THE REPUBLICAN STUDY COMMITTEE
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H.R. 2—Medicare Access and CHIP Reauthorization Act of 2015 (Burgess, R-TX)

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FLOOR SCHEDULE: **MARCH 26, 2015 UNDER CLOSED RULE THAT PROVIDES ONE HOUR OF DEBATE.**

TOPLINE SUMMARY: This bill would repeal the current Sustainable Growth Rate (SGR) payment method and replace it with a new incentive payment program that would focus on providing value and quality, and encourage providers to participate in alternative payment models (APM). This bill would also extend current law Medicare provisions that are set to expire. In addition, the bill would make structural changes to Medicare, including reforms to Medigap and increased means testing for Parts B and D. Finally, this bill would extend the State Children's Health Insurance Program (CHIP) for two years.

COST: Over the 2015–2025 period, the Congressional Budget Office (CBO) estimates enacting H.R. 2 would increase both direct spending (by about $145 billion) and revenues (by about $4 billion), resulting in a $141 billion increase in the deficit.

According to CBO, longer term projections are more difficult to measure due to uncertainty regarding the future of healthcare delivery and financing. With this caveat, CBO estimates that in the decade after 2025, compared to a baseline that assumes freezing Medicare's payment rate for physicians, H.R. 2 would result in either a net cost or net savings, with the middle outcome resulting in a small net savings.

CONSERVATIVE CONCERNS:

ARGUMENTS IN OPPOSITION— Some have raised concerns that H.R. 2 would not offset costs over the next ten years, or over the longer term. Others have raised concerns that this proposal is unlikely to reduce long-term Medicare spending. Although this bill does contain structural reforms, some argue that the bill's reforms do not go far enough, by omitting certain conservative proposals such as balanced billing and private contracting in Medicare. Finally, some conservatives are concerned about the extension of CHIP at Affordable Care Act (ACA)-enhanced levels for an additional two years.

ARGUMENTS IN SUPPORT— Supporters of H.R. 2 have argued that the cost of SGR repeal should be scored against a baseline that reflects Congress's tendency to "patch" SGR cuts before they take effect. Specifically, supporters argue that by scoring SGR repeal against a baseline that assumes that future SGR cuts will go into effect, SGR repeal is charged with a significantly higher "cost." The cost of repeal under the SGR-will-go-into-effect baseline scenario is higher as compared to a more realistic baseline that assumes Congress is likely to patch future SGR cuts. Supporters argue that under a more realistic baseline, the actual cost of SGR should be zero since the SGR has never been put into place. In addition, many supporters view the structural reforms to Medicare as a first step to achieving premium support, as well as achieving savings over the next 20 years without raising taxes. Finally, ending the "must-pass" nature of the yearly SGR patch legislation would prevent the opportunity for questionable legislation to be incorporated in a must-pass SGR bill.

- **Expand the Size and Scope of the Federal Government?** Yes, this bill makes several temporary programs permanent as well as increased authorities for the Secretary of Health and Human Services. It is important to note the secretary already has vast authority under Medicare.
- **Encroach into State or Local Authority?** No.
- **Delegate Any Legislative Authority to the Executive Branch?** No.
- **Contain Earmarks/Limited Tax Benefits/Limited Tariff Benefits?** No.

DETAILED SUMMARY AND ANALYSIS: The Sustainable Growth Rate (SGR) is the statutory method for determining the annual updates to the Medicare physician fee schedule (MPFS). The SGR system was established due to the concern that the Medicare fee schedule would not adequately constrain overall increases in spending for physicians' services. In SGR's first few years, the actual expenditures did not exceed the targets, and the updates to the physician fee schedule were close to the Medicare economic index. Beginning in 2002, the actual expenditure exceeded allowed targets, and the discrepancy has grown with each year. However, with the exception of 2002, Congress has acted 17 times to override the reductions. These "patches" have varied from as short as a month to as long as two years and have generally kept payments at current levels (0 percent update) or have provided for modest updates (.2 to 2.2 percent).

It is estimated $170 billion has been spent on patches which is more than the $141.9 billion CBO estimates it would cost to repeal the SGR. In addition, CBO estimates enacting H.R. 2 would cost $0.9 billion less over the 2015–2025 period than freezing payment rates for physicians' services.

However, some believe temporary patches allow for incremental changes to health care due to the must-pass nature of the bill. Although that is true, it is also important to remember democratic priorities – including Obamacare created programs – have been extended years past their original authorization in order to garner support for passage. Unless legislative action is taken, the current patch will expire on March 31, 2015 and providers could expect a 21 percent decrease in reimbursement levels.

Title I

Section 101: Repealing the Sustainable Growth Rate (SGR) and Improving Medicare Payment for Physicians' Services

- This bill would repeal the current SGR payment structure. January 1, 2015 to June 30, 2015, the update to the single conversion factor would be 0.0 percent, while July 1, 2015 to December 31, 2015, the update would be 0.5 percent. For each year beginning in 2016 through 2019, there would be a 0.5 percent update, and for each year beginning in 2020 through 2025 there would be a 0.0 percent update.
- Beginning in 2026, there would be two separate conversion factors for determining physician reimbursement: (1) services furnished by a qualifying alternative payment models (APM) participant; and (2) for other items furnished by non-qualifying APM participants. The qualifying APM conversion factor would be 1.0 percent in 2026 and each subsequent year, while the conversion factor for non-qualifying APMs would be 0.5 percent.
- This bill would consolidate three current law programs which currently affect provider reimbursement, and replace with a merit-based incentive payment system (MIPS).
    - The three consolidated programs would be: (1) electronic health record (EHR) meaningful use incentive program; (2) physician quality reporting; and (3) value-based payments.
- The secretary of Health and Human Services (HHS) would establish the eligible professional MIPS. Under this system the secretary would: (1) develop a methodology for accessing the total performance of each MIPS-eligible professional according to performance standards; (2) provide a composite score based on that methodology. The composite score would be determined by certain performance categories such as quality, resource use, clinical practice improvement activities, and meaningful use of certified EHR

technology; and (3) use that composite score to determine and apply a MIPS adjustment factor to the professional for the year.

- Under the MIPS, the secretary would establish an annual list of quality measures from which eligible professional may choose for the purposes of an assessment for each performance period.
    - The quality measures, or any changes to the quality measures, would be published in the Federal Register more than one year before the first day of the performance period.
    - Eligible professional organizations, such as nationally recognized specialty boards of certification, and stakeholders would submit quality measures as well as edit previously included quality measures.
    - Prior to a new quality measure being included on the final list of measures, the secretary would submit the measure and the method of development to applicable peer-reviewed journals.
- Under the MIPS, the secretary would establish performance standards with respect to the quality measures for a performance period. These performance standards would take into consideration: (1) historical performance standards; (2) improvement; and (3) the opportunity for continued improvement.
- The secretary would develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards for applicable measures and activities. Using this methodology, the secretary would provide a composite assessment score using a scale of 0 to 100 for each professional for each performance period.
- The secretary would specify a MIPS adjustment factor for each eligible processional which would be determined by comparing the composite score to the performance threshold. The performance threshold would be the mean or median, as determined by the secretary, of the composite scores for all the MIPS eligible professionals.
    - Composite scores at or above the performance threshold would receive zero or positive payment adjustment factor for the year.
    - Higher composite scores would receive a higher adjustment factor.
    - Composite scores below the performance threshold would receive a negative payment adjustment, with those having the lowest composite score receiving the lower adjustment factor.
- 30 days prior to the end of the year, the secretary would release the MIPS adjustment score for eligible professionals. The adjustment factors would only apply to the year involved, and the secretary could not take the previous year's adjustment factor into consideration for the following year.
    - The eligible professional could make and submit corrections
    - Beginning on July 1, 2017, the secretary would be required to provide timely (such as quarterly) confidential feedback to eligible professionals.
- The secretary would make available on the Physician Compare website the composite score for each eligible professional.
- For small practices and those in health professional shortage areas, the secretary would provide for $20,000,000 for each fiscal year 2016-2020 for guidance and technical assistance to MIPS eligible professionals.
- This bill would encourage participation in alternative payment models (APM).
    - From 2019-2024 qualifying APM participants would receive a 5 percent bonus each year.
    - Two tracks would be available for professionals to qualify for the bonus. The first option would be based on receiving a significant percent of Medicare revenue through an APM; the second would be based on receiving a significant percent of APM revenue combined from Medicare and other payers.
    - This bill would encourage the development and testing of new APM, such as those focusing primarily on physician's services furnished by non-primary care physicians or small physician practices.

- A Technical Advisory Committee (TAC) would be established to consider physician-focused APM proposals. The secretary would review and respond to the TAC's recommended APM proposals.
- CBO estimates that those changes to how Medicare sets payment rates for physicians' services would increase direct spending, relative to the current-law baseline, by about $175 billion over the 2015–2025 period.

