THE REPUBLICAN STUDY COMMITTEE
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Legislative Bulletin……December 12, 2013

Contents:

Pathway to SGR Reform Act
(Amendment #2 to the Senate Amendment to H.J. Res. 59)

Pathway to SGR Reform Act

Order of Business: The bill is expected to be considered on Thursday, December 12, 2013, under what is expected to be a closed rule.

Summary: **Title I: Medicare Extenders**

Physician Payment Update:

- There will be a three month physician payment update which will last through March 31, 2014, where the update to the single conversion factor will be .5 percent. This provision prevents a 20.1 percent cut in reimbursements to physicians treating Medicare patients. The Sustainable Growth Rate is the statuary method which determines the annual updates to the Medicare physician fee schedule. Beginning in 2002, the actual expenditures began to exceed the allowed targets. In order to avoid a decrease in reimbursements, Congress has enacted a series of laws to override the system. In the findings, it is noted that Congress acknowledges the need to reform the physician payment system, commonly known as the SGR, but that will happen next year.

Extension of Work GPCI (Geographic Price Cost Indices) Floor:

- Extends the floor for the work geographic index under current law until April 1, 2014. GPCIs are adjustments that are applied to account for geographic variations in the costs of practicing medicine in different areas of the country. In 2003, Congress set in place a floor that suspends the GPCI at 1.0 for those localities with resource costs that are below the national average.

Extensions of Therapy Cap Exceptions Process

- Under current law, Medicare Part B outpatient physical and speech language therapy services have a combined cap of $1,880 per year. This provision extends the Medicare therapy caps exceptions process until March 31, 2014.

Extension of Ambulance Add-Ons

- Provides an extension through April 1, 2014, to the temporary increase for ground ambulance services: two percent for urban ground ambulance services; three percent for rural ground ambulance services; and an increase to the base rate for ambulance trips originating in qualified "super rural" areas as calculated by the Secretary (currently 22.6 percent). Medicare pays for ambulance services using a fee schedule that is similar in structure to the physician fee schedule. The fee schedule pays ambulance suppliers (those that are freestanding, non–institution based) and ambulance providers (those that are based at an institution, such as a hospital) a fixed payment that reflects the intensity of the ambulance service provided and a mileage rate that depends on the distance a patient is transported.

Medicare Inpatient Hospital Payment Adjustment for Low Volume Hospitals

- Qualifying low-volume hospitals receive add-on payments based on the number of Medicare discharges. To qualify as a low-volume the hospital must be more than 15 road miles from the nearest hospital and have fewer than 1600 Medicare discharges. This provision extends through April 1, 2014.

Medicare Dependent Hospital (MDH) Program

- The Medicare Dependent Hospital (MDH) program provides enhanced reimbursement to support rural health infrastructure and to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. A hospital qualifies for the MDH program if it is located in a rural area, has no more than 100 beds, is not classified as a Sole Community Hospital, and has at least 60 percent of inpatient days or discharges covered by Medicare. This program is extended through April 1, 2014.

1 Year Extension of Authorization for Special Needs Plans

- Extends the authority of specialize plans to target enrollment to certain populations through 2016.

1 Year Extension of Medicare Reasonable Cost Contracts

- This provision allows Medicare cost plans to continue in an area where at least two Medicare Advantage coordinated care plans operate. Cost plans are private plans that operate in much the same ways as a Medicare Advantage plan. However, plans with cost contracts provide Medicare services on a reasonable per person amount based on the actual costs of services. This provision would extend these plans until January 1, 2015.

Extension of Existing Funding for Contract with Consensus-Based Entity

- Under the Medicare Improvement for Patients and Providers Act of 2008, HHS entered into a five year contract with a consensus-based entity for certain activities relating to health care performance. This section was to expire in 2013; however, this section allows amounts transferred to remain available until expended.

Extension of Funding Outreach and Assistance for Low-Income Programs

- Extends funding for the State Health Insurance Program, the Area Agencies on Aging and The National Center for Benefits and Outreach Enrollment through April 1, 2014.

Title II: Other Health Provisions

Extension of the Qualifying Individual (QI) Program

- Under current law, states pay the Medicare Part B premiums for a mandatory group of low-income Medicare beneficiaries called Qualifying Individuals, or QI. States receive an annual allocation to permit Medicaid to pay Medicare Part B premiums for a limited number of Qualifying Individuals with income above 120% and less than 135% of the Federal Poverty Level (FPL.) This extends the federal reimbursement program to the states through March 2014.
- Extends funding of $200,000,000 from January 1, 2014 and March 31, 2014.

Temporary Extension of Transitional Medical Assistance (TMA)

- TMA was created to provide health coverage to families transitioning to the workforce. TMA helps low-income families with children transition to jobs by allowing them to keep their Medicaid coverage for a limited period of time after a family member receives earnings that would make them ineligible for regular Medicaid. This program is extended through March 31, 2014.

Extension of Funding for Family-to-Family Health Information Centers

- The Family-to-Family Health Information Center (F2F HIC) program funds grants to help aid families of children with special health care needs and ensure they are able to participate in decision-making at all levels and be satisfied with the services they receive. This provision will help families navigate the health care system so that their children can get the care and benefits they need through Medicaid, SCHIP, SSI, early intervention services, private insurance and other programs. In addition, F2F HICs provide leadership and training for health care providers and policymakers to promote family-centered "medical home" for every child. This program is extended through April 1, 2014.

Delay of Reductions in DSH Allotments

- Under current law, Medicaid Disproportionate Share Hospital (DSH) allotments would be reduced annually from FY14-FY20. These allotments are part of the Medicaid payment program for hospitals which serve a disproportionate share of low income patients, and therefore, may have more uncompensated care costs. This bill pushes back the reduction of allotments from beginning in 2014 to 2016. In addition to striking reductions in 2014 and 2015, it changes the aggregate reductions for 2016 from $600,000,000 to $1,200,000,000. For FY23 the DSH allotment for a state will be equal to the DSH allotment for FY22 increased by the percentage change in consumer price index for all urban consumers for FY22. The effective date for this provision is October 1, 2013.

Realignment of the Medical Sequester for Fiscal Year 2023

- This provision realigns the Medicare sequester in 2023 without increasing the overall effect of the sequester on Medicare providers.

Payment for Inpatient Services in Long-term Care Hospitals (LTCHS)

- This section establishes criteria for the application of site neutral payment. Site neutral payments are meant to equalize payment rates between hospitals and free standing physician offices. Beginning on October 1, 2015, payment to a long-term care hospital for inpatient hospital services (with certain exceptions) shall be made at the applicable site neutral payment rate. For discharges in cost reporting in FY 2016 and FY 2017 a blended payment will be used which is comprised of half of the site neutral payment rate and half the payment rate that would otherwise be applicable as determined by the Secretary. For discharges in FY 2018 and beyond, a defined site neutral payment rate will be employed. The Medicare Payment Assessment Commission (MEDPAC) will submit a report to Congress which examines the affect of the changes and recommendations it deems appropriate.
- Included in Section 206 are the extensions of certain long-term care payment rules and moratorium on the establishment of certain hospitals and facilities including:
    - Payment for hospitals within hospitals – Extended for nine years
    - 25 percent patient threshold payment adjustment; making the grandfathered exemption for long-term care hospitals permanent – Delayed for 3 years
    - Extension of the moratorium on the establishment of an increase in beds for LTCHS

To read a summary prepared by the Energy and Commerce Committee and Ways and Means, click here.

Additional Information: H.R. 8, American Taxpayer Relief Act, which passed the house with a vote of 256-171 in its final version on January 1, 2013, contains many of the same Medicare extenders including: physician payment update, work geographic adjustment, payment for outpatient therapy services, ambulance add-on payments, extension of Medicare inpatient hospital adjustment for low-volume hospitals, extension of the Medicare dependant program, extension of reasonable cost contracts, extension of funding outreach and assistance for low-income program, extension of the QI program, extension of the transitional medical assistance, and the extension of family-to-family health information centers.

Administration Position: No Statement of Administration Position on this amendment was available at this time. To read the Administration's position of the Bipartisan Budget Act of 2013, click here.

Cost to Taxpayers: CBO estimates that enacting this bill would result in a savings in direct spending outlays of $300 million.

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