

H.R. 2 MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT (MACRA) *Section by Section*

TITLE I—SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION

The legislation repeals the flawed Sustainable Growth Rate (SGR) formula and replaces it with the bicameral, bipartisan agreement to return stability to Medicare physician payments. The SGR formula is a cap on aggregate spending on physicians' services where exceeding the cap resulted in punitive recoupments in subsequent years. The formula was passed into law in the Balanced Budget Act of 1997 to control physician spending, but it has failed to work. Since 2003, Congress has spent nearly \$170 billion in short-term patches to avoid unsustainable cuts imposed by the flawed SGR. The most recent patch will expire on March 31st.

Based on H.R. 1470, the bicameral, bipartisan unified Committee bill to replace the SGR, this policy removes the imminent threat of draconian cuts to Medicare providers and ensures a 5-year period of stable annual updates of 0.5 percent to transition to a new system. The new system moves Medicare away from a volume-based system towards one that rewards value, improving the quality of care for seniors. For more information, click [here](#).

TITLE II—MEDICARE AND OTHER HEALTH EXTENDERS

Subtitle A—Medicare Extenders

Sec. 201. Extension of work Geographic Practice Cost Index (GPCI) 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 January 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 January 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 January 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 and Medicaid Services (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 October 1, 2017.

Sec. 205. Extension of the Medicare-dependent hospital (MDH) 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.

Sec. 206. Extension for specialized Medicare Advantage (MA) plans for special needs individuals. MA special needs plans (SNPs) 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 December 31, 2018.

Sec. 207. Extension of funding for quality measure endorsement, input, and selection. Funds the National Quality Forum'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. 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 September 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 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 January 1, 2018.

Subtitle B—Other Health Extenders

Sec. 211. Permanent extension of the qualifying individual (QI) 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). 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.

Sec. 213. Extension of special diabetes program for type I diabetes and for Indians.

Extends both the Type I Diabetes and Type II Indian Health Service programs through fiscal year 2017.

Sec. 214. Extension of abstinence education. Extends abstinence only programs and associated funding through fiscal year 2017.

Sec. 215. Extension of personal responsibility education program (PREP). Extends the PREP program and associated funding for one year through fiscal year 2017. PREP provides states, community groups, tribes, and tribal organizations with grants to implement evidence-based, or evidence-informed, innovative strategies for teen pregnancy and HIV/STD prevention, youth development, and adulthood preparation for young people.

Sec. 216. Extension of funding for family-to-family health information centers. Extends the Family-to-Family Health Information Centers funding through fiscal year 2017. This program, administered by the Health Resources and Services Administration (HRSA), provides grants to support family-staffed organizations in each state to assist families of children with disabilities or special health care needs.

Sec. 217. Extension of health workforce demonstration project for low-income individuals.

Extends this program at the current funding level, which provides funding to help low-income individuals obtain education and training in high-demand, well-paid, health care jobs, through fiscal year 2017.

Sec. 218. Extension of maternal, infant, and early childhood home visiting programs.

Extends the Maternal, Infant, and Early Childhood Home Visiting Program funding through fiscal year 2017. This program provides states, territories, and tribes with grants to support evidence-based in-home visiting programs for at-risk families.

Sec. 219. Tennessee disproportionate share hospital (DSH) allotment for fiscal years 2015 through 2025.

The Medicaid statute requires that states make DSH payments to hospitals treating large numbers of low-income patients. States receive an annual DSH allotment, which is the maximum amount of federal matching funds a state is permitted to claim for Medicaid DSH payments. Hawaii and Tennessee have had different DSH arrangements provided through multiple previous laws due to unique past circumstances. This legislation provides parity by treating Tennessee like other states, thus providing an annual DSH allotment for fiscal years 2015 through 2025.

Sec. 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 dealing with 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. The Protecting Access to Medicare Act of 2014 package delayed this provision until October 1, 2016. The legislation provides an additional delay, until October 1, 2017.

Sec. 221. Extension of funding for Community Health Centers and National Health Service Corps Fund and Teaching Health Centers. The fund for the Community Health Center (CHC) Program will expire in September 2015. These dedicated mandatory funds supplement annual spending for the CHC program. In 2013, the most recent data available, 1,302 federally funded health centers located in all 50 states, the District of Columbia, and six U.S. territories, distributed evenly between urban and rural areas, served 22.7 million patients across 9,518 sites. Meanwhile, the vast majority of the 90 million visits to health centers were for primary medical care. This provision will provide two additional years of this funding through fiscal year 2017.

The funding for the National Health Service Corps (NHSC) will end in 2015. The NHSC helps bring health care professionals to the areas where they are needed the most by providing scholarships and loan repayment in exchange for a commitment of service in an underserved community. This provision will fund the NHSC for an additional two years through fiscal year 2017.

The Teaching Health Center Graduate Medical Education Payment Program expanded residency training in community-based settings. Residents are trained in family and internal medicine, pediatrics, obstetrics and gynecology, psychiatry, and general and pediatric dentistry through this program. This provision adds additional funding for the program through fiscal year 2017.

TITLE III— The Children’s Health Insurance Program (CHIP)

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.

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 that 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 (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. 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 1.0 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 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 (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 Fiscal Year (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 6 years beginning in fiscal year 2018.

TITLE V—MISCELLANEOUS

Subtitle A—Protecting the Integrity of Medicare Act of 2015 (PIMA). This legislation includes bipartisan provisions that strengthen Medicare’s ability to fight fraud and build on existing program integrity policies. Significant provisions include prohibiting Social Security numbers on Medicare cards, reducing wrongful or improper Medicare payments, removing duplicative Medicare Secondary Payer reporting requirements, and eliminating civil money penalties for inducements to physicians to limit services that are not medically necessary. This legislation passed out of the Committee on Ways and Means with bi-partisan support.

Subtitle B—Other provisions

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 (MAC) “probe and educate” program to assess provider

understanding and compliance with the “two-midnight rule,” on a pre-payment basis, through September 30, 2015.

Sec. 522. Requiring bid surety bonds and State licensure for entities submitting bids under the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive acquisition program. This bill makes modifications to the DMEPOS competitive acquisition program. It prohibits the Secretary of Health and Human Services (HHS) from accepting a bid from a DMEPOS entity for a bidding area unless the entity: (1) meets state licensure requirements applicable within a product category; and (2) has obtained a bid surety bond of between \$50,000 and \$100,000 for each such geographic area. Suppliers whose bids are at or below the median price but do not accept a contract forfeit their surety bond. This bill passed out of the Ways & Means Committee via voice vote and passed the House floor via voice vote on March 16.

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.

Sec. 524. Secure Rural Schools. Provides a two-year extension of Secure Rural Schools and Community Self-Determination Act of 2000. This program allows 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 fiscal year 2013 funding levels per current law.

Sec. 525. Exclusion from PAYGO scorecards.