Section 102: Priorities and Funding for Measure Development

- No later than January 1, 2016, the secretary would develop and post online a draft plan for the development of quality measures for the use in MIPS and APMs, which account for how clinical best practices and practice guideline should be used in the development of quality measures, and how measures used by private payers could be utilized in Medicare.
- The secretary would consider gaps in quality measure programs and whether the measures are applicable across health care settings. Priority would be given to measures such as: (1) outcome measures; (2) patient experience measures; (3) care coordination measures; and (4) measure of appropriate use of services, including over time.
- The secretary would accept stakeholder input through March 1, 2016, and post the final measure development plans no later than May 1, 2016.
- The secretary would submit an annual report on the progress made in developing quality measures. The report would include a description of the total number of quality measures developed during the previous year and a timeline for new quality measures being developed.
- This section would be funded for each of FY 2015-2019 at $15,000,000 and remain available through FY 2022.

Section 103: Encouraging Care Management for Individuals with Chronic Care Needs

- This section would establish at least one payment code for care management services for those with chronic care needs.
- To prevent duplicative payments, only one professional or group practice will receive payment for these services provided to an individual during a specified period.
- Payments for chronic care management would not require that an annual wellness visit or an initial preventive physician examination be furnished as a condition of payment.

Section 104: Empowering Beneficiary Choice through Continued Access to Information on Physicians' Services

- Beginning in 2015, the secretary would make publically available physician information as it relates to items and services to Medicare beneficiaries, as appropriate.
- The information would include: (1) the number of services furnished by the physician; and (2) information on submitted charges and payments.
- Beginning in 2015, the secretary would integrate this information on the Physician Compare website.

Section 105: Expanding Availability of Medicare Data

- Entities currently receiving Medicare data for public reporting purposes will be permitted to provide non-public analyses and claims data to physicians, other professionals, providers, medical societies, and hospital associations.
- To ensure privacy, qualified entities must have a data use agreement with providers and entities to which they provide data, and be subject to an assessment for breach of such agreement.
- Any qualified entity that provides or sells an analysis or data would annually submit a report to the secretary that includes a summary of the analyses provides and a description of the topics and purposes of such analyses.

Section 106: Reducing Administrative Burden and Other Provisions

- This section would allow professionals who opt-out of Medicare to automatically renew at the of each two-year cycle.
- It would require EHR to be interoperable by 2018 and would prevent the blocking of sharing of information.
- This section would require a study by the GAO on the use of federal teleheath programs and on remote patient monitoring services. The study would include issues that facilitate or inhibit the use of telehealth under Medicare.
- This section would include certain rules of construction to clarify that federal health care guidelines or standards do not establish the standard of care or duty of care owed by a health care provider to a patient in medicinal malpractice claims under common or state law.

Title II: Medicare and Other Health Extenders

Section 201: Extension of Work GPCI (Geographic Price Cost Indices) Floor

- The section would extend the floor for the work geographic index under current law until January 1, 2018. 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.

Section 202: Extension of Therapy Cap Exceptions Process

- Under current law, Medicare Part B outpatient physical and speech language (PT/SLP) therapy services have a combined cap of $1,920 per year. This provision would extend the Medicare therapy caps exceptions process until December 31, 2017.
- This section would implement a new process for the manual medical review process that applies to patients who meet or exceed $3,700 in therapy expenditures for PT/SLP and a separate $3,700 in occupational therapy expenditures.

Section 203: Extension of Ambulance Add-Ons

- This section would provide an extension through January 1, 2018, to the temporary payment increase for ground ambulance services and super rural ground ambulance services.

Section 204: Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low Volume Hospitals

- Qualifying low-volume hospitals receive add-on payments based on the number of Medicare discharges. Low-volume hospitals must be more than 15 road miles from the nearest hospital and have fewer than 1600 Medicare discharges. This section would extend this provision through October 1, 2017.

Section 205: Extension of the 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 would be extended through October 1, 2017.

Section 206: Extension for Specialized Medicare Advantage Plans for Special Needs Individuals

- Medicare Advantage coordinated care plans were specifically designed to provide targeted care to individuals with special needs. For example, these plans are targeted to: (1) individuals with chronic conditions; (2) those who live in an institution; or (3) are duel eligible beneficiaries. This section would extend the authority of these plans through December 31, 2018.

Section 207: Extension of Funding for Quality Measure Endorsement, Input, and Selection

- This section would provide $30,000,000 for each FY 2015-2017 for the National Quality Form's (NQF) 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.

Section 208: Extension of Funding Outreach and Assistance for Low-Income Programs

- This section would extend funding for the State Health Insurance Program, the Area Agencies on Aging and the National Center for Benefits and Outreach Enrollment through FY2017.

Section 209: Extension and Transition of Reasonable Cost Reimbursement Contracts

- This section would address Medicare plans that are no longer offered due to failing to meet statutory requirements to operate under Medicare in their service area. The section would also outline rules and beneficiary protections for cost plans to transition to Medicare Advantage plans

Section 210: Medicare Home Health Rural Add-On

- This section would extend the three percent add-on to payments made for home health services in rural areas through January 1, 2018.

Section 211: Permanent 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 (QI). States receive an annual allocation to allow Medicaid to pay Medicare Part B premiums for a limited number of Qualifying Individuals with incomes above 120 percent and less than 135 percent of the Federal Poverty Level (FPL) which is currently $14,124-$15,890 a year.
- The section would make the QI program permanent.
- CBO estimates that enacting this provision would increase direct spending by $14.6 billion over the 2015–2025 period.

Section 212: Permanent Extension of Transition 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 up to one year after a family member receives earnings that would make them ineligible for regular Medicaid.
- This section would make the TMA program permanent.
- CBO and JCT's estimate the increased costs for Medicaid would be more than offset by a decline in the net costs of federal subsidies provided for insurance offered through exchanges and employment-based insurance. On net, the provision is estimated to reduce the deficit by $2.8 billion over the 2015–2025 period.

Section 213: Extension of Special Diabetes Program for Type I Diabetes and for Indians

- Congress established the Special Diabetes Program for Indians (SDPI) in 1997 as part of the Balanced Budget Act to address the growing epidemic of diabetes in American Indian and Alaska Native (AI/AN) communities. The Special Diabetes Program for Type 1 Diabetes (SDP) was established at the same time to address the opportunities in type 1 diabetes research.
- These two programs would be extended through FY 2017.

Section 214: Extension of Abstinence Education

- This section would extend programs for abstinence education which would teach the social, psychological, and health gains to abstinence.
- This program would be funded at $75,000,000 for each of FY 2016-2017.

- The extension of abstinence education program is a priority of Chairman Flores.

Section 215: Extension of Personal Responsibility Education Program (PREP)

- As part of the Affordable Care Act (ACA), Congress authorized the Personal Responsibility Education Program (PREP) which would provide federal funding for programs that teach about abstinence and contraception for the prevention of pregnancy and sexually transmitted infections.
- This program would be extended through FY 2017.

Section 216: Extension of Funding for Family-to-Family Health Information Centers

- The Family-to-Family Health Information Center program funds grants to assure that families of children with special healthcare needs are able to participate in decision making at all levels and be satisfied with the services they receive.
- This program would be funded at $5,000,000 for each of FY 2015-2017.

Section 217: Extension of Health Workforce Demonstration Project for Low-Income Individuals

- The ACA created demonstration projects that would provide education and training to Temporary Assistance for Needy Families (TANF) recipients and other low-income individuals for occupations in the healthcare field.
- This program would be extended through FY 2017.

Section 218: Extension of Maternal, Infant, and Early Childhood Home Visiting Programs

- The ACA created the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.
- This program facilitates collaboration at the federal, state, and community levels to improve health outcomes for at-risk children through evidence-based home visiting programs.
- This program would be funded at $400,000,000 for each fiscal year through 2017.

Section 219: Tennessee DSH Allotment for Fiscal Years 2015-2025

- Disproportionate Share Hospitals (DSH) serve a significantly disproportionate number of low-income patients and receive payments from the Centers for Medicaid and Medicare Services to cover the costs of providing care to uninsured patients. Hawaii and Tennessee have had different DSH arrangements provided through multiple previous laws due to unique past circumstances.
- This section would allot Tennessee $53,100,000 for each fiscal year 2015-2025 for their DSH allotment.

Section 220: Delay in Effective Date for Medicaid Amendments Relating to Beneficiary Liability Settlements

- In December 2013, the Bipartisan Budget Act of 2013 overturned a circuit court case addressing Medicaid estate recovery, allowing a state to recover medical expense claims from any portion of a Medicaid beneficiary settlement, potentially allowing a state to commandeer money set aside for a beneficiary's future care or living expenses. This provision had been previously delayed until October 1, 2016.
- This section would further delay the effective date until October 1, 2017.

Section 222: Extension of Funding for Community Health Centers, the National Health Service Corps, and Teaching Health Centers

- The Community Health Center Program provides comprehensive primary healthcare services to medically underserved areas and vulnerable populations. These mandatory funds would supplement annual spending for the CHC program.
- The National Health Service Corps is a part of HHS that is comprised of health professional that provide primary health care services to underserved communities. In exchange for service in the National Health Service Corps, the providers are given loan repayment or scholarships throughout their medical education.

- This section would extend funding for community health centers and the National Health Service Corps through FY 2017.
- The teaching Health Center Graduate Medical Education Payment Program was created by the ACA to increase the number of primary care residents and dentists trained in community-based settings. This funding would pay for direct and indirect medical expenses for training residents in new or expanding community-based primary care residency programs. Clinical training sites include federally qualified health centers (FQHCs) and FQHC Look-Alikes, community mental health centers, rural health clinics, Indian Health Service or Tribal clinics, and Title X clinics (family planning clinics).
- This program would be extended through FY 2027.

Title III – CHIP

Enacted in 1997, the State Children's Health Insurance Program (CHIP) is a means-tested program that provides health coverage to low-income children and pregnant women with an annual income above Medicaid eligibility. This program is jointly financed by the state and the federal government; however, states are given flexibility in the design of their CHIP program. States may design their CHIP program in three ways: a CHIP Medicaid expansion, a separate CHIP program, or a combination approach where the state operates a CHIP Medicaid expansion and one or more separate CHIP programs concurrently. In FY 2013, 8.4 million individuals were enrolled in CHIP and expenditures totaled $13.2 billion. The ACA authorized CHIP through 2019, but only provided funding through the end of FY 2015. In addition, the ACA increased each state's enhanced federal match rate by 23-percentage points, not to exceed a total match rate of 100 percent, between FY 2016 and FY 2019. If the CHIP program is not funded, it is estimated 1.1 million children would become uninsured, 1.4 million would obtain a premium tax credit for coverage in the ACA exchanges, and 1.2 million would obtain coverage through a parent's employer.

Section 301: 2 Year Extension of the Children's Health Insurance Program

- The CHIP program would be funded for FY 2016-2017 at the following levels:
  - FY 2016: $19,300,000,000;
  - First half of FY 2017: $2,850,000,000 for October 1, 2016- March 31, 2017;
  - Second half of FY 2017: $2,850,000,000 for April 1, 2017- September 30, 2017.
- In addition to the funding above, $14,700,000 would be appropriated to accompany the allotment made from October 1, 2016 - March 31, 2017.
- This section would also extend the Child Enrollment Contingency Fund through FY 2017. This fund is financed through a separate appropriation and is set at 20 percent of the national allotment amount each year. The contingency fund would provide states with a source of supplemental CHIP funding in the event they experience a shortfall (assuming they have met a specified target enrollment level). States that use the contingency fund will have the next year's allotment increased by the amount accessed from the contingency fund.
- CBO and JCT estimate that enacting this provision would increase outlays by $7.0 billion and revenues by $1.4 billion, for a net cost of $5.6 billion over the 2015–2025 period relative to CBO's baseline.

Section 303: Extension of Express Lane Eligibility

- The Express Lane Option was created under the Children's Health Insurance Program Reauthorization Act of 2009 and was created to provide states with new avenues to ensure that children eligible for Medicaid or CHIP have a fast and simplified process for having their eligibility determined or renewed.
- This section would extend the program through FY 2017, and be funded at $40,000,000 for each fiscal year.

Section 304: Extension of Certain Programs and Demonstration Projects

- The ACA created the Childhood Obesity Research Demonstration Project which aims to improve children's nutrition and physical activity behaviors in the places where they live, learn, and play.
- This program would be extended through 2017.
- This section would also extend the Pediatric Quality Measures Program through FY 2017. The purpose of this program is to improve and strengthen the initial core set of children's health quality measures.

Section 305: Report of Inspector General of HHS on use of Express Lane Option under Medicaid and CHIP

- This section would require the Inspector General of the Department of Health and Human Services to submit a report that provides data on the number of individuals enrolled in Medicaid and CHIP through the Express Lane option.

Title IV – Offsets

Section 401: Limitation on Certain Medigap Policies for Newly Eligible Medicare Beneficiaries

Due to the fragmented nature of traditional Medicare fee-for-service (FFS) program, many beneficiaries have some form of additional health care coverage to help pay for out-of-pocket expenditures. Medigap policies are a set of standardized insurance plans sold by private insurance companies to cover certain costs not paid for by Medicare FFS. In 2012, it was estimated about 66 percent of beneficiaries with Medigap were enrolled in plans that had "first-dollar coverage"—meaning that the plans covered all of the deductibles and coinsurance not covered by Medicare FFS. According to the Government Accountability Office (GAO), beneficiaries with Medigap had estimated average spending about 94 percent higher than beneficiaries with Medicare FFS-only. The RSC budget included Medigap reforms that would prohibit new plans from covering the first $650 for Part A and Part B services.

- Beginning on January 1, 2020, a Medicare supplement policy that provides coverage of the Part B deductible would not be allowed to be sold or issued to a newly eligible Medicare beneficiary.
    - A newly eligible beneficiary is one who has turned 65 before January 1, 2020.
    - For 2015, the Part B deductible is $147 per year.

Section 402: Income Related Premium Adjustment for Parts B and D

- Under current law, the Medicare Part B and Part D premium that a beneficiary pays is based on their income. This section would increase the percentage that Medicare beneficiaries with modified adjusted gross income (MAGI) between $133,501 and $160,000 ($267,001-$320,000 for a couple) from 50 percent to 65 percent. Beneficiaries that have incomes at $160,001 and above ($320,001 and above for a couple) would pay 80 percent. Below is a table which outlines the cost-sharing percentage for each income group for Medicare Part B and Part D:

Modified Adjusted Gross Income	Applicable Percentage of Premium
More than $85,000, but less than $107,000	35 percent
More than $107,000, but less than $133,500	50 percent
More than $133,500, but less than $160,000	65 percent
More than $160,000	80 percent

- CBO estimates that these changes would increase offsetting receipts, and thereby reduce direct spending, by $34.3 billion over the 2018–2025 period.

Section 411: Medicare Payment Updates for Post-Acute Providers

- In 2018, the post-acute provider market basket percentage update would increase by no more than 1.0 percent.

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

Section 412: Delay of Reduction to Medicaid DSH Allotments

- Under current law, Medicaid Disproportionate Share Hospital (DSH) allotments would be reduced annually beginning in 2017. These allotments are part of the Medicaid payment program for hospitals, which serve a disproportionate share of low income patients, and may have higher uncompensated care costs. This bill would delay the reductions until 2018 and extend them through 2025 by the following amounts:
  - $2,000,000,000 for FY 2018;
  - $3,000,000,000 for FY 2019;
  - $5,000,000,000 for FY 2021;
  - $6,000,000,000 for FY 2022;
  - $7,000,000,000 for FY 2023;
  - $8,000,000,000 for FY 2024; and
  - $8,000,000,000 for FY 2025.
- CBO estimates that this provision would reduce direct spending by $4.1 billion over the 2016–2025 period.

Section 413: Levy on Delinquent Providers

- This section would allow the Department of the Treasury to impose a levy of up to 100 percent on tax delinquent Medicare providers. Under current law, the Treasury can only impose a levy of 30 percent.

Section 414: Adjustments to Inpatient Hospital Payment Rates

- The American Taxpayer Relief Act (ATRA) 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 would provide for the anticipated hospital payment increase of 3.2-percentage points to be phased in at 0.5-percentage points per year over 6 years beginning in FY 2018.
- CBO estimates this provision would reduce direct spending by $15.1 billion over the 2018–2025 period.

Title V: Miscellaneous

Section 501: Prohibition of Inclusion of Social Security Account Numbers on Medicare Cards

- This section would require the Secretary of Health and Human Services, in consultation with the Commissioner of Social Security, to establish cost-effective procedures to ensure social security numbers are not displayed, coded, or embedded on a Medicare card.

Section 502: Preventing Wrongful Medicare Payments for Items and Services Furnished to Incarcerated Individuals, Individuals Not Lawfully Present, and Deceased Individuals

- This section would require the secretary to establish and maintain procedures to ensure that payment is not made for items and serviced furnished to: (1) those who are incarcerated; (2) an individual who is not lawfully present; and (3) deceased individuals.

Section 503: Consideration of Measurers Regarding Medicare Beneficiary Smart Cards

- This section would require the secretary to take into consideration the use of electronic Medicare beneficiary cards, and submit a report to the Energy and Commerce and Ways and Means Committee outlining such considerations.

Section 504: Modifying Medicare Durable Medical Equipment Face-to-Face Encounter Documentation Requirement

- This section would expand which providers can document the face-to-face encounter required for Medicare durable medical equipment prescriptions to include nurse practitioners and physician assistants, as allowed by state law.

Section 505: Reducing Improper Medicare Payments

- This section would require each Medicare administrative contractor to establish and have in place an improper payment outreach and education program.

Section 506: Improving Senior Medicare Patrol and Fraud Reporting Rewards

- This section would require the secretary to develop a plan to revise the incentive program to encourage greater participation by individuals to report fraud and abuse in Medicare.

Section 507: Requiring Valid Prescriber National Provider Identifiers on Pharmacy Claims

- For plan years 2016 and beyond, this section would require a claim for a covered Part D drug to include a prescriber National Provider Identifier. The secretary, in consultation with stakeholders, would establish procedures for determining the validity of prescriber National Providers Identifiers.

Section 508: Option to Receive Medicare Summary Notice Electronically

- Beginning in 2016, this section would allow Medicare beneficiaries to receive their statements electronically.

Section 509: Renewal of MAC Contracts

- This section would extend from at least once every 5 years to at least once every 10 years the application of competitive procedures when the contract of a Medicare administrative contractor (MAC) comes up for renewal. In addition, the secretary would make available to the public the performance of each MAC with respect to performance requirements and measurement standards.

Section 510: Study on Pathway for Incentives to States for State Participation in Medicaid Data Match Program

- The Medicare-Medicaid Data Match program (Medi-Medi program) enables program safeguard contractors (PSC) and participating state and federal government agencies to collaboratively analyze billing trends across Medicare and Medicaid to identify potential fraud, waste, and abuse.
- This section would require the secretary to study and specify incentives for states to work to coordinate appropriate actions to protect the federal and state share of expenditures under Medicaid.

Section 511: Guidance on Application of Common Rule to Clinical Data Registries

- This section directs the secretary to issue a clarification or modification to the Common Rule which provides protections for individuals involved in research.

Section 512: Eliminating Certain Civil Money Penalties; Gainsharing Study and Report

- This section would eliminate civil money penalties for inducements to physicians to limit services that are not medically necessary.

Section 513: Modification of Medicare Home Health Surety Bond Condition of Participation Requirement

- This section would require each home health agency to obtain a surety bond in the amount of no less than $50,000 as a condition of participation in the Medicare program.

Section 514: Oversight of Medicare Coverage of Manual Manipulation of the Spine to Correct Subluxation

- Medicare coverage of chiropractic service is limited to treatment by means of manual manipulation of the spine to correct a subluxation. No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order is covered.
- This section would require the secretary to implement a process for the medical review of treatment by a chiropractor for services furnished after January 1, 2017.
- The secretary would use prior authorization medical review for services furnished part of an episode of treatment that includes more than 12 services.

Section 515: National Expansion of Prior Authorization Model for Repetitive Scheduled Non-Emergent Ambulance Transport

- Medicare covers ambulance services, including air ambulance services, when furnished to a beneficiary whose medical condition is such that other means of transportation are unable to be used. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.
- Non-emergent transportation by ambulance is appropriate if either: (1) the beneficiary is bed-confined ,and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or (2) the beneficiary's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.
- This section would expand the prior authorization model for repetitive non-emergent ambulance transport to MAC regions L and 11 (consisting of Delaware, the District of Columbia, Maryland, New Jersey, Pennsylvania, North Carolina, South Carolina, West Virginia, and Virginia).
- On January 1, 2017, if the expanded model is found to reduce costs and improve the quality of patient care, the secretary would be directed to expand this model to all states.

Section 516: Repealing Duplicative Medicare Secondary Payor Provision

- This section would repeal a duplicative provision in statute causing unnecessary paperwork and burdens on employers. It would be effective for all information required to be provided after July 1, 2016.

Section 517: Plan for Expanding Data in Annual Cert Report

- This section would require the secretary to submit a plan for including in the annual report of the Comprehensive Error Rate Testing (CERT) program data on services paid under the physician fee schedule where the amount is in excess of $250 and where the error rate is in excess of 20 percent.

Section 518: Removing Funds for Medicare Improvement Fund Added by the IMPACT Act of 2014

- This section would remove $195,000,000 from the Medicare Improvement fund established under the IMPACT Act. This fund was created to make improvements under the original Medicare fee-for-service program under parts A and B.
- The IMPACT Act (H.R. 4994) passed the House in the 113th Congress.

Section 521: Extension of the Two-Midnight PAMA Rules on Certain Medical Activates

- In the 2014 Medicare inpatient prospective payment system final rule, CMS included a new regulation for hospitals and health systems: the two-midnight rule. This rule attempts to provide greater clarity regarding when inpatient hospital admissions are generally appropriate for Medicare Part A payment. The new rules are intended to address concerns about Medicare beneficiaries having long stays in the hospital as outpatients and improve program integrity.
- This section would prevent the secretary from conducting patient status reviews through September 30, 2015.

Section 522: Requiring Bid Surety Bond and State Licensure for Entitles Submitting Bids Under the Medicare DEMPOS Competitive Acquisition Program

- This section would require entities wishing to submit a DME bid for a competitive acquisition to show proof of a bid surety bond worth $50,000 - $100,000 before submitting their bid. In the event the entity's bid was at or below the median composite bid rate and the entity does not accept the contract, the bid surety bond would be forfeited and the secretary would collect on it. In addition, all entities would be required to meet all applicable state licensure requirements. Finally, this section would require the comptroller general to conduct a study that evaluates the effect of the bid surety bond requirement on the participation of small suppliers and in the Medicare DMEPOS program.
- This section mirrors H.R. 284 which passed the House by voice vote on March 16, 2015.

Section 523: Payment for Global Surgical Packages

- In the 2015 Medicare Physician Fee Schedule Proposed Rule, CMS indicated it would get rid of all 10-day and 90-day global periods for CPT procedure codes starting in 2017. Currently, payments for these procedure codes are given as a lump sum designed to account for all services provided to the patient related to the surgery, including any required follow-ups and tests, and treatment for certain post-surgical complications. CMS wanted to move away from this system due to concerns that the reimbursement levels were inaccurate and the global surgery payments were too high.
- Under the new rule, CMS would transition surgical procedure codes with 10-day global periods to 0-day global periods beginning in 2017. Procedures that currently have 90-day global periods will have 0-day global periods starting in 2018.
- This section would prevent the secretary from implementing the new rule that would require the transition of all 10-day and 90-day global surgery packages to be 0-day global periods.
- The secretary would be directed to develop and implement a process to gather information to value surgical service no later than January 1, 2017. This information would be used to improve the accuracy of valuation of surgical services.

Extension of Secure Rural Schools and Community Self-Determination Act of 2000

- This section would provide a two-year extension of the Secure Rural Schools and Community Self-Determination Act of 2000. It was last reauthorized in 2013 as part of H.R. 527, the Helium Stewardship Act.
- This program would allow for payments to mitigate impacts on counties containing national forested public lands with declining timber revenues. It enables flexibility for county elections to spend payments over two years or the normal timeframe at a five percent reduction from FY 2013 funding levels per current law.

Section 525: Exclusion from Paygo Scorecard

- The budgetary effects of this act would not be entered on the Paygo scorecard.

OUTSIDE SUPPORT:

- GOP Doctors Caucus
- American Medical Association coalition letter with 750 supporting groups
- American Hospital Association
- Hospital and Health System Coalition Letter
- Nursing Coalition Letter
- American Academy of Pediatrics
- Health Data Consortium
- America's Essential Hospitals
- American Association of Nurse Practitioners
- American College of Radiology

- Medical Group Management Association
- National Voice of Retail will consider this votes as Opportunity Index Votes on the annual voting scorecard
- Center for American Progress
- Families USA

OUTSIDE OPPOSITION:

- Club for Growth will include this vote on the Club's 2015 Congressional Scorecard
- Heritage Action will include this vote as a key vote on their legislative scorecard.

COMMITTEE ACTION: This bill was introduced by Representative Burgess on March 24, 2105, and referred to the Committee on Energy and Commerce, the Committees on Ways and Means, the Judiciary, Agriculture, Natural Resources, and the Budget where it awaits further action.

On January 21, 2015, the Energy and Commerce Committee held a legislative hearing entitled, "A Permanent Solution to the SGR: The Time is Now."

In the 113th Congress, the Energy and Commerce Committee held a legislative hearing entitled, "The Future of the Children's Health Insurance Program."

In the 113th Congress, the House passed H.R. 4015, the SGR Repeal and Medicare Provider Payment Modernization Act of 2014, by a vote of 226-181. This SGR reform component of this bill is very similar to the SGR reforms in H.R. 2.

ADMINISTRATION POSITION: The Administration supports House passage of H.R. 2.

CONSTITUTIONAL AUTHORITY: According to the sponsor, "Congress has the power to enact this legislation pursuant to the following: Article I, Section 8, Clause 1 of the United States Constitution."

NOTE: *RSC Legislative Bulletins are for informational purposes only and should not be taken as statements of support or opposition from the Republican Study Committee.*

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