality improvement and patient safety activities. Providers identified in public reports will have an opportunity to review and submit corrections.

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SEC. 106. Reducing administrative burden and other provisions.

Beginning not later than Feb. 1, 2016, the Secretary shall make publicly available through an appropriate publicly accessible website of the Department of Health & Human Services information on the number and characteristics of opt-out physicians and practitioners and shall update such information on such website not less often than annually.

As a consequence of a significant Federal investment in the implementation of health information technology through the Medicare and Medicaid EHR incentive programs, Congress declares it a national objective to achieve widespread exchange of health information through interoperable certified EHR technology nationwide by Dec. 31, 2018.

The development, recognition or implementation of any guideline or other standard under any Federal health care provision shall not be construed to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim.

The following items where previously reported when the House passed H.R. 2.

TITLE II — MEDICARE AND OTHER HEALTH EXTENDERS

Subtitle A: Medicare Extenders

SEC. 201. Extension of work Geographic Practice Cost Index floor.

Boosts payments for the work component of physician fees in areas where labor cost is lower than the national average. The provision extends the existing 1.0 floor on the "physician work" cost index until Jan. 1, 2018.

SEC. 202. Extension of therapy cap exceptions process.

The Medicare program currently limits ("caps") the amount of annual per-patient therapy expenditures. Congress created an exceptions process in 2006 that allows patients to exceed the cap based on medical necessity. This provision extends the therapy cap exceptions process through Dec. 31, 2017, and reforms the process of medical manual review to help support the integrity of the Medicare program.

SEC. 203. Extension of ambulance add-ons.

Extends the add-on payment for ground ambulance services, including in super-rural areas until Jan. 1, 2018.

SEC. 204. Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals.

This provision extends Medicare low-volume hospital payments. CMS has traditionally provided an additional payment to hospitals for the higher costs associated with operating a hospital with a low volume of discharges. This provision extends special add-on payments until Oct. 1, 2017.

SEC. 205. Extension of the Medicare-dependent hospital program.

MDHs are rural hospitals with no more than 100 beds that serve a high percentage of Medicare beneficiaries. MDHs are paid based on a blend of current prospective payment system rates and costs. This provision extends special payments to MDHs until October 1, 2017.

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SEC. 206. Extension for specialized Medicare Advantage plans for special needs individuals.

MA special needs plans are plans that may limit enrollment to certain populations, such as beneficiaries dually eligible for both Medicare and Medicaid or those suffering from certain chronic conditions. This provision extends authority for SNPs through Dec. 31, 2018.

SEC. 207. Extension of funding for quality measure endorsement, input and selection.

Funds the National Quality Forum's review, endorsement and maintenance of quality and resource use measures, as well as the NQF and Secretary regarding the pre-rulemaking process and measure dissemination and review activities. The provision provides funding for each of fiscal years 2016 and 2017.

SEC. 208. Extension of funding outreach and assistance for low-income programs.

Provides additional funding for outreach and education activities for Medicare beneficiaries through Sept. 30, 2017, including State Health Insurance Programs, Area Agencies on Aging, Aging and Disability Centers, and the National Center for Benefits Outreach and Enrollment.

SEC. 209. Transition and extension of Medicare reasonable cost contracts.

This provision will allow for a smooth transition policy for cost plans that no longer meet statutory requirements to operate under Medicare in their service area. This policy outlines rules and beneficiary protections for cost plans to transition to Medicare Advantage plans.

SEC. 210. Medicare home health rural add-on.

This policy extends a three percent add-on to payments made for home health services provided to patients in rural areas through Dec. 31, 2017.

Subtitle B: Other Health Extenders

SEC. 211. Permanent extension of the qualifying individual program.

This program assists low-income Medicare beneficiaries with incomes between 120 percent and 135 percent of poverty (currently between $14,124 - $15,890 a year) in covering the cost of their Medicare Part B premium. This provision makes the QI program permanent.

SEC. 212. Permanent extension of transitional medical assistance.

TMA allows low-income families to maintain their Medicaid coverage for up to one year as they transition from welfare to work. This provision extends TMA permanently.

TITLE III — THE CHILDREN'S HEALTH INSURANCE PROGRAM

CHIP covers more than 8 million children and pregnant women in families that earn income above Medicaid eligibility levels. While the CHIP program is authorized through 2019, no new funding is available after fiscal year 2015. This provision preserves and extends CHIP, funding the program fiscal year 2017.

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TITLE IV — OFFSETS

Subtitle A: Medicare Reforms

SEC. 401. Medigap.

Some Medigap plans on the market today provide first-dollar coverage for beneficiaries which means the plan pays the deductibles and co-payments so the beneficiary has no out-of-pocket costs. Beginning in 2020 for new enrollees only – this provision will limit coverage to costs above the amount of the Part B deductible (currently $147 a month).

SEC. 402. Income-related premium adjustment for Parts B and D.

The portion of the Medicare Part B and Part D premium that a beneficiary pays is based on the beneficiary's income. This policy increases the percentage that Medicare beneficiaries with modified adjusted gross incomes (MAGI).

If the modified adjusted gross income is:

- more than $85,000 but not more than $107,000, the applicable percentage is 35 percent
- more than $107,000 but not more than $133,500 , the applicable percentage is 50 percent
- more than $133,500 but not more than $160,000, the applicable percentage is 65 percent
- more than $160,000, the applicable percentage is 80 percent

The above amounts are for individuals. Double the amount for couples filing jointly.

Additionally, current law freezes the income thresholds through 2019; at which point the income thresholds will be indexed to inflation as if they had not been frozen.

This provision will also apply to Part D premiums, meaning that beneficiaries who have income above the set thresholds are assessed an income-related monthly adjustment amount in addition the base Part D monthly premium.

Subtitle B: Other Offsets

SEC. 411. Marketbasket reductions.

Medicare reimbursements for post-acute care providers will increase by no more than 1.0 percent in fiscal year 2018.

SEC. 412. Medicaid DSH.

Medicaid DSH payments provide additional payments to hospitals that serve a disproportionate number of low-income patients. Currently, reductions in state DSH allotments are scheduled to begin in fiscal year 2017. This policy will delay Medicaid DSH cuts until fiscal year 2018 and add another year of DSH cuts in 2025.

SEC. 413. Levy on Medicare providers for nonpayment of taxes.

Under current law, the Department of the Treasury may impose a levy of up to 30 percent against Medicare service providers with tax delinquencies. This provision will permit the Treasury to impose a levy of up to 100 percent on tax delinquent Medicare service providers.

SEC. 414. Adjustments to inpatient hospital payment rates.

The American Taxpayer Relief Act of 2012 required CMS to retrospectively recoup $11 billion in Medicare overpayments to hospitals. Hospitals are scheduled to receive a one-time 3.2 percentage points payment increase in fiscal year 2018. This section provides for the anticipated hospital payment increase of 3.2 percentage points to be phased

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in at 0.5 percentage points per year throughout six years beginning in fiscal year 2018.

TITLE V — MISCELLANEOUS

SEC. 521. Delay of two-midnights.

Per CMS regulation, the two-midnight policy requires a patient stay of two-midnights in a hospital to qualify for inpatient status in most instances; stays less than that will be paid as an outpatient visit. This provision allows CMS to continue use of the Medicare Administrative Contractor "probe and educate" program to assess provider understanding and compliance with the "two-midnight rule," on a pre-payment basis, through Sept. 30, 2015.

SEC. 523. Payment for global surgical packages.

This provision reverses the CMS decision to eliminate the bundled payment for surgical services that span a 10- and 90-day period. It requires CMS to periodically collect information on the services that surgeons furnish during these global periods beginning not later than 2017 and use that information to ensure that the bundled payment amounts for surgical services are accurate. The Secretary has the authority to delay a portion of payment for services with a 10 and 90-day global period to incentivize reporting of information. The Secretary can cease the collection of information from surgeons once the needed information can be obtained through other mechanisms, such as clinical data requires and electronic medical records.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting