Issue Brief

FEDERAL ISSUE BRIEF • MARCH 24, 2015

KEY POINTS

The legislation:

- permanently replaces Medicare's sustainable growth rate
- delays Medicare DSH cuts until fiscal year 2018
- extends therapy cap exception process
- extends Medicare-dependent hospital program to Oct. 1, 2017
- preserves and extends Medicaid CHIP program through 2017

Bipartisan Committee Leaders Post SGR Package to be Considered This Week

Today, members of the House Ways and Means and Energy and Commerce Committees have today introduced H.R. 2, the *Medicare Access and CHIP Reauthorization Act*, to permanently replace Medicare's Sustainable Growth Rate. The agreement builds upon H.R. 1470, the SGR Repeal and Medicare Provider Payment Modernization Act. The bipartisan committee leaders on Friday released a working framework of these additional proposals, some of which will help to offset the costs of this package.

Read the complete bill online here. Read it section-by-section online here.

Below is a brief section-by-section summary of this bills major "extenders" and "pay-fors."

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 until Jan. 1, 2018 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. The Centers for Medicare & Medicaid Services 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.

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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 Oct. 1, 2017.

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 would 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 MA plans.

Sec. 210. Medicare home health rural add-on.
This policy extends a 3 percent add-on to payments made for home health services provided to patients in rural areas through Jan. 1, 2018.

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 copayments so the beneficiary has no out-of-pocket costs. Beginning in 2020 for new enrollees only — this provision would 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 would increase the percentage that Medicare beneficiaries with modified adjusted gross income between $133,501 and $160,000 ($267,001 -$320,000 for a couple) from 50 percent to 65 percent. Beneficiaries who have incomes at $160,001 and above ($320,001 and above for couples) would pay 80 percent.

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

This provision would 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. Market basket reductions.
Medicare reimbursements for post-acute care providers will increase by no more than 1 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 would 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 FY 2018. This section provides for the anticipated hospital payment increase of 3.2 percentage points to be phased in at 0.5 percentage points per year over six years beginning in FY 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.

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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 no 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.

COMMENT

Congressional actions to fix the SGR continue. But, it is still a ways from enactment. The Senate is still in process and it may or may not agree to what the House has achieved so far. There are just a few more days until the current doc fix expires — March 31.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting