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H.R. 2: The Medicare Access and CHIP Reauthorization Act of 2015

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Summary

On March 26, 2015, the House passed H.R. 2, the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. This act would repeal the current sustainable growth rate (SGR) formula for calculating updates to Medicare payment rates to physicians and establish an alternative set of annual updates. MACRA would also introduce a new merit-based incentive payment system and put in place processes for developing, evaluating, and adopting alternative payment models (APMs).

H.R. 2 also extends funding for the Children's Health Insurance Program (CHIP) for two additional years. Currently, CHIP is funded through FY2015.

In addition to repealing the SGR (Title I) and extending funding for CHIP (Title III), the act also makes other health-related changes. Title II extends several expiring provisions in the Medicare and Medicaid programs including the qualifying individual (QI) program and the transitional medical assistance (TMA) program. Title IV includes Medicare program changes to offset the cost of repealing the SGR mechanism. These proposed offsets include limiting certain Medigap policies and making adjustments to income-related premiums in Medicare Parts B and D and to inpatient hospital payment rates. Title V includes provisions related to program integrity in Medicare including a prohibition on including Social Security numbers on beneficiaries' Medicare cards.

This report provides a brief summary of each provision of H.R. 2. Each summary includes a brief description of current law and a description of how the act would change current law.

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Overview

On March 26, 2015, the House passed H.R. 2, the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. This act would repeal the current sustainable growth rate (SGR) formula for calculating updates to Medicare payment rates to physicians and establish an alternative set of annual updates. MACRA would also introduce a new merit-based incentive payment system and put in place processes for developing, evaluating, and adopting alternative payment models (APMs).

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This report provides a brief summary of each provision of H.R. 2. Each summary includes a brief description of current law and a description of how the act would change current law. Please see the **Appendix** for a list of the abbreviations used throughout this report.

Summary of Provisions

Title I—SGR Repeal and Medicare Provider Payment Modernization

Sec. 101. Repealing the sustainable growth rate (SGR) and improving Medicare payment for physicians’ services.

Currently, Medicare payments for services of physicians and certain nonphysician practitioners are made on the basis of a fee schedule. The Medicare physician fee schedule (MPFS) assigns relative values to each of the approximately 7,500 service codes that reflect physician work (i.e., time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative value for a service compares the relative work involved in performing one service with the work involved in providing other physicians’ services. The scale used to compare the value of one service with another is known as a resource-based relative value scale (RBRVS). The relative values are adjusted for geographic variation in input costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor.

The Centers for Medicare and Medicaid Services (CMS), which is responsible for maintaining and updating the fee schedule, continually modifies and refines the methodology for estimating relative value units (RVUs). The American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) has historically provided advice and recommendations to CMS to assist in the assessments. CMS is required to review the RVUs no less than every five years.

In determining adjustments to RVUs used as the basis for calculating Medicare physician reimbursement under the fee schedule, the Secretary has authority to adjust the number of RVUs for any service code to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary of Health and Human Services (HHS) is required to publish an explanation of the basis for such adjustments. These adjustments are subject to a budget neutrality condition. With the exception of certain expenditures that are exempt by statute, the adjustments may not cause the amount of expenditures made under the MPFS to differ from year to year by more than \$20 million from the expenditures that would have been incurred without such an adjustment.

The Balanced Budget Act of 1997 (BBA97; P.L. 105-33) requires that, in developing the resource based practice expense RVUs, the Secretary (1) use generally accepted cost accounting principles, to the maximum extent possible, that recognize all staff, equipment, supplies, and expenses, not solely those that can be linked to specific procedures and actual data on equipment utilization, (2) develop a refinement method to be used during the transition, and (3) consider, in the course of notice and comment rulemaking, impact projections that compare new proposed payment amounts to data on actual physician practice expense.

Created by BBA97, the Sustainable Growth Rate (SGR) is the statutory method for determining the annual updates to the MPFS. The SGR methodology was established because of the concern that the Medicare fee schedule itself would not adequately constrain overall increases in spending for physicians' services. Generally, under the SGR formula, if cumulative expenditures from the current period going back to 1996 (the base year) are less than the cumulative spending target over the same period, the annual update is increased according to a statutory formula. However, if spending exceeds the cumulative spending target over the same period, the SGR methodology necessitates fee schedule update reductions to bring spending back in line with the target growth rate.

In the first few years of the SGR system, the actual expenditures did not exceed the targets and the updates to the physician fee schedule were close to the Medicare economic index (MEI, a price index of inputs required to produce physician services). Beginning in 2002, the cumulative actual expenditures exceeded allowed targets, resulting in SGR-mandated reductions in the update adjustment factor, and the discrepancy has grown with each year. However, with the exception of 2002, when a 4.8% decrease was applied, Congress has enacted a series of laws to override the reductions.

Most recently, the Protecting Access to Medicare Act (PAMA; P.L. 113-93) included a provision that averted the reduction and maintained the MPFS payments at current rates through March 31, 2015. CMS actuaries estimate that, without additional Congressional intervention, the statutory change in the update factor would result in a 21.2% reduction in payment rates under the MPFS, keeping April 1, 2015.

The MPFS currently has several modifications and adjustments that depend on actions taken by the physician with regard to reporting quality data. The Tax Relief and Health Care Act of 2006

(TRHCA; P.L. 109-432) required the establishment of a physician quality reporting system that would include an incentive payment to eligible professionals who satisfactorily report data on quality measures, based on a percentage of the allowed Medicare charges for covered professional services. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA; P.L. 110-275) made this program permanent and extended the bonuses through 2010; the incentive payment was increased from 1.5% of total allowable charges under the physician fee schedule in 2007 and 2008 to 2% in 2009 and 2010. The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) extended quality measure reporting incentive payments through 2014 and put in place a penalty for providers who do not report quality measures beginning in 2015. Similarly, the bonus payment for meaningful use of electronic health records eventually becomes a penalty for those who do not meet the criteria.

As a result of changes in MIPPA and the ACA, eligible professionals who successfully reported in 2010 received a 1% bonus in 2011; those who successfully reported in 2011, 2012, and 2013 received a 0.5% bonus in 2012, 2013, and 2014, respectively. In contrast, eligible professionals who fail to participate successfully in the program face a 1.5% payment penalty in 2015, and a 2% payment penalty in 2016 and in subsequent years. The incentive payments and adjustments in payment will be based on the allowed charges for all covered services furnished by the eligible professional, based on the applicable percentage of the fee schedule amount.

Both Medicare Payment Advisory Commission (MedPAC) and the Government Accountability Office (GAO) have suggested that CMS provide information to physicians on their resource use with the expectation that physicians who are outliers would alter their practice patterns in response. MedPAC asserts that physicians would be able to assess their practice styles, evaluate whether they tend to use more resources than their peers or what evidence-based research (if available) recommends, and revise practice styles as appropriate. MIPPA (Section 131(c)) established such a physician feedback program. The Physician Feedback Program uses Medicare claims data and other data to provide confidential feedback reports to physicians (and as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to Medicare beneficiaries. CMS initially called this effort the Physician Resource Use Feedback Program, but has renamed this initiative the “Physician Resource Use Measurement and Reporting Program.”

Incentives for the adoption and “meaningful use” of electronic health records (EHR) also modify payments under the MPFS. The American Recovery and Reinvestment Act (ARRA, P.L. 111-5) authorized incentive payments over a five-year period through Medicare Part B to physicians who are meaningful users of certified EHR technology. Meaningful use is defined as (1) demonstrating to the satisfaction of the Secretary the use of certified EHR technology in a meaningful manner (including e-prescribing), including for the purpose of exchanging electronic health information to improve health care quality; and (2) using such certified EHR technology to report clinical quality measures, as selected by the Secretary. The incentive payments equal 75% of the allowed Part B charges during the reporting year. However, the total amount that a physician could receive is capped and decreases over time. For EHR adopters in 2011 and 2012, eligible physicians received up to \$18,000 in the first payment year, \$12,000 in the second year, \$8,000 in the third year, \$4,000 in the fourth year, and \$2,000 in the fifth, and final, year. For eligible physicians practicing in health professional shortage areas, the incentive payment amounts are increased by 10%.

Eligible physicians first becoming meaningful EHR users after 2012 received fewer payments, and those who did not adopt EHRs until after 2014 received no bonus. No incentive payments

will be made after 2016. Incentive payments are not available for hospital-based physicians. Eligible physicians who are not meaningful users of certified HIT systems by 2015 will see their Medicare payments reduced by the following amounts: 1% in 2015, 2% in 2016, 3% in 2017 and in each subsequent year. For 2018 and each subsequent year, if the proportion of eligible physicians who are meaningful EHR users is less than 75%, the payment reduction would be further decreased by one percentage point from the applicable amount in the previous year, though the reduction cannot exceed 5%. The Secretary may, on a case-by-case basis, exempt eligible physicians (e.g., rural physicians that lack sufficient Internet access) from the payment reduction for up to five years if it is determined that being a meaningful EHR user would result in significant hardship.

MPFS payments, based on fee-for-service, have been criticized for rewarding volume of care without incentivizing quality or improved outcomes. While payments vary across geography by design and are sometimes modified to satisfy a policy objective, such as when providing an incentive for physicians to provide care in underserved areas or to meet quality reporting metrics, there has historically been no variance in payments with respect to quality or efficiency.

The ACA required the Secretary to establish and apply a separate, budget-neutral payment modifier to the MPFS. The separate value-based payment modifier is to be based on the relative quality and cost of the care provided by physicians or physician groups. Quality of care is to be evaluated on a composite of risk-adjusted measures of quality established by the Secretary, such as measures that reflect health outcomes. Costs, defined as expenditures per individual, are to be evaluated based on a composite of appropriate measures of costs established by the Secretary that eliminate the effect of geographic adjustments in payment rates and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals) and other factors determined appropriate by the Secretary.

Beginning January 1, 2015, the value-based payment modifier applies for items and services furnished for physicians in groups of 100 or more eligible professionals who submit claims to Medicare under a single tax identification number. By 2017, the value-based payment modifier will apply to all physicians who participate in fee-for-service Medicare. The Secretary is to apply the payment modifier in a manner that promotes systems-based care and takes into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

This provision of H.R. 2 would make fundamental changes to the way Medicare payments to physicians are determined, how they are updated, and how they incentivize physicians. The bill would (1) repeal the sustainable growth rate (SGR) methodology for determining updates to the MPFS and establish annual fee updates in the short term and put in place a new method for determining updates afterwards, (2) establish a merit-based incentive payment system (MIPS) to consolidate and replace several existing incentive programs, (3) incentivize the development of, and participation, in alternative payment models (APMs), and (4) make other changes to Medicare physician payment statutes.

For the first few years after enactment, the bill would set the annual MPFS payment updates. From January through June of 2015, the update would be 0%; for the remainder of the year—July through December of 2015, the payments would be increased by 0.5%. In each of the next four years, 2016 through 2019, the payment increase would be 0.5% each year. For the next six years from 2020 through 2025, the payment update would be 0%.

Beginning in 2026, there would be two update factors; one for items and services furnished by a participant in a new alternative payment model (APM, see below), and another for those who do not participate in an APM. The update factor for the APM participants would be 0.75% while those not participating in an APM would see an update factor of 0.25%.

MedPAC would prepare reports to assist the Congress in evaluating the changes. By July 1, 2017, MedPAC would be required to submit a report to Congress on the relationship between (1) utilization of physician and other health professional services and Medicare expenditures on items and services, and (2) total utilization and expenditures and their rates of increase under Medicare Parts A, B, and D. The report would include a methodology to describe the relationship between the practice and ordering patterns of physician and other health professionals and total utilization and expenditure of healthcare services in Medicare Part A, B, and D. A final report would be due to Congress by July 1, 2021. A second report, due no later than July 1, 2019, would examine the effect of the 2015 through 2019 payment updates on the efficiency, economy, and quality of care provided, whether the update ensured a sufficient number of providers to maintain access to care by Medicare beneficiaries, and make recommendations for future payment updates to ensure adequate access.

The provision would create a new incentive payment system while sunsetting several existing programs on the last day of 2018: (1) the meaningful use incentive program for certified electronic health record (EHR) technology, (2) the quality reporting incentive program currently called PQRI, and (3) the value-based payment modifier. The Secretary would establish a replacement program, the merit-based incentive payment system (MIPS) that would accomplish the following:

1. develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards described below;
2. using the methodology above, provide for a composite performance score as specified below for each professional for each performance period; and
3. use the composite performance score of the MIPS eligible professional to make MIPS program incentive payments (as described below) to the professional for the year.

The MIPS program would apply to payments for items and services furnished on or after January 1, 2019.

The types of health care professionals eligible for the MIPS incentive payments would change over time. Subject to the exclusions and definitions of newly eligible participants described below, only physicians, as defined under current law as well as physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists—including groups that included such professionals—would be eligible for MIPS program incentives in the first and second years for which the MIPS program would apply. The Secretary would decide which other health care professionals, in addition to those already specified, would be eligible in subsequent years. Health care professionals excluded from the MIPS incentive payment program would include otherwise eligible professionals who (1) would be qualifying APM participants (as defined below), (2) would be partial qualifying APM participants (as defined below), and (3) would not exceed the low-volume threshold measurement.

The term “alternative payment model” would 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 SSA;
- A demonstration required by Federal law.

The term “eligible alternative payment entity” would mean an entity that (i) 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 established above, and (ii) 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” would mean the following:

1. For 2019 and 2020, an eligible professional for whom the Secretary determines that at least 25% 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 alternative payment model,
2. For 2021 and 2022, an eligible professional who meets either of the following criteria:
 - a. Medicare payment threshold. At least 50% of Medicare 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
 - b. Combination all-payer and Medicare payment threshold. Satisfies conditions on (i) the amount of Medicare payments made under qualified APMs and (ii) payments made by other payers under arrangements in which quality measures, EHR technology, and other conditions apply.
3. For 2023 and in subsequent years, an eligible professional as described in (2), but meeting a criteria of 75% for a. and a similarly higher condition for b.

A “partial qualifying APM participant” would 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 achieved a lower threshold. The Secretary would 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 would be determined by the Secretary.

With the sunset of the incentive programs mentioned above, the MIPS program would use a new set of measures and activities under four performance categories to determine whether an individual qualified for an incentive payment. A composite performance score would be calculated for each MIPS eligible professional, which would be used to determine the incentive payment. The Secretary would use the following performance categories to determine the composite performance score.

1. Quality. The final quality measures under current law for existing incentive payments for quality reporting and quality of care.
2. Resource use. The measures of resource use established for the value-based modifier under current law and, to the extent feasible, accounting for the cost of Part D drugs.
3. Clinical practice improvement activities. The clinical practice improvement activities would be specified by the Secretary and would include at least the following subcategories:
 - a. expanded practice access, such as same day appointments for urgent needs and after-hours access to clinician advice;
 - b. population management, such as monitoring health conditions of individuals to provide timely health care or participation in a qualified clinical data registry;
 - c. care coordination, such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth;
 - d. beneficiary engagement, such as the establishment of care plans for individuals with complex care needs and beneficiary self-management assessment and training, and using shared decision-making mechanisms;
 - e. patient safety and practice assessment, such as thorough use of clinical or surgical checklists and practice assessments related to maintaining certification; and
 - f. participation in an alternative payment model.

In establishing the clinical practice improvement activities, the Secretary would give consideration to the circumstances of small practices (15 or fewer professionals) and practices located in rural areas and in health professional shortage areas.
4. Meaningful use of certified EHR technology. The requirements established under current law for determining whether an eligible professional is a meaningful EHR user.

By November 1 of each year, the Secretary would establish and publish in the Federal Register an annual list of quality measures from which MIPS eligible professionals could choose, to serve as the basis for the MIPS payment adjustment. The list would be updated to remove measures that are no longer meaningful (e.g., when a measure is topped out) and to add new quality measures.

The Secretary would establish MIPS performance standards and the performance period with respect to the measures and activities. The performance standards would take into account (i) historical performance standards, (ii) improvement, and (iii) the opportunity for continued

improvement. The Secretary would establish a performance period for each year in which incentive payments would be determined, beginning with 2019; the performance period would begin and end prior to the beginning of the year in which the incentive payments would be paid.

The Secretary would develop a methodology for assessing the total performance of each MIPS eligible professional according to the performance standards and the applicable measures and activities specified above and determine a composite assessment (“composite performance score”) for each such professional for each performance period. As incentive, the Secretary would 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% of the initial score would be based on performance on the quality measure; outcome measures would be encouraged, as feasible. The weight for the resource use category would also initially be 30%, while the clinical practice category would receive a weight of 15%. The meaningful use of certified EHR technology would receive 25% weight. These weights would change over time. For example, should the percentage of meaningful EHR users exceed 75%, the Secretary could reduce the weight for that category, but not below 15%, with the other weights increased appropriately.

The Secretary would be given flexibility in weighting performance categories, measures, and activities. The Secretary may assign different scoring weights (including a weight of 0) for (1) each performance category based on the extent to which the category is applicable to the type of eligible professional involved, and (2) each measure and activity based on the extent to which the measure or activity is applicable to the type of eligible professional involved.

The Secretary would specify a MIPS program incentive payment adjustment factor for each MIPS eligible professional for a year, which would be determined by the composite performance score of the eligible professional for the year. The application of the adjustment factors would result in differential payments reflecting the professional’s composite performance score relative to an established performance threshold. Professionals with composite scores at the threshold would receive no adjustment; higher composite scores would receive higher adjustments and composite performance scores below the threshold would lead to a negative adjustment. The MIPS adjustment factor (positive or negative) would be 4% in 2019, 5% in 2020, 7% in 2021, and 9% in 2022 and in subsequent years; each professional’s MIPS adjustment factor would be between 0% and +/- (adjustment factor)%, reflecting his or her composite score between 0 and 100 on a sliding scale.

An additional MIPS adjustment could be earned for exceptional performance. For years 2019 through 2024, eligible professionals with a composite performance score at or above the additional performance threshold could receive an additional positive MIPS adjustment factor that would vary with the amount by which the score exceeds the threshold, to be specified by the Secretary.

The performance threshold would be the mean or median (as selected by the Secretary) of the composite performance scores for all MIPS eligible professionals; the Secretary could reassess the selection of the mean or the median every three years. The exceptional performance threshold would be determined in one of two ways: (1) the score equal to the 25th percentile of the range of possible composite scores higher than the performance threshold above, or (2) the score equal to the 25th percentile of the actual composite scores for MIPS eligible professionals with scores at or

higher than the performance threshold above. For the first two years to which the MIPS applies, the Secretary would establish the two thresholds based on (i) information from a period prior to the performance period, (ii) data available with respect to performance on measures and activities that may be used in the four MIPS performance categories, and (iii) other factors the Secretary determines to be appropriate. Beginning with 2019, the payment received by a MIPS eligible professional would be the amount otherwise paid (under the MPFS) multiplied by the MIPS adjustment factor expressed as a percentage.

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% for an eligible professional in a year. Thus, the aggregate increase in payments may be less than \$500 million if this restriction is applied. Each MIPS-eligible professional would be notified as to their MIPS adjustment factor (including the additional adjustment factor for exceptional performance) no later than December 2 (30 days prior to January 1) of the year before the adjustment factor would be applied. The MIPS adjustment factor(s) would apply only with respect to the year involved, and the Secretary would not take such adjustments into account in making payments to a MIPS eligible professional in a subsequent year.

The Secretary would make information regarding the performance of MIPS eligible professionals under the MIPS program available to the public, in an easily understandable format on CMS' Physician Compare Internet website. This information would include the composite score for each MIPS eligible professional and the performance of each MIPS eligible professional with respect to each performance category, and could include their performance on each measure or activity in the four performance categories. This information would indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated. The Secretary would provide for an opportunity for an eligible professional to review, and submit corrections for, the individual's information to be made public prior to such information being made public. The Secretary would periodically post aggregate information on the MIPS program on the Physician Compare Internet website, including the range of composite scores for all MIPS eligible professionals and the range of the performance of all MIPS eligible professionals with respect to each performance category.

The Secretary would consult with stakeholders in carrying out the MIPS program, including for the identification of performance category measures and activities and the methodologies for developing the composite score and regarding the use of qualified clinical data registries. These consultations would include the use of requests for information or other mechanisms determined appropriate.

To provide technical assistance to small practices and practices in health professional shortage areas, the Secretary would enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers, or regional health collaboratives) to offer guidance and assistance to MIPS eligible professionals in practices of 15 or fewer professionals with priority given to professionals located in rural areas, health professional shortage areas, or practices with low composite scores. The guidance and assistance would be provided with respect to (i) the performance categories, or (ii) how to transition to the implementation of and participation in an alternative payment model (as specified below).

For purposes of implementing the technical assistance program, \$20 million from the Federal Supplementary Medical Insurance (SMI) Trust Fund would be made available to CMS for each of FY2016-FY2020. These amounts would be available until expended.

In order to provide feedback to eligible professionals to improve performance, beginning July 1, 2017, the Secretary would make available timely (such as quarterly) confidential feedback to each MIPS eligible professional on the individual's performance with respect to the quality and resource use performance categories. Information on the clinical practice improvement activities and meaningful EHR use categories could also be provided. The Secretary could use one or more mechanisms to provide this feedback, including use of a web-based portal or other mechanisms determined appropriate by the Secretary.

The Secretary could use data from periods prior to the current performance period with respect to MIPS eligible professionals and could use rolling periods in order to make illustrative calculations about the performance of these professional. This feedback would be exempt from disclosure under the Freedom of Information Act (FOIA).

Beginning July 1, 2018, the Secretary would make available to each MIPS eligible professional information about items and services furnished to the professional's patients by other suppliers and providers of services. This information would include the following: (1) the name of each provider furnishing items and services to such patients during the period, the types of items and services so furnished, and the dates these items and services were furnished, and (2) historical data, such as averages and other measures of the distribution if appropriate, of the total allowed charges as well as the components of the charges, as well as other figures as determined appropriate by the Secretary.

The Secretary would establish a process under which a MIPS eligible professional could seek an informal review of the calculation of the individual's MIPS program incentive payment. The results of such a review would 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 would be no administrative or judicial review of the following:

1. the methodology used to determine the amount of the MIPS adjustment factors, including for exceptional performance,
2. the establishment of the performance standards and the performance period,
3. the identification of performance category measures and activities and information made public or posted on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services,
4. 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.

The Comptroller General of the United States (GAO) would submit four MIPS program evaluation reports to the Congress. The first report, due October 1, 2021, would (1) examine the distribution of the composite performance scores and MIPS adjustment factors and their patterns, including an analysis of the scores and factors across types of provider, practice size, geographic location, and patient mix, (2) provide recommendations for improving the MIPS program, (3)

evaluate the impact of technical assistance funding on the ability of professionals to improve within the MIPS program or to transition successfully to an alternative payment model, with priority for evaluation given to practices located in rural areas, health professional shortage areas, and medically underserved areas, and (4) provide recommendations for optimizing the use of such technical assistance funds.

The second GAO report, due 18 months after enactment, would examine the alignment of quality measures used in public and private programs by (1) comparing the similarities and differences in the use of quality measures under the original Medicare fee-for-service program under Parts A and B, the Medicare Advantage program, and private payer arrangements, and (2) making recommendations on how to reduce administrative burden involved in applying such quality measures.

The third GAO report, due January 1, 2017, would study the role of independent risk managers and examine whether entities that pool financial risk for physician practices, such as independent risk managers, can play a role in supporting physician practices, particularly small physician practices, in assuming financial risk for the treatment of patients. The report would examine barriers that small physician practices currently face in assuming financial risk for treating patients, the types of risk management entities that could assist physician practices in participating in two-sided risk payment models, and how such entities could assist with risk management and with quality improvement activities. The report would also include an analysis of any existing legal barriers to such arrangements.

The fourth GAO report, due October 1, 2021, would examine the transition of professionals in rural areas, health professional shortage areas, or medically underserved areas to an alternative payment model. The report would make recommendations for removing administrative barriers to practices to participate in such models, including small practices consisting of 15 or fewer professionals, in rural areas, health professional shortage areas, and medically underserved areas.

To implement the MIPS program and the related activities described above, \$80 million would be transferred to CMS from the SMI Trust Fund for each fiscal year from 2015 through 2019; these funds would be available until expended.

The bill would make modifications to improve quality reporting for constructing MIPS composite scores. The existing physician feedback program would be succeeded by reports under the MIPS program beginning in 2018, and the meaningful EHR use clinical quality measure reporting requirement would be combined with the MIPS program.

In addition to creating the MIPS, which modifies but is still fundamentally based on fee-for-service payment, this bill would also establish pathways for implementing new payment models that might eventually replace traditional fee-for-service based payment.

To advise and evaluate the development of alternative payment models, the bill would establish an ad hoc committee to be known as the “Physician–Focused Payment Models Technical Advisory Committee” (“Committee”). The Committee would provide comments and recommendations to the Secretary as to whether the alternative payment models meet the criteria (to be established by the Secretary) for assessing physician–focused payment models.

The Committee would be composed of 11 members appointed by the Comptroller General, and include individuals with national recognition for their expertise in physician–focused payment

models and related delivery of care. No more than 5 members of the Committee would be providers of services or suppliers, or their representatives. Federal employees would not be allowed to be members of the Committee. Members of the Committee would be required to publicly disclose financial and other potential conflicts of interest. The initial appointments, to be made no later than 180 days after enactment, would be staggered with three years being the length of a full term. Vacancies would be filled in the same manner as original appointments. Committee members would serve without compensation (travel expenses would be allowed), and the Committee would meet as needed.

The HHS Assistant Secretary for Planning and Evaluation would provide technical and operational support for the Committee, which could be by use of a contractor. The Office of the Actuary of the Centers for Medicare and Medicaid Services would provide actuarial assistance as needed. To establish and operate the Committee, the Secretary would transfer amounts as necessary from the SMI Trust Fund, not to exceed \$5 million for each fiscal year beginning in 2015.

The creation and recognition of alternative payment models under the Medicare program would follow a process of submission, review, and evaluation. By November 1, 2016, the Secretary would establish through rulemaking the criteria for physician-focused payment models, including models for specialist physicians that could be used by the Committee for making comments and recommendations. During the comment period for the proposed rule, MedPAC could submit comments to the Secretary on the proposed criteria. The Secretary could update the criteria through rulemaking. Individuals and stakeholder entities could also submit proposals to the Committee for physician-focused payment models that they believe meet the criteria. The Committee would review models submitted on a periodic basis and provide comments and recommendations to the Secretary regarding whether the models meet the criteria. The Secretary would review the Committee's comments and recommendations and post a detailed response on the CMS website.

Eligible Medicare professionals would be incentivized to participate in Medicare APMs through higher payments. Beginning in 2019 and ending with 2024, eligible professionals in a qualifying APM (see below) providing covered services would receive payment for the services provided that year as well as an amount equal to 5% of the estimated aggregate payment amounts for covered professional services for the preceding year. The incentive payment would be made in a lump sum on an annual basis, as soon as practicable. These incentive payments would 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.

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

1. The determination that an eligible professional is a qualifying APM participant as described above and the determination that an entity is an eligible alternative payment entity.
2. The determination of the amount of the 5% payment incentive for participation in APMs.

To encourage the development and testing of certain APMs, demonstration project authority regarding the testing of models (section 1115A(b)(2) of the SSA) is amended to allow for models focusing

- primarily on physicians' services, with particular focus on such services furnished by physicians who are not primary care practitioners,
- on practices of 15 or fewer professionals,
- on risk-based models for small physician practices that may involve two-sided risk and prospective patient assignment, and which examine risk-adjusted decreases in mortality rates, hospital readmissions rates, and other relevant and appropriate clinical measures, and
- primarily on Medicaid, working in conjunction with the Center for Medicaid and CHIP Services.

The demonstration authority is also modified to add "statewide payment models" in addition to "other public sector or private sector payers" as a factor for consideration.

The provision would require additional studies regarding the development and testing of APMs. By July 1, 2016, the Secretary would submit to Congress a study examining the feasibility of integrating APMs in the Medicare Advantage payment system; the study would include the feasibility of including a value-based modifier and whether such a modifier should be budget neutral. No later than two years after enactment, the Secretary, in consultation with the HHS Inspector General (IG), would submit a study that would (1) examine the applicability of the Federal fraud prevention laws to items and services furnished under the Medicare program for which payment is made under an APM; (2) identify aspects of APMs that are vulnerable to fraudulent activity; and (3) examine the implications of waivers to such laws granted in support of APMs, including under any potential expansion of APMs. The report would include recommendations for actions to be taken to reduce the vulnerability of such APMs to fraudulent activity and, as appropriate, recommendations of the IG for changes in Federal fraud prevention laws to reduce such vulnerability.

To improve the measurement of resource use, and in order to involve physician, practitioner, and other stakeholder communities in enhancing the infrastructure for resource use measurement—including for purposes of the MIPS and the APMs as added by this provision, the bill would require 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.

In order to classify similar patients into care episode groups and patient condition groups, the Secretary would be required to develop new classification codes. No later than 180 days after enactment, the Secretary would post a list of episode groups and related descriptive information as developed pursuant to the episode grouper (under current law). For 120 days after such posting, the Secretary would accept suggestions from physician specialty societies, applicable practitioner organizations, and other stakeholders for episode groups in addition to those posted as well as specific clinical criteria and patient characteristics in order to classify patients into (1) care episode groups and (2) patient condition groups. Taking into account this information, the Secretary would (a) establish care episode groups and patient condition groups that account for a target of an estimated one-half of Part A and Part B expenditures (with the target increasing over time as appropriate), and (b) assign codes to the groups.

In establishing the care episode groups, the Secretary would take into account the patient's clinical problems at the time items and services are furnished during an episode of care, such as

the patient's clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished, and other factors as appropriate.

In establishing the patient condition groups, the Secretary would take into account the patient's clinical history at the time of the medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months), and other factors as appropriate such as eligibility for Medicare and Medicaid.

The Secretary would draft a list of the care episode and patient condition codes (and the criteria and characteristics assigned to the codes) on the CMS website no later than 270 days after the end of the comment period. For 120 days after posting the list, the Secretary would seek comments from physician specialty societies, applicable practitioner organizations, and other stakeholders including representatives of Medicare beneficiaries, regarding the care episode and patient condition groups and codes. The Secretary would use mechanisms in addition to notice and comment rulemaking that could include the use of open door forums, town hall meetings, or other appropriate mechanisms. No later than 270 days after the end of the comment period, the Secretary would post an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to the codes) on the CMS website.

The Secretary would revise the lists through rulemaking no later than November 1 of each year. The revisions could be based on experience, new information developed pursuant to the episode grouper, and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders.

To develop patient relationship categories and codes to facilitate the attribution of patients and episodes to physicians or applicable practitioners, the Secretary would develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time an item or service is furnished. These patient relationship categories would include different relationships of the physician or practitioner to the patient (and the codes could reflect combinations of such categories). Examples of such relationship categories might include a physician or practitioner who

1. considers himself or herself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;
2. considers himself or herself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;
3. furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;
4. furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or
5. furnishes items and services only as ordered by another physician or practitioner.

No later than one year after enactment, the Secretary would post a draft list of the patient relationship categories and codes on the CMS website. For 120 days after posting the list, the Secretary would seek comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of Medicare beneficiaries, regarding the patient relationship categories and codes. The Secretary would use mechanisms in

addition to notice and comment rulemaking that could include the use of open door forums, town hall meetings, or other appropriate mechanisms. No later than 240 days after the end of the comment period, the Secretary would post an operational list of patient relationship categories and codes on the CMS website.

The Secretary would revise the lists through rulemaking no later than November 1 of each year. The revisions could be based on experience, new information developed pursuant to the episode grouper, and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders.

To gather more information for resource use measurement, the Secretary would require that Medicare claims submitted on or after January 1, 2018 include the applicable codes as established above, and the national provider identifier of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

In order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups) the Secretary would, as appropriate (i) use the patient relationship codes reported on claims to attribute patients to one or more physicians and practitioners, (ii) use the care episode and patient condition codes reported on claims as a basis to compare similar patients and care episodes and patient condition groups, and (iii) conduct an analysis of resource use with respect to care episodes and patient condition groups of such patients. In conducting an analysis with respect to patients attributed to physicians and providers as specified above, the Secretary would (1) use the claims data experience of patients by the patient condition codes during a common period, such as 12 months, (2) use the claims data experience of patients by care episode codes in the case of episodes both with and without hospitalization.

In measuring the resource use, the Secretary (i) would use per patient total allowed charges for all Medicare Part A and Part B services (and Part D, if appropriate) for the analysis of patient resource use, by care episode codes and by patient condition codes, and (ii) could use other measures of allowed charges (such as subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes). The Secretary would seek comments regarding the resource use methodology.

Sec. 102. Priorities and funding for measure development.

Section 931 of the Public Health Service Act (PHSA; P.L. 78-410) (42 U.S.C. 299b-31) and Section 1890A(e) (42 U.S.C. 1395aaa-1) of the Social Security Act (SSA), as added by section 2013 of the ACA, require (1) the Secretary of HHS to award grants and contracts to eligible entities for purposes of developing, improving, updating, or expanding quality measures, as specified; and (2) the Administrator of the Centers for Medicare and Medicaid Services (CMS) to develop quality and efficiency measures for use under the SSA through the awarding of contracts. In addition, section 931 of the PHSA required the Secretary to develop provider-level outcome measures for hospitals and physicians, and specifically, 10 outcome measures each for acute and chronic diseases and primary and preventive care.

This provision of H.R. 2 would amend section 1848 of the SSA to add a new subsection (s), “Priorities and Funding for Quality Measure Development.” The Secretary would be required, not later than January 1, 2016, to develop a draft plan for the development of quality measures under applicable provisions, as specified. Such plan would be required to address how measures used in

integrated delivery systems and by private payers could be incorporated under Title XVIII; how coordination of measure development would occur; and how clinical guidelines should be used in measure development. It would be required to consider gaps analyses, as specified; whether measures apply across health care settings; clinical practice improvement activities; and quality domains, as specified. In addition, the plan would be required to prioritize, among other things, outcome, patient experience, care coordination, and appropriate use measures. The Secretary would be required to accept stakeholder comments, through March 1, 2016, on the draft plan, and would be required to, not later than May 1, 2016, post on the CMS website an operational plan for the development of quality measures for use as specified. This plan would be required to be updated as appropriate.

The Secretary would also be required to enter into contracts or other arrangements to develop, improve, update, or expand quality measures, in accordance with the plan. In entering into contracts, the Secretary would be required to give priority to developing measures of outcomes, patient experience of care, and care coordination, among other things, and would be required to consider whether measures developed would be electronically specified and relevant clinical practice guidelines, to the extent they exist.

The Secretary would be required, not later than May 1, 2017, and annually thereafter, to post on the CMS website a report on the progress made in developing quality measures for application as specified. The reports would be required to include the following: (1) a description of the Secretary's efforts to implement the subsection; (2) information about measures developed over the previous year, as specified; (3) information about measures currently in development, as specified; (4) a description of any updates to the plan, including newly identified gaps, as well as the inventory of measures applicable, as specified; and (5) other information as the Secretary determines would be appropriate.

The Secretary would be required to seek stakeholder input with respect to: (1) the identification of gaps where no measures exist, and specifically with respect to measures of outcomes, patient experience of care, care coordination, and overuse; (2) prioritization of quality measure development to address such gaps; and (3) other quality measure development areas, as determined by the Secretary.

The Secretary would be required to provide for the transfer of \$15 million, for each of fiscal years 2015 through 2019, from the Federal Supplementary Medical Insurance Trust Fund to the CMS Program Management Account. The funds would remain available through FY2022. The Paperwork Reduction Act of 1980 (U.S.C. Title 44, Chapter 35) would not apply to information collection for measure development activities.

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

Prior CMS regulations have established payment for chronic care management (CCM) services under the Medicare Part B physician fee schedule. Under these regulations, beginning January 1, 2015, CMS would allow a physician or qualified health practitioner (QHP) to be reimbursed under the Medicare physician fee schedule (MPFS) for providing CCM services per calendar month to patients with two or more chronic conditions. Specifically, the chronic conditions are expected to last at least 12 months (or until the death of the patient) and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. The patient must also be residing at their home or in a domiciliary, rest home, or assisted living facility.

This provision of H.R. 2 would codify in statute existing CMS initiatives with respect to CCM services and provide other requirements for such services. This provision would require the Secretary to make payment under the MPFS for CCM services provided by a physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife furnished on or after January 1, 2015. Additionally, this provision would require that (1) payment for CCM services could not be made to more than one applicable provider for such services, (2) could not be duplicative of payment that is otherwise made by Medicare, and (3) would not require that an annual wellness visit or an initial preventive physical examination be furnished as a condition of payment.

This provision of H.R. 2 would also require the Secretary to conduct an education and outreach campaign to inform professionals who provide Part B services and beneficiaries enrolled in Part B of the benefits for CCM services and to encourage individuals with chronic care needs to receive such care. This campaign would be directed by the Office of Rural Health Policy within HHS and the Office of Minority Health within CMS, and it would focus on encouraging participation by underserved, rural populations and racial/ethnic minority populations. No later than December 31, 2017, the Secretary would be required to submit a report to Congress on the use of CCM services by individuals in underserved, rural populations and racial/ethnic minority populations. The report would identify barriers to receiving CCM services and make recommendations for increasing the appropriate use of CCM services.

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

Section 10331 of the ACA required the Secretary of HHS to develop, not later than January 1, 2011, a Physician Compare website with information about physicians enrolled in Medicare (under section 1866(j) of the SSA) and other eligible professionals who participate in the Physician Quality Reporting Initiative (now the Physician Quality Reporting System). The Secretary was required, by January 1, 2013, to implement a plan to make publicly available comparative information on physician performance on quality and patient experience measures (consistent with privacy protections codified at 5 U.S.C. 552 and 552a). This information is required to include, among other things, measures collected under PQRS, and an assessment of efficiency, patient health outcomes, and patient experience, as specified. In developing and implementing this plan, the Secretary was required to consider a number of factors, including among others, processes to ensure appropriate attribution and processes to ensure that data made publicly available is statistically valid and reliable. The Secretary is required to consider the feedback from the multi-stakeholder groups (consistent with section 1890(b)(7) and section 1890A) when selecting measures for use under this section, and must consider the plan to transition to a value-based purchasing program for physicians (under section 131 of MIPPA) when developing and implementing the plan under this section. The Secretary is required to report to Congress, not later than January 1, 2015, on the Physician Compare website, as specified; at any time before the submission of this report, the Secretary is authorized to expand the information available on the Physician Compare website to other provider types (under Title XVIII), and is authorized to establish, at any time not later than January 1, 2019, a demonstration program to provide financial incentives to Medicare beneficiaries who utilize high quality physicians (as determined by the Secretary based on information included on the Physician Compare website).

On April 9, 2014, CMS released the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File, including information about services provided to Medicare beneficiaries by physicians and other health care professionals. The data set contains over 9 million Part B fee-for-service claims with information on utilization, payment (allowed amount and Medicare payment), submitted charges, and the place of service, organized for over 800,000 physicians or other non-institutional health care providers.

This provision of H.R. 2 would require the Secretary to make publicly available, on an annual basis, information with respect to physicians and other eligible professionals on items and services furnished to Medicare beneficiaries. The information made available under this section would be required to be similar to, and made available in a similar manner to, the information in the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File. The information made available would be required to include, at a minimum: (1) information on the number of services furnished under Part B; (2) information on submitted charges and payments for services; and (3) a unique identifier for the physician or eligible professional that is available to the public. The information would further be required to be made searchable by at least: (1) specialty or type of physician or eligible professional; (2) characteristics of the services furnished (e.g., volume); and (3) the location of the physician or eligible professional. Beginning in 2016, this information would be required to be integrated on Physician Compare.

Sec. 105. Expanding availability of Medicare data.

Section 105(a). Expanding Uses of Medicare Data by Qualified Entities.

The information contained in Medicare claims is extensive and voluminous, encompassing many decades of historical records and serving as a repository for the comprehensive record of the Medicare experience of both providers and beneficiaries. Researchers, insurers, patient advocates, and others have long argued that the ability to access and analyze Medicare data would lead to a better understanding of our health care delivery system and the ability to improve patient care. Under current law (SSA Sec. 1874(e)), certain qualified entities (defined as public or private entities qualified to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use) have access to standard extracts of Parts A, B, and D claims data, subject to some restrictions and limitations.

This provision of H.R. 2 would expand the uses of Medicare data by qualified entities, to the extent consistent with applicable information, privacy, security, and disclosure laws. Beginning July 1, 2016, a qualified entity could use Medicare claims data combined with claims data from other sources in the evaluation of the performance of providers of services and suppliers, to conduct additional non-public analyses (as determined appropriate by the Secretary), and to provide or sell such analyses to authorized users for non-public use (including for the purposes of assisting providers of services and suppliers to develop and participate in quality and patient care improvement activities, including developing new models of care).

Any analyses provided or sold to an employer could only be used by the employer for purposes of providing health insurance to its employees and retirees. A qualified entity could not provide or sell an analysis to a health insurance issuer unless the issuer is providing the qualified entity with data as part of the combined claims data as mentioned above.

Beginning July 1, 2016, a qualified entity could (i) provide or sell the combined data to a provider of services, a supplier, or a medical society or hospital association for non-public use, including for assisting providers of service and suppliers in developing and participating in quality and patient care improvement activities, including developing new models of care.

An analysis or data that is provided or sold as described above could not contain information that individually identifies a patient except in the case of information on patients of the provider of services or supplier itself. An authorized user would be prohibited from using an analysis or data provided or sold as described above for marketing purposes.

A data use agreement would be required of qualified entities and authorized users regarding the use of any data that the qualified entity is providing or selling to the authorized user. The agreement would describe the requirements for privacy and security of the data and, as determined appropriate by the Secretary, any prohibitions on using the data to link to other individually identifiable sources of information. If the authorized user were not a covered entity under the Health Insurance Portability and Accountability Act rules, the agreement would identify the relevant regulations, as determined by the Secretary, with which the user would comply if it were to act in the capacity of a covered entity.

An authorized user that is provided or sold an analysis or data would not redisclose or make public the analysis or data or any analysis using the data, except for the purposes of performance improvement and care coordination activities. Prior to a qualified entity providing or selling an analysis to an authorized user, the qualified entity would provide the provider or supplier with the opportunity to appeal and correct errors.

In the case of a breach of a data use agreement, the Secretary would impose on the qualified entity an assessment of up to \$100 for each individual entitled to or enrolled for Medicare Part A or Part B benefits. This would apply both in the case of (i) an agreement between the Secretary and a qualified entity; and (ii) an agreement between a qualified entity and an authorized user. Any amounts thereby collected would be deposited in Federal Supplementary Medical Insurance Trust Fund.

Any qualified entity that provides or sells an analysis or data as described above would submit an annual report to the Secretary that includes (a) a summary of the analyses provided or sold, including the number of such analyses, the number of purchasers of such analyses, and the total amount of fees received for such analyses; (b) a description of the topics and purposes of such analyses; (c) information on the entities who received the data, the uses of the data, and the total amount of fees received for providing, selling, or sharing the data; and (d) other information determined appropriate by the Secretary.

Section 105(b)-(d). Access to Medicare Data by Qualified Clinical Data Registries to Facilitate Quality Improvement.

Section 601(b) of the American Taxpayer Relief Act of 2012 (SSA Sec. 1848(m)(3)(E)) required the Secretary of Health and Human Services to deem those eligible professionals who satisfactorily participate in a “qualified clinical data registry” as having met the quality reporting requirements for Physician Quality Reporting System (PQRS) for 2014 and subsequent years. PQRS was established by the Centers for Medicare & Medicaid Services to reward eligible professionals for reporting specified quality data to the agency. The section also required the Secretary to establish requirements for a qualified clinical data registry and in so doing to

consider, among other things, whether an entity has mechanisms in place to ensure transparency and to support quality improvement initiatives for participants. Measures used in the qualified clinical data registries may be endorsed by the National Quality Forum (NQF). These measures are not subject to the process for measure selection being carried out by multi-stakeholder groups under SSA Section 1890A. In defining the requirements for the qualified clinical data registries, the Secretary was required to consult with interested parties and establish a process to determine whether the requirements have been met. The Government Accountability Office (GAO) was required to conduct a study on the potential of clinical data registries to improve the quality and efficiency of care in the Medicare program, including through payment incentives. As required by statute, GAO submitted a report to Congress on this study in December 2013.¹

This provision of H.R. 2 would require the Secretary, beginning on July 1, 2016, to provide upon request Medicare claims data and, as the Secretary determines appropriate, Medicaid and CHIP claims data, to qualified clinical data registries. This data would be provided for the purpose of linking it with clinical outcomes data and for performing analyses and research in support of quality improvement activities. The provision would further require that any public reporting of these analyses or research that identifies a provider gives the provider an opportunity to appeal and correct errors, as specified. The provision would require that the data be provided at a fee equal to the cost of providing such data.

Sec. 106. Reducing administrative burden and other provisions.

Section 106(a). Medicare Physician and Practitioner Opt-Out to Private Contract.

Physicians can furnish health care services to Medicare beneficiaries and receive payment from the Medicare program as either a participating physician or as a non-participating physician. Participating physicians sign an agreement (affidavit) to accept Medicare payment rates as payment in full for care provided to Medicare beneficiaries and cannot balance-bill beneficiaries. Nonparticipating physicians can still provide care to Medicare beneficiaries, but receive Medicare payments for covered services that are 95% of the amount for participating physicians. However, nonparticipating physicians are allowed to balance-bill beneficiaries subject to certain limits. The balance-billing limit is 115% of the fee schedule amount for nonparticipating physicians, which works out to 9.25% higher than the amount recognized for participating physicians (i.e., $1.15 \times 0.95 = 1.0925$).

Alternatively, beginning in 1998, physicians and certain practitioners can enter into private contracts (under Section 1861(r) of the SSA) with Medicare Part B beneficiaries, provide services, and bill patients without being subject to the upper payment limits specified by Medicare. “Opting-out” is available to physicians, including doctors of medicine and osteopathy, dentists, podiatrists, optometrists; physician assistants, nurse practitioners, and clinical nurse specialists; certified registered nurse anesthetists; certified nurse midwives; clinical psychologists; clinical social workers; and registered dietitians and nutrition professionals. Physical and occupational therapists in independent practice and chiropractors are not allowed to opt-out. However, if and when a physician/practitioner decides to enter a private contract with a

¹ GAO, “Clinical Data Registries: HHS Could Improve Medicare Quality and Efficiency through Key Requirements and Oversight,” December 2013, <http://www.gao.gov/assets/660/659701.pdf>.

Medicare patient, that physician/practitioner must agree to forego any reimbursement by Medicare for all Medicare beneficiaries for two years. In the case of emergency or urgent care, Medicare will pay for services provided by an “opt-out” physician/practitioner to a beneficiary with whom they have not signed an opt-out agreement.

The patient is not subject to the two-year limit; the patient would continue to be able to see other physicians who were not private contracting physicians and have Medicare pay for the services. A private contract is unnecessary and private contracting rules do not apply for non-covered services, e.g., cosmetic surgery; there are no limits on what may be charged for the non-covered service.

This provision of H.R. 2 would permit automatic extensions of private contracts unless the physician or practitioner provides a notice of non-extension not later than 30 days before the end of the period. This policy would be effective for affidavits signed on or after 60 days of enactment. The Secretary of HHS would be required to make certain information on providers and practitioners in private contracts publicly available. No later than February 1, 2016, the Secretary would make information on the number and characteristics of opt-out physicians and practitioners publicly available through a public HHS website and update the information annually. At a minimum, the website would include information about the opt-out physicians’ and practitioners’ (i) number, (ii) professional specialty or other designation, (iii) geographic distribution, (iv) timing regarding becoming opt-out physicians and practitioners, relative to when they first enrolled in the Medicare program and with respect to applicable two-year periods, and (v) proportion (of opt-out physicians and practitioners) who billed for emergency or urgent care services.

Section 106(b). Gainsharing Study and Report.

Section 646 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (i.e., SSA Section 1866C) authorized a budget-neutral Medicare gainsharing demonstration—the Physician Hospital Collaboration Demonstration—to test whether allowing hospitals to provide financial incentives to physicians promotes better coordination of care beyond the acute inpatient stay, resulting in improved patient outcomes, fewer short- and longer-term complications, and an overall reduction in the cost of care. Gainsharing refers to an arrangement between a hospital and physicians under which the hospital pays the physicians a share of any savings achieved through their collaborative efforts to improve utilization of inpatient hospital resources. The demonstration, which involved a consortium of 12 hospitals in New Jersey, ended in 2013 and was evaluated in 2014.

A second Medicare gainsharing demonstration authorized by Section 5007 of the Deficit Reduction Act of 2005 was completed in 2011.

This provision of H.R. 2 would require the Secretary, within six months of enactment and in consultation with the HHS Inspector General, to report to Congress with recommendations on amending existing anti-fraud and abuse laws (e.g., Civil Monetary Penalty and anti-kickback statutes) to permit physician-hospital gainsharing. The report must (1) consider what types of ownership interests, compensation arrangement, or other relationships should be covered; (2) describe how the recommendations address accountability, transparency, and quality, including how best to limit inducements to limit medically necessary care; and (3) consider whether any savings generated by gainsharing should accrue to Medicare.

Section 106(c). Promoting Interoperability of Electronic Health Record Systems.

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 amended Medicare (i.e., SSA Sections 1814(l)(3), 1848(o), 1853(l)&(m), and 1886(n)) and Medicaid (i.e., SSA Section 1903(a)(3)(F) & (t)) to authorize incentive payments to eligible hospitals and physicians—and certain other health care professionals—who attest to being “meaningful users” of certified electronic health record (EHR) technology. The HITECH Act defined meaningful use as using certified EHR technology in a meaningful manner (e.g., e-prescribing), and using the technology to exchange electronic health information with another EHR system and to report clinical quality measures to the Secretary. The law also instructed the Secretary to make the measures of meaningful use more stringent over time, which CMS is doing in stages.

To meet the initial stage (i.e., Stage 1) of meaningful use, eligible hospitals and physicians must use their EHR technology to meet a series of objectives that generally involve capturing and storing structured patient data (e.g., vital signs, medications, lab test results). Providers must use EHR technology that has been certified by an accredited certification authority to perform these functions. Providers now in their third or fourth year of participation in the program are moving to meaningful use Stage 2, under which they must use their EHR technology to perform certain additional functions including some exchange of patient data during transitions of care (e.g., a hospital discharge to a rehabilitation facility, or a physician referral). The term EHR interoperability is used to refer to the ability of EHR systems not just to exchange electronic information but to be able to use the information based on common standards. While the Medicare and Medicaid incentive programs have had a significant impact on promoting the widespread adoption and use of EHR technology in hospitals and physician practices across the country, significant challenges remain in achieving widespread EHR interoperability.

This provision of H.R. 2 would declare it a national objective to achieve widespread interoperability of certified EHR technology by December 31, 2018. The Secretary would be required, in consultation with stakeholders, by July 1, 2016, to establish interoperability metrics to measure progress towards achieving that objective. If the objective were not met by December 31, 2018, then the Secretary would have until December 31, 2019, to submit a report to Congress identifying the barriers to widespread interoperability and providing recommendations for achieving the objective. Such recommendations may include (1) payment adjustments for not being meaningful EHR users under the Medicare EHR incentive program; and (2) the criteria for decertifying certified EHR technology products.

The Medicare EHR incentive program would be amended to require eligible hospitals and physicians, beginning one year after enactment, to indicate through meaningful use attestation (or some other process specified by the Secretary) that they had not knowingly and willfully taken any action to limit or restrict the interoperability of their certified EHR technology.

The Secretary would be required, within one year of enactment, to submit to Congress a report on ways to help providers compare and select certified EHR technology, such as through surveying EHR users and vendors and making such information publicly available.

Section 106(d). GAO Studies and Reports on the Use of Telehealth Under Federal Programs and on Remote Patient Monitoring Services.

Section 1834(m) of the SSA authorizes Medicare reimbursement to physicians for telehealth services provided via live video conferencing. Such reimbursement is limited to certain types of services provided; mostly, consultations, psychological counseling and screenings, and pharmacologic management. The services must be provided to an eligible Medicare beneficiary in an eligible facility (e.g., physician office, hospital, health center, or rural health clinic) located outside of a Metropolitan Statistical Area. Medicare reimbursement for telehealth services totaled \$12 million in 2013.

This provision of H.R. 2 would require the Government Accountability Office (GAO), within two years of enactment, to submit two reports to Congress, each with recommendations for legislative and administrative actions. GAO would be permitted to combine both reports into a single document. The first report, focused on the Medicare telehealth program, would examine and evaluate (1) how the various definitions of telehealth used in federal programs can inform the use of telehealth under Medicare; (2) factors that can facilitate or inhibit the use of telehealth under Medicare; and (3) the potential implications of expanding telehealth in the transformation of payment and delivery systems under Medicare (and Medicaid); and (4) how CMS monitors Medicare telehealth payments.

The second report, focused on remote patient monitoring technology and services, would examine and evaluate (1) the private health insurance incentives for adopting such technology; (2) the patients, conditions, and clinical circumstances that could most benefit from using such services; (3) the barriers to adopting such services under Medicare; and (4) the challenges in placing a value on remote patient monitoring services under the Medicare PFS in order to reflect accurately the resources involved in furnishing such services.

Section 106(e). Rule of Construction Regarding Health Care Providers.

This provision of H.R. 2 would provide that the development, recognition, or implementation of any guideline or standard under the ACA, Medicare, or Medicaid cannot 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. However, this provision would not preempt any state or common law governing medical professional or medical product liability actions or claims.

Title II—Medicare and Other Health Extenders

Subtitle A—Medicare Extenders

Sec. 201. Extension of work GPCI floor.

The Medicare physician fee schedule is adjusted geographically for three factors to reflect differences in the cost of resources needed to produce physician services: physician work, practice expense, and medical malpractice insurance. The geographic adjustments are indices—known as Geographic Practice Cost Indices (GPCIs)—that reflect how each area compares to the national average in a “market basket” of goods. A value of 1.00 represents the average across all

areas. These indices are used in the calculation of the payment rate under the Medicare physician fee schedule. A series of bills set a temporary floor value of 1.00 on the physician work index beginning January 2004 and continuing through March 31, 2015.

This provision of H.R. 2 extends the 1.00 floor for the physician work geographic index through December 31, 2017.

Sec. 202. Extension of therapy cap exceptions process.

Medicare beneficiaries face two annual payment limits for all Medicare-covered outpatient therapy services. Established by the Balanced Budget Act of 1997 (BBA97), this limit initially applied to therapy services provided by *non-hospital providers*, to be applied separately (1) for physical therapy services and speech-language pathology services, and (2) for occupational therapy services. Initially set at \$1,500 to apply beginning in 1999, these limits were suspended from 2000-2005. The DRA re-implemented the limits beginning in 2006 and required the Secretary to implement an exceptions process for services meeting specified criteria for medically necessary services. A series of legislative acts have extended the exceptions process, increased the limits, and modified the conditions for the application of the caps each year since.

The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) set the annual threshold at \$3,700, to be applied separately for the two categories of therapy services effective October 1, 2012. However, this increased amount applied to therapy service received *both in physicians' offices and hospital outpatient departments* for the first time. The American Taxpayer Relief Act of 2012 (ATRA) extended the application of the cap and threshold to therapy services furnished in a hospital outpatient department and in a Critical Access Hospital (CAH). ATRA extended the mandate that Medicare perform manual medical review of therapy services for which an exception is requested when the beneficiary has reached a dollar aggregate threshold amount of \$3,700 for therapy services. PSRA and PAMA extended the therapy cap exceptions process through March 31, 2015.

This provision in H.R. 2 would extend the exceptions process through December 31, 2017 and require the Secretary to implement a new medical review process for outpatient therapy services. In determining which therapy services to review, the Secretary could identify services furnished by a therapy provider who (i) has had a high claims denial percentage or is less compliant with applicable Medicare program requirements; (ii) has a pattern of billing for therapy services that is aberrant compared to peers or otherwise has questionable billing practices, such as billing medically unlikely units of services in a day; (iii) is newly enrolled or has not previously furnished therapy services under the Medicare program; (iv) provides services to treat a type of medical condition; or (v) is part of a group that includes another therapy provider identified by the preceding factors.

To implement this new medical review process, CMS would receive \$5 million from the Federal Supplementary Medical Insurance (Medicare Part B) Trust Fund for fiscal years 2015 and 2016, to remain available until expended. These funds could not be used by a Medicare recovery audit contractor (RAC) for medical reviews of therapy services.

Sec. 203. Extension of ambulance add-ons.

The SSA provides for bonus payments for ground ambulance services that originate in qualified rural areas (called super rural areas) furnished on or after July 1, 2004 and before April 1, 2015. The super rural areas are those counties with the lowest population densities that collectively represent 25% of the total population. CMS estimated and set the super rural bonus as a 22.6% increase in the base rate for the transport. Subsequently the Medicare rates for ground ambulance services otherwise established for the year were increased an additional 3% for rural ambulance services and 2% for urban ambulance services before April 1, 2015.

H.R. 2 would extend the super rural, rural and urban add-ons to Medicare's ambulance fee schedule until January 1, 2018.

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

Under the Medicare Inpatient Prospective Payment System (IPPS), qualifying hospitals receive increased payments to account for the higher incremental costs associated with a low volume of discharges. The Secretary is required to determine an empirically appropriate percentage increase per discharge, up to a ceiling of 25%, for low-volume hospitals more than 25 road miles from a comparable hospital. These hospitals could have as many as 800 *total* discharges. CMS determined that hospitals with fewer than 200 *total* (Medicare and non-Medicare) discharges located more than 25 road miles from another acute care hospital qualified for a 25% increase. ACA temporarily relaxed the requirements for hospitals to receive increased low-volume payment, starting for discharges in FY2011. The low volume standards were changed from no more than 800 *total* discharges and no comparable hospital closer than 25 road miles to no more than 1,600 *total Medicare* discharges and no comparable hospital closer than 15 road miles. Qualifying hospitals with 200 or fewer Medicare discharges receive a payment increase of 25% per discharge which diminishes to no increase for hospitals with 1,600 Medicare discharges. The low-volume adjustment will revert to the original, more stringent standards (total discharges, more than 25 road miles, a flat 25% increase) starting for discharges on April 1, 2015.

H.R. 2 would extend the more generous low-volume adjustment standards until October 1, 2017.

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

MDHs are small rural hospitals with a high proportion of patients who are Medicare beneficiaries. Specifically, MDHs have no more than 100 beds and at least 60% of acute inpatient days or discharges attributable to Medicare in FY1987 or in two of the three most recently audited cost reporting periods. MDHs receive special treatment, including higher payments, under Medicare's IPPS. The MDH special payment status will expire by April 1, 2015.

H.R. 2 would extend the MDH program until October 1, 2017, and would make other technical conforming changes.

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

MMA established a new type of Medicare Advantage (MA) coordinated care plan focused on individuals with special needs. Special needs plans (SNPs) are allowed to target enrollment to one or more types of special needs individuals including (1) institutionalized, (2) dually eligible, and (3) individuals with severe or disabling chronic conditions. Among other changes, ACA §3205 extended SNP authority through December 31, 2013 and temporarily extended authority through the end of 2012 for SNPs that do not have contracts with state Medicaid programs to continue to operate, but not to expand their service area.

ATRA extended SNP authority to operate through December 31, 2014, and also temporarily authorized SNPs without contracts with state Medicaid programs to continue to operate, but not to expand their service areas. PSRA temporarily extended SNP authority through December 31, 2015. PAMA temporarily extended SNP authority through December 31, 2016.

This provision of H.R. 2 would extend SNP authority to operate for two additional years through December 31, 2018.

Sec. 207. Extension of funding for quality measure endorsement, input, and election.

Section 183 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (SSA Sec. 1890) required the Secretary of HHS to have a contract with a consensus-based entity (e.g., National Quality Forum, or NQF) to carry out specified duties related to performance improvement and measurement. These duties include, among others, priority setting; measure endorsement; measure maintenance; convening multi-stakeholder groups to provide input on the selection of quality measures and national priorities; and annual reporting to Congress. Section 183 of MIPPA required the Secretary to provide for the transfer of \$10 million for each of FY2009 through FY2012 from the Medicare Part A and B Trust Funds to carry out the activities under section 1890 of the SSA; section 609 of ATRA extended this funding through FY2013.

Section 3014(b) of the ACA required the Secretary to establish a pre-rulemaking process to select quality measures for use under Title XVIII (SSA Sec. 1890A(a)-(d)). This process includes gathering multi-stakeholder input; making measures under consideration available to the public; transmission to, and consideration by, the Secretary of the input of multi-stakeholder groups; and the publication of the rationale for the use of any quality measure in the Federal Register; among others. The Secretary is required to establish a process for disseminating quality measures used by the Secretary; the Secretary is also required to periodically review quality measures and determine whether to maintain the use of a measure or to phase it out. In addition, ACA Sec. 3014(a) adds new duties for the consensus-based entity under the contract in SSA Sec. 1890 (multi-stakeholder group convening and reporting duties). Through its Measure Applications Partnership (MAP), NQF has been convening multi-stakeholder groups to provide input into the selection of quality measures for use in the Medicare and other federal health programs; MAP publishes annual reports with recommendations for selection of quality measures in February of each year. Section 3014(c) of the ACA provided for the transfer of \$20 million for each of FY2010 through FY2014 from the Medicare Part A and B Trust Funds for these activities.

Section 109 of the Protecting Access to Medicare Act of 2014 (PAMA) required the transfer of \$5 million for FY2014 and \$15 million for the first six months of FY2015 from the Medicare Part A and B Trust Funds to carry out both section 1890 and section 1890A(a)-(d) of the SSA; funds are required to remain available until expended.

This provision of H.R. 2 would strike the language in PAMA providing for \$15 million for the first six months of FY2015, and replace it with language that would provide for the transfer of \$30 million for each of FY2015 through FY2017 from the Medicare Part A and B Trust Funds to carry out the activities under SSA Sec. 1890 and SSA Sec. 1890A(a)-(d). These funds are required to remain available until expended.

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

Section 119 of MIPPA appropriated \$25 million for FY2008 and FY2009 for low-income Medicare beneficiary outreach and education activities through the following programs: State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and the Administration on Aging (AoA). Section 3306 of the ACA extended these programs and appropriated a total of \$45 million for FY2010 through FY2012 for these and other programs such as Medicare Part D low income subsidy outreach and the Medicare Savings Program.

ATRA extended MIPPA section 119 authorities through FY2013 and appropriated a total of \$25 million in the following amounts for low-income Medicare beneficiary outreach and assistance programs: SHIPs, \$7.5 million; AAAs, \$7.5 million; ADRCs, \$5 million; and the Contract with the National Center for Benefits and Outreach Enrollment, \$5 million.

The Pathway for SGR Reform Act of 2013 (PSRA) extended MIPPA section 119 authorities through the second quarter of FY2014 (March 31, 2014) and appropriated funding at FY2013 funding levels pro-rated for the first two quarters of FY2014 (i.e., PSRA appropriated half a year's worth of FY2014 funding).

PAMA extended MIPPA section 119 authorities through the second quarter of FY2015 (March 31, 2015). For FY2014, it provided a total of \$25 million in funding for low-income Medicare beneficiary outreach and assistance programs at FY2013 funding levels: SHIPs, \$7.5 million; AAAs, \$7.5; ADRCs, \$5.0 million; and the Contract with the National Center for Benefits and Outreach Enrollment, \$5.0 million. In addition, PAMA appropriated funding at FY2014 funding levels pro-rated for the first two quarters of FY2015 (i.e., PAMA appropriated half a year's worth of FY2015 funding).

H.R. 2 would extend MIPPA section 119 authorities through FY2017. For FY2015, it would provide a total of \$25 million in funding at the previous year's funding levels, as shown in **Table 1**. For each of FY2016 and FY2017, it would appropriate a total of \$37.5 million for low-income Medicare beneficiary outreach and assistance programs, a \$12.5 million increase from FY2015 funding levels. It would increase funding for SHIPs by \$5.5 million and the Contract with the National Center for Benefits and Outreach Enrollment by \$7 million for each of FY2016 and FY2017.

Table 1. H.R. 2, Sec. 208 Low-Income Outreach and Assistance Programs Appropriations
FY2015 through FY2017

Low-Income Program/Appropriations	FY2015 Appropriations	FY2016 Appropriations	FY2017 Appropriations
State Health Insurance Assistance Programs (SHIPs)	\$7.5 million	\$13 million	\$13 million
Area Agencies on Aging (AAAs)	\$7.5 million	\$7.5 million	\$7.5 million
Aging and Disability Resource Centers (ADRCs)	\$5.0 million	\$5.0 million	\$5.0 million
Contract with the National Center for Benefits and Outreach Enrollment	\$5.0 million	\$12.0 million	\$12.0 million
Total	\$25 million	\$37.5 million	\$37.5 million

Source: CRS summary of section 208 of H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015.

Sec. 209. Extension and transition of reasonable cost reimbursement contracts.

Reasonable cost plans (or cost plans) are Medicare managed care plans that are reimbursed by Medicare for the actual cost of providing services to enrollees. Cost plans were created in TEFRA. The BBA97 included a provision to phase-out the reasonable cost contracts, however, the phase-out has been delayed over the years through congressional action. After January 1, 2016, the Secretary cannot extend or renew a cost contract for a service area if (1) during the entire previous year there were either two or more Medicare Advantage (MA) regional plans or two or more MA local plans in the service area offered by different MA organizations, and (2) these regional or local plans met specified minimum enrollment requirements.

In contrast to reasonable cost plans, MA plans under Medicare Part C are paid a capitated monthly payment for each beneficiary enrolled in their plan regardless of the actual cost of providing required services to each enrollee. The plan is at-risk if costs for all of its enrollees exceed program payments and beneficiary cost sharing; conversely, in general, the plan can retain savings if aggregate enrollee costs are less than program payments and cost sharing.

The per-beneficiary payment under MA is determined by comparing a plan’s bid to a benchmark. A bid is the plan’s estimated cost of providing Medicare-covered services (excluding hospice, but including the cost of medical services, administration, and profit). A benchmark is the maximum amount the federal government will pay for providing those services in the plan’s service area. If a plan’s bid is less than the benchmark, its payment equals its bid plus a rebate equal to the difference between the bid and the benchmark. If a plan’s bid is equal to or above the benchmark, its payment equals the benchmark amount and each enrollee in that plan will pay an additional premium that is equal to the amount by which the bid exceeds the benchmark. Benchmarks are adjusted based on plan quality such that a plan with 4 or 5 stars on a 5-star quality rating scale receives a 5 percentage point increase in their benchmark. Plans that are new (and do not have data upon which to base a quality rating) or have low enrollment receive a 3.5 percentage point increase in their benchmark.

H.R. 2 would transition reasonable cost plans that can no longer qualify to be cost plans under the current statutory requirements, into Medicare Advantage plans. It would also allow cost plans that would otherwise qualify under the statutory requirement, to voluntarily transition into MA plans.

The following five provisions of H.R. 2 would apply if (a) a reasonable cost contract plan could not be renewed because, during the previous year, the plan's service area was also served by two or more MA regional or two or more MA local plans that met specific enrollment requirements, or (b) an organization with a reasonable cost contract voluntarily sought not to renew its contract, but rather, convert it to an MA plan.

1. The contract may be extended for the two years subsequent to 2016. The contract's final year is referred to as the "last reasonable cost reimbursement contract year for the contract" or the "last year".
2. The organization would be prohibited from enrolling new beneficiaries during the last year, and new enrollment during the prior year would be restricted. Beneficiaries would not be allowed to enroll in the cost plan during the annual election period that applied to the last year. A beneficiary whose spouse was an enrollee under the cost contract would not be able to enroll in the cost plan during the year prior to the last year. A beneficiary who was covered by an employer group health plan offered through the cost contract would also be prohibited from enrolling in the cost plan in the year prior to the last year. In addition, beneficiaries who become eligible for Medicare and, just prior to Medicare eligibility, were enrolled in a non-Medicare plan offered by the organization, would not be able to enroll in the cost plan for the year prior to the last year.
3. The organization offering the cost plan would be required to notify the Secretary whether or not the contract was to be converted, in whole or in part, to an MA plan for the year following the last year.
4. If the organization was to convert the cost plan to an MA plan, the organization would be required to provide the Secretary with the information necessary to carry out the deeming enrollment process (described below) and the bidding review process used to determine MA payments.
5. If a cost plan enrolls a beneficiary during the last year, the organization would be required to notify the individual that it was the last year for the contract. During the last year and the year prior to the last year, the organization would be permitted to offer an MA plan in the same area, and would be allowed to enroll beneficiaries in both the MA plan and the cost plan.

If an organization offering a cost plan informs the Secretary that it will be converted to an MA plan, enrollees would be deemed to enroll in the new MA plan under certain circumstances. A beneficiary, who was enrolled in a cost plan during the last year of a reasonable cost contract, is deemed to elect to receive benefits through an applicable MA plan, unless they elect otherwise, but only if certain provisions apply. First, the beneficiary would have to have been enrolled in the reasonable cost plan in the previous year, and the plan would have had to have been extended or renewed for the last year. Second, the cost plan would have had to provide notice to the enrollees that it was to be converted to an MA plan. Third, the applicable MA plan was, in fact, converted from a cost plan and was offered by the same entity or organization that had previously entered into the cost contract, and in the same service area. Fourth, the premiums and other costs

determined by the Secretary for both the cost plan and the subsequent MA plan would not be allowed to exceed a threshold established by the Secretary.

The subsequent MA plan would be required to maintain networks of providers and suppliers, and courses of treatment for beneficiaries currently in care for at least 90 days after the conversion to help enrollees with the transition. During the 90-day transition, the MA plan would be required to pay providers and suppliers amounts that were not less than what is paid under original Medicare. Beneficiaries, who are eligible for the deemed enrollment process, that did not have drug coverage in their reasonable cost plans would be enrolled in a MA plan without a Part D drug benefit. Concurrently, beneficiaries that had drug coverage under a cost plan would be enrolled in a MA plan with Part D coverage. The Secretary would be required to identify and notify the enrollees affected by the deemed enrollment process no later than 45 days before the first day of the annual, coordinated election period for the plan year beginning on or after January 1, 2017 .

H.R. 2 would create a special election period for beneficiaries who were deemed to enroll into a newly converted MA plan or MA-PD plan. The special election period would last from after the last day of the annual coordinated election period (December 8th) until the end of February of the first plan year for which the beneficiary is enrolled in the MA plan. Eligible beneficiaries would be able to change their plan selection during that time, including changing from an MA plan to an MA-PD plan or from an MA-PD plan to an MA plan. However, the beneficiary would only be able to exercise this option once. A beneficiary who developed end-stage renal disease while enrolled in a cost contract that converted to an MA contract would be eligible for the deemed enrollment process as well.

H.R. 2 would require an MA organization offering a newly converted MA plan to provide enrollees with the following information: (1) a notification that the individual will be deemed to have made an election to receive benefits under an MA plan or an MA-PD plan for the next year, but that the individual may make a different election during the annual, coordinated election period, (2) the information that the Secretary is required to send to all beneficiaries prior to the beginning of the annual, coordinated election period, (3) a description of the differences between an MA plan or an MA-PD plan and the reasonable cost plan in which the individual was recently enrolled, including information on benefits, cost-sharing, premiums, drug coverage, and provider networks, (4) information about special election periods, and (5) other information the Secretary may specify.

With respect to any quality adjustments applied to the newly converted plan's MA benchmark, for the first three years after a cost plan converts to an MA plan, H.R. 2 would require that the plan would not be treated as a new MA plan. Rather, the star rating for the converted MA plan would be determined based on available data. To the extent that data is not available, the Secretary would be required to use data from a period during which the plan was still a reasonable cost plan.

Sec. 210. Extension of home health rural add-on.

As required by Congress, Medicare provides increased payments under the home health prospective payment system (HH PPS) for home health care provided to beneficiaries in rural areas. BIPA established a 10% increase to Medicare's HH PPS rates for home health care provided to beneficiaries in rural areas beginning April 1, 2001 through March 31, 2003. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) reestablished this rural add-on at a 5% increase beginning April 1, 2004 through March 31, 2005. DRA

reestablished the 5% rural add-on beginning January 1, 2006 through December 31, 2006. ACA reestablished the rural add-on at a 3% increase beginning April 1, 2010 through December 31, 2015.

H.R. 2 would extend the rural add-on under the HH PPS at a 3% increase for home health care provided to beneficiaries in rural areas from January 1, 2016 through December 31, 2017.

Subtitle B—Other Health Extenders

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

BBA97 required states to pay Medicare Part B premiums for a new group of low-income Medicare beneficiaries—Qualifying Individuals (QIs)—whose income was between 120% and 135% of FPL. BBA97 also amended the Social Security Act to provide for Medicaid payment for QIs through an annual transfer from the Medicare Part B Trust Fund to be allocated to states. States (and the District of Columbia) receive 100% federal funding to pay QI's Medicare premiums up to the federal allocation, but no additional matching beyond the annual allocation. In September 2014, approximately 499,700 low-income Medicare beneficiaries received financial assistance from state Medicaid programs to pay their Part B premiums. The QI program was reauthorized and funded a number of times since it was established by BBA97, and most recently, Section 201 of the Protecting Access to Medicare Act (PAMA, P.L. 113-93) re-authorized the QI program through March 31, 2015 and appropriated \$1.035 billion in funding.

This provision of H.R. 2 would permanently extend the QI program and appropriate \$535 million for the remainder of CY2015 (April 1, 2015-December 31, 2015) and \$980 million for CY2016. The amount of funding for CY2017 and subsequent calendar years would be determined by the product of the following: (1) the previous year's QI allocation, (2) the increase from the previous year in Medicare Part B premium, and (3) the estimated increase from the previous year in Part B enrollment.

Sec. 212. Permanent extension of transitional medical assistance (TMA).

Medicaid requires states to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in income. This continuation is known as transitional medical assistance (TMA). States must provide TMA to families losing eligibility based on §1931 of the SSA under two scenarios. First, states were permanently required to provide four months of TMA coverage to families who lose Medicaid eligibility under §1931 due to increased child *or* spousal support collections. At state option, families eligible for this 4-month extension must have been receiving Medicaid under Section 1931 in at least three of the preceding six months.² The 4-month extension of coverage for individuals losing eligibility due to increased spousal support does not have a sunset date. However, with the transition to the Modified Adjusted Gross Income (MAGI) income counting rules by January 1, 2014, the extension of eligibility for individuals losing coverage under §1931 due to increased child support is no longer relevant, as child support is not counted as income under MAGI-based income counting methodologies.

² The American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) gave states the option to waive the requirement that individuals be enrolled in Medicaid for three out of the past six months in order to qualify for TMA.

Second, under §1902(e)(1) and §1925, states are required to provide TMA to families losing §1931 Medicaid eligibility for work-related reasons (otherwise referred to as work-related TMA). States were originally required to provide four months of TMA to families losing eligibility due to an increase in hours of work or income from employment. However, the Family Support Act (FSA) of 1988 (P.L. 100-485) expanded state TMA requirements under §1925, requiring states to provide at least six, and up to 12, months of TMA to families losing §1931 Medicaid eligibility due to increased hours of work or income from employment, as well as to families who lose eligibility due to the loss of a time-limited earned income disregard that allows families to qualify for Medicaid at higher income levels for a set period of time. States are given the option of meeting this requirement by using Medicaid funds to pay for a family's premiums or other related costs for employer-based coverage when available. After the initial 6-month period, families may continue coverage for an additional six months if the family's earnings, minus child care costs, do not exceed 185% of the federal poverty level, among other requirements.³ Additionally, in the second 6-month period, states may require families with incomes at or above 100% FPL to pay a premium for the additional coverage. The American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) created an additional work-related TMA option, allowing states to provide work-related TMA for a full twelve-month period rather than two consecutive six-month periods.

The Family Support Act of 1988 (FSA; P.L. 100-485) originally authorized §1925 to replace the four-month requirement in §1902(e)(1) through FY1998. The welfare reform law of 1996 (P.L. 104-193) extended §1925 through FY2001, and the provision has continued to exist under a series of short term extensions (most recently, through March 31, 2015).

H.R. 2 would permanently extend §1925 work-related TMA, requiring states to provide at least six, and up to 12, months of TMA coverage to families losing §1931 Medicaid eligibility due to increased hours of work or income from employment, as well as to families who lose eligibility due to the loss of a time-limited earned income disregard. The provision would not impact the 4-month TMA coverage for individuals losing eligibility due to increased spousal support.

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

The BBA97 authorized two diabetes-related programs through the PHSA. The first, authorized in PHSA §330B, provides funding for the National Institutes of Health⁴ to award grants for research into the prevention and cure of Type I diabetes. The second, authorized in PHSA §330C, provides funding for the Indian Health Service (IHS)⁵ to award grants for services related to the prevention and treatment of diabetes for American Indians and Alaska Natives who receive services at IHS-funded facilities.⁶ BBA97 appropriated funding for both programs from FY1998 through

³ The American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) gave states the option to waive the requirements for TMA enrollees in the second six-month period (i.e., requirements to report earnings and child care and to remain below 185 percent FPL).

⁴ For more information on the National Institutes of Health, see CRS Report R41705, *The National Institutes of Health (NIH): Background and Congressional Issues*, by Judith A. Johnson.

⁵ For more information on the Indian Health Service, see CRS Report R43330, *The Indian Health Service (IHS): An Overview*, by Elayne J. Heisler.

⁶ IHS-funded facilities refer to facilities operated directly by the IHS, by an Indian Tribe, a Tribal Organization, or an Urban Indian Organization as these terms are defined in §4 of the Indian Health Care Improvement Act (25 U.S.C. §1604).

FY2002; funding years were extended and amounts appropriated were increased in subsequent legislation (BIPPA, P.L. 107-360, MMSEA, MMEA, and ATRA). The programs' most recent extension was in PAMA, which provided \$150 million for FY2015 for each program.

This provision of H.R. 2 would extend the annual appropriation of \$150 million for each program for each of FY2016 and FY2017.

Sec. 214. Extension of abstinence education.

Section 912 of PRWORA authorized abstinence education formula grants in Section 510 of the SSA.⁷ To receive these formula grants, states must request funding when applying for Maternal and Child Health Block Grant funds⁸ authorized in SSA Section 501. Funds provided must be used exclusively for teaching abstinence from sexual activity outside of marriage. PRWORA authorized and appropriated \$250 million (\$50 million for each of FY1998 through FY2002) for abstinence education. Subsequently, funding for this program was extended through June 30, 2009, by a series of legislation detailed below. ACA Section 2954 appropriated \$50 million for each of FY2010 through FY2014 for this program. Most recently, PAMA (Section 205) extended funding for the program through FY2015. This program is administered by the Administration for Children and Families (ACF). In addition, several appropriation laws included an additional \$5 million for competitive grants for abstinence-only education for each of FY2012, FY2013, FY2014, and FY2015 (P.L. 112-74, P.L. 113-6, P.L. 113-76, and P.L. 113-164/P.L. 113-235, respectively). The funding designated for abstinence education grants expires September 30, 2015.

H.R. 2 would increase and extend funding for Section 510 Abstinence Education grants to \$75 million for each of fiscal years 2016 and 2017.

Sec. 215. Extension of personal responsibility education program (PREP).

Section 2953 of the ACA established the Personal Responsibility Education Program (PREP) in Section 513 of the SSA. PREP is a state formula grant program to support evidence-based programs designed to educate adolescents about abstinence, contraception, and adulthood. The ACA also required the Secretary of Health and Human Services to award grants to implement innovative youth pregnancy prevention strategies and to target services to high-risk populations. The ACA (in Section 2953) appropriated a total of \$375 million with \$75 million appropriated for each of FY2010 through FY2014. The ACA required that \$10 million each year be reserved for the youth pregnancy prevention grants. PAMA (in Section 206) extended funding for the program through FY2015. The funds are available until expended. The program is administered by ACF. The funding designated for PREP expires September 30, 2015.

H.R. 2 would extend funding for PREP through FY2017 at \$75 million per year.

⁷ For more information on abstinence education programs in Title V of the SSA, see CRS Report RS20301, *Teenage Pregnancy Prevention: Statistics and Programs*, by Carmen Solomon-Fears.

⁸ For more information on the Maternal and Child Health Block Grant, see CRS Report R42428, *The Maternal and Child Health Services Block Grant: Background and Funding*, by Carmen Solomon-Fears.

Sec. 216. Extension of funding for family-to-family health information centers.

The Family-to-Family Health Information Centers program, administered by the Health Resources and Services Administration (HRSA), provides grants to family-staffed organizations that provide health care information and resources to families of children with special health care needs. ACA §5507 appropriated \$5 million for each of FY2009-FY2012 for Family-to-Family Health Information Centers. ATRA subsequently extended this appropriation an additional year, through FY2013. P.L. 113-67 provided a half year of funding (\$2.5 million) for this program that expired April 1, 2014. PAMA provided \$2.5 million for the remainder of FY2014 (from April 1, to September 30, 2014) and provided \$2.5 million for the first half of FY2015 (October 1, 2014 through March 31, 2015).

This provision of H.R. 2 would strike the partial funding provided in PAMA and provide full year funding of \$5 million for FY2015; and provide \$5 million for each of FY2016 and FY2017.

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

ACA §5507(a) required the Secretary to establish a demonstration project in SSA §2008 that awarded funds to states, Indian tribes, institutions of higher education, and local workforce investment boards for health profession opportunity grants (HPOG). These grants were used to help low-income individuals—including individuals receiving assistance from State Temporary Assistance for Needy Families (TANF) programs—to obtain education and training in health care jobs that pay well and are in high demand. Funds were also used to provide financial aid and other supportive services. This program is administered jointly by the HRSA and the Administration for Children and Families (ACF). ACA appropriated \$85 million for HPOG in each of FY2010 through FY2014 (\$425 million total), but reserved a total of \$15 million for a demonstration project for personal and home care aides. PAMA provided \$85 million for HPOG for FY2015.

This provision of H.R. 2 would extend the HPOG appropriation of \$85 million for each of FY2016 and FY2017.

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

Section 2951 of the ACA established the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program in SSA §511.⁹ This program provides grants to states, territories, and tribes for the support of evidence-based early childhood home visiting programs. These programs support in-home visits by health or social service professionals with at-risk families. The ACA appropriated a total of \$1.45 billion for FY2010 through FY2014 for the program: \$100 million for FY2010, \$200 million for FY2011, \$350 million for FY2012, \$400 million for FY2013, and \$400 million for FY2014. Of the amount appropriated for this program, 3% annually is reserved for research and evaluation, and 3% annually is reserved to make grants to tribal entities for home

⁹ For more information, see CRS Report R43930, *Maternal and Infant Early Childhood Home Visiting (MIECHV) Program: Background and Funding*, by Adrienne L. Fernandes-Alcantara.

visitation services to Indian families. This program is administered by the Health Resources and Services Administration and the Administration for Children and Families, both at HHS.

PAMA provided \$400 million for the MIECHV program for the first half of FY2015 (October 1, 2014 through March 31, 2015). It also reserved portions of this part-year funding for Indian tribal entities (3% of the appropriation) and research and evaluation (3% of the appropriation).

H.R. 2 would extend the \$400 million made available under PAMA through all of FY2015 (October 1, 2014 through September 30, 2015). It would also provide \$400 million for each of FY2016 and FY2017.

Sec. 219. Tennessee DSH allotment for fiscal years 2015 through 2025.

The Medicaid statute requires states to make disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income patients.¹⁰ While most federal Medicaid funding is provided on an open-ended basis, federal DSH funding is capped. Each state receives an annual DSH allotment, which is the maximum amount of federal matching funds a state is permitted to claim for Medicaid DSH payments. States' Medicaid DSH allotments are based on each state's prior year DSH allotment, but Hawaii and Tennessee have special statutory arrangements for the determination of their respective DSH allotments provided through multiple laws. Most recently, the ACA provided Hawaii a Medicaid DSH allotment for FY2012 and subsequent years, while the Tennessee provision provided an allotment for FY2012 and FY2013. Under current law, Tennessee is the only state without a Medicaid DSH allotment for FY2014 and subsequent years.

This provision would provide a Medicaid DSH allotment to Tennessee in the amount of \$53.1 million for each fiscal year from FY2015 through FY2025.

Sec. 220. Delay in effective date for Medicaid amendments relating to beneficiary liability settlements.

Under third-party liability (TPL) rules, Medicaid is the payer of last resort. If another insurer or payer has financial responsibility for medical services provided to Medicaid beneficiaries, generally that third party is required to pay all or part of the bill before Medicaid pays. Under federal Medicaid law applicable to TPL, states are required to determine if third parties exist, and to ensure that providers bill third parties first, before billing Medicaid. DRA strengthened Medicaid TPL by clarifying what entities are considered third parties and requiring states to pass laws that stipulate third parties comply with federal Medicaid TPL law.

States also are required under federal Medicaid TPL law to recover from judgments awarded to Medicaid beneficiaries. For example, if an individual receives medical care following an accident for which Medicaid paid, and the individual later wins a judgment against a third party responsible for that accident (for instance another driver's auto insurance), the state must recover the amount Medicaid paid for the beneficiary's treatment from that third party. Recent court cases

¹⁰ For more information about Medicaid DSH payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*, by Alison Mitchell.

limited states' ability to recover from such judgments to the medical care costs, not the entire settlement, or the settlement amounts attributable to lost wages or non-medical costs.¹¹

The Bipartisan Budget Act of 2013 (P.L. 113-67), section 202, Strengthening Medicaid Third-Party Liability, amended the SSA to enable states to recover all portions of judgments received by Medicaid beneficiaries. In addition, section 202 clarified that states may impose liens against Medicaid beneficiaries' property. These changes were effective October 1, 2014. The Protecting Access to Medicare Act (PAMA, P.L. 113-93), section 211, delayed the effective date of the beneficiary liability settlement amendment from October 1, 2014 until October 1, 2016.

This provision of H.R. 2 would extend the effective date of the beneficiary liability settlements from October 1, 2016 until October 1, 2017.

Sec. 221. Extension of funding for community health centers, the National Health Service Corps, and teaching health centers.

The ACA created the Community Health Center Fund (CHCF) that provided mandatory funding for federal health centers authorized in PHSA Section 330.¹² These centers are located in medically underserved areas and provide primary care, dental care, and other health and supportive services to individuals regardless of their ability to pay. Specifically, ACA §10503 (as amended by HCERA §2303) appropriated a total of \$9.5 billion from FY2011 through FY2015 annually as follows: \$1.0 billion for FY2011; \$1.2 billion for FY2012; \$1.5 billion for FY2013; \$2.2 billion for FY2014; and \$3.6 billion for FY2015. Funds are to remain available until expended. The CHCF also provided funding for the National Health Service Corps (NHSC), authorized in Title III of the PHSA, which provides scholarships and loan repayments to certain health professionals in exchange for providing care in a health professional shortage area for a period of time that varies based on the length of the scholarship or the number of years of loan repayment received.¹³ Specifically, the CHCF provided \$1.5 billion for the NHSC from FY2011 through FY2015 annually as follows: \$290 million for FY2011; \$295 million for FY2012; \$300 million for FY2013; \$305 million for FY2014; and \$310 million for FY2015. Funds are to remain available until expended. ACA Section 5508 created PHSA Section 340H, which required the Secretary to make direct and indirect Graduate Medical Education (GME) payments to qualified teaching health centers: community-based outpatient facilities that train medical residents. The section also appropriated \$230 million in direct and indirect GME payments for the period of FY2011 through FY2015.

This provision would extend the CHCF by providing funding for health centers and the NHSC at the FY2015 level (\$3.6 billion for health centers and \$310 million for the NHSC) for each of FY2016 and FY2017 and would provide \$60 million for each of FY2016 and FY2017 to support direct and indirect GME payments to teaching health centers. This section would also apply an existing restriction on the use of funds for abortions—included in P.L. 113-235, Division G, Title V, §§506-507¹⁴, which provided appropriations for FY2015—to funds that would be appropriated

¹¹ *Arkansas Dept. of Health and Human Services v. Ahlborn and Wos v. E.M.A.*

¹² For more information on health centers, see CRS Report R43937, *Federal Health Centers: An Overview*, by Elayne J. Heisler.

¹³ For more information on the National Health Service Corps, see CRS Report R43920, *National Health Service Corps: Changes in Funding and Impact on Recruitment*, by Bernice Reyes-Akinbileje.

¹⁴ Specifically, these sections of P.L. 113-235 state “(a) None of the funds appropriated in this Act, and none of the (continued...)”

by this act to health centers, the NHSC, and qualified teaching health centers for FY2016 and FY2017.

Title III—CHIP

Sec. 301. 2-year extension of the Children’s Health Insurance Program.

Section 301(a). Funding

Federal funding for the State Children’s Health Insurance Program (CHIP) is provided through FY2015 with appropriated amounts as specified in statute.¹⁵ Since CHIP was established, other federal laws have provided additional years of federal CHIP funding. For instance, the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) provided federal CHIP funding for FY2009 through FY2013. Then, the ACA provided federal CHIP funding for an additional two years with FY2015 being the last year of federal CHIP funding under current law.

For FY2014 and FY2015, the annual appropriation amounts are \$19.1 billion and \$21.1 billion, respectively. The FY2015 appropriation is the combination of semi-annual appropriations of \$2.85 billion from Section 2104(a) of SSA plus a one-time appropriation in the amount of \$15.36 billion from Section 108 of CHIPRA, which is provided for the first six months of the fiscal year and remains available until expended.

Section 301(a) of H.R. 2 would extend federal CHIP funding for two years by adding federal appropriations for FY2016 and FY2017. The funding amounts are \$19.30 billion for FY2016 and \$20.40 billion for FY2017. The funding for FY2017 would be structured like FY2015 with semi-annual appropriations of \$2.85 billion plus a one-time appropriation (discussed below) in the amount of \$14.7 billion.

(...continued)

funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion. (b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion. (c) The term “health benefits coverage” means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement. Sec. 507. (a) The limitations established in the preceding section shall not apply to an abortion—(1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. (b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State’s or locality’s contribution of Medicaid matching funds). (c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State’s or locality’s contribution of Medicaid matching funds). (d)(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions. (2) In this subsection, the term “health care entity” includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.”

¹⁵ For more information about CHIP financing, see CRS Report R43949, *Federal Financing for the State Children’s Health Insurance Program (CHIP)*, by Alison Mitchell.

Section 301(b)(1) and (2). Allotments

The federal government reimburses states for a portion of every dollar they spend on CHIP up to state-specific annual limits called allotments, which are the federal funds allocated to each state for the federal share of their CHIP expenditures. State CHIP allotment funds are provided annually, and the funds are available to states for two years. There are two formulas for determining state allotments: an even-year formula and an odd-year formula.

In even years, such as FY2014, state CHIP allotments are based on each state's *allotment* for the prior year plus any Child Enrollment Contingency Fund payments (described below) from the previous year adjusted for health care inflation and child population growth in the state. For even years, the allotment amount can be adjusted to reflect CHIP eligibility or benefit expansions.

In odd years, state CHIP allotments are each state's *spending* for the prior year (including federal CHIP payments from the state CHIP allotment, Child Enrollment Contingency Fund payments, and redistribution funds) adjusted using the same growth factor as the even-year formula (i.e., health care inflation and child population growth in the state). Since the odd year formula is based on states' actual use of CHIP funds, it is called the "re-basing year," and a state's CHIP allotment can either increase or decrease depending on each state's CHIP expenditures in the previous year.

Under current law, FY2015 is the last year CHIP allotments are authorized. Section 301(b)(1) and (2) of H.R. 2 would authorize CHIP allotments for FY2016 and thereafter maintaining the allotment formulas for odd- and even-year allotments.

Section 301(b)(1)(B)(ii). Special Rule for FY2016

The federal government pays about 70% of CHIP expenditures, and the federal government's share of CHIP expenditures (including both services and administration) is determined by the enhanced federal medical assistance percentage (E-FMAP) rate. The E-FMAP rate is derived each year by the Secretary of Health and Human Services using a set formula, and it varies by state. By statute, the E-FMAP (or federal matching rate) can range from 65% to 85%, and in FY2015, the E-FMAP ranges from 65% (13 states) to 82% (Mississippi).

The ACA included a provision to increase the E-FMAP rate by 23 percentage points (not to exceed 100%) for most CHIP expenditures from FY2016 through FY2019. This would increase the statutory range of the E-FMAP rate to 88% through 100%. With this 23 percentage point increase, the federal share of CHIP will be significantly higher, which means states are expected to spend through their allotments faster when the 23 percentage point E-FMAP increase takes effect.

Section 301(b)(1)(B)(ii) of H.R. 2 includes a special rule for the FY2016 allotments in order to account for the 23 percentage point increase in the E-FMAP that begins in FY2016. Under this provision, the FY2016 allotments would be each state's FY2015 *allotment* (including Child Enrollment Contingency Fund payments and redistribution funds) but determined as if the 23 percentage point increase in the E-FMAP were in place for FY2015. Then, that amount would be adjusted using the same growth factor as the even- and odd-year formulas (i.e., health care inflation and child population growth in the state).

Section 301(b)(1)(B)(ii). Reduction in FY2018

Although FY2017 is the last year for which federal CHIP funding is provided under H.R. 2, states could have federal CHIP spending in FY2018 because states will have access to unspent funds from their FY2017 allotments and to unspent FY2016 allotments redistributed to shortfall states. Section 301(b)(1)(B)(ii) of H.R. 2 includes a provision that would reduce the amount of states' unspent funds from their FY2017 allotments available for expenditures in FY2018 by one-third.

Section 301(b)(1)(C). Allotment for FY2017

Under current law, CHIP allotments for the first half of the FY2015 are available from the appropriation amount provided in Section 2104(a)(18)(A) of SSA in addition to the FY2015 one-time appropriation provided for in Section 108 of CHIPRA (discussed below). For the second half of the year, allotments are to be made available from the funding provided in the first half of the year in addition to the appropriation amount provided in Section 2104(a)(18)(B) of SSA.

In FY2015, the full year amount for state allotments is to be equal to federal payments from the prior year (including Child Enrollment Contingency Fund payments and redistributed funds) multiplied by the allotment increase factor.

Section 301(b)(1)(C) of H.R. 2 includes a provision that would make the allotment formula for FY2017 the same as the formula for FY2015. For FY2017, funding for the first half of the year would be available from Section 2104(a)(20)(A) of SSA in addition to the FY2017 one-time appropriation provided for in Section 301(b)(3) of H.R. 2, and the funding for the second half of the year would be provided in Section 2104(a)(20)(B) of SSA.

Section 301(b)(3). One-Time Appropriation for FY2017

A one-time appropriation in the amount of \$15.4 billion is provided for allotments for the first six months of FY2015 in addition to the semi-annual appropriations provided in Section 2104(a)(18)(A) of SSA. The funds from the one-time appropriation are to remain available until expended.

CHIPRA provided a one-time appropriation for FY2013 (which was the last year of federal CHIP funding provided in CHIPRA) through Section 108 of CHIPRA. When the ACA added two years of federal CHIP financing, it provided the one-time appropriation for FY2015 (which was the last year of federal CHIP funding provided in ACA) by amending Section 108 of CHIPRA.

Section 301(b)(3) of H.R. 2 would provide a one-time appropriation in the amount of \$14.7 billion for FY2017. This funding would accompany the allotments for the first half of FY2017, and the funding would remain available until expended. Also, rather than amend Section 108 of CHIPRA as was done in the ACA for the FY2015 one-time appropriation, H.R. 2 includes the one-time appropriation language.

Section 301(c). Extension of Qualifying State Option

In a few situations, federal CHIP funding is used to finance Medicaid expenditures. For instance, certain states had significantly expanded Medicaid eligibility for children prior to the enactment of CHIP in 1997, and these states are allowed to use their CHIP allotment funds to finance the

difference between the Medicaid and CHIP matching rates (i.e., FMAP and E-FMAP rates respectively) for the cost of children in Medicaid in families with income above 133% FPL. The following 11 states meet the definition: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin. This is referred to as the *qualifying state* option, and FY2015 is the last year the qualifying state option is authorized.

Section 301(c) of H.R. 2 would extend the qualifying state option through FY2017.

Section 301(d). Child Enrollment Contingency Fund

CHIPRA established the Child Enrollment Contingency Fund to provide shortfall funding to certain states. The Child Enrollment Contingency Fund was funded with an initial deposit equal to 20% of the appropriated amount for FY2009 (i.e., \$2.1 billion). In addition, for FY2010 through FY2015, such sums as are necessary for making Child Enrollment Contingency Fund payments to eligible states are deposited into this fund, but these transfers cannot exceed 20% of the appropriated amount for the fiscal year or period.

For FY2009 through FY2015, states with a funding shortfall and CHIP enrollment for children exceeding a state-specific target level shall receive a payment from the Child Enrollment Contingency Fund equal to the amount by which the enrollment exceeds the target multiplied by the product of projected per capita expenditures and the E-FMAP.

Section 301(d) of H.R. 2 would extend the funding mechanism for the Child Enrollment Contingency Fund and payments from the fund through FY2017.

Sec. 302. Extension of express lane eligibility.

CHIPRA created a state plan option for “Express Lane” eligibility, through September 30, 2013, whereby states are permitted to rely on a finding from specified “Express Lane” agencies (e.g., those that administer programs such as Temporary Assistance for Needy Families, Medicaid, CHIP, and Food Stamps) for (1) determinations of whether a child has met one or more of the eligibility requirements necessary to determine his or her initial eligibility, (2) eligibility redeterminations, or (3) renewal of eligibility coverage under Medicaid or CHIP. This provision was extended through subsequent legislation. Under current law, authority for “Express Lane” eligibility determinations expires after September 30, 2015.

H.R. 2 would extend authority for “Express Lane” eligibility determinations through September 30, 2017.

Sec. 303. Extension of outreach and enrollment program.

CHIPRA authorized \$100 million in outreach and enrollment grants for fiscal years 2009 through 2013 to be used by eligible entities (e.g., states, local governments, community-based organizations, elementary or secondary schools) to conduct outreach and enrollment efforts that increase the participation of Medicaid and CHIP-eligible children. Ten percent of the allocation is directed to a national enrollment campaign to improve the enrollment of underserved child populations, and 10% is targeted to outreach for Native American children. The remaining 80% is distributed among eligible entities for the purpose of conducting outreach campaigns, focusing on

rural areas and underserved populations. Grant funds are also targeted to proposals that address cultural and linguistic barriers to enrollment. The ACA appropriated \$140,000,000 for fiscal years 2009 through 2015 for outreach and enrollment grants. Authority for outreach and enrollment grants will expire after September 30, 2015.

H.R. 2 would authorize \$40,000,000 for fiscal years 2016 and 2017 for outreach and enrollment grants.

Sec. 304. Extension of certain programs and demonstration projects.

Section 304(a). Childhood Obesity Demonstration Project.

Section 401(a) of CHIPRA required the Secretary of Health and Human Services to conduct a childhood obesity demonstration project by awarding grants to eligible entities (e.g., community-based organizations, Federally-qualified health centers, universities or colleges) to carry out individual programs. CHIPRA authorized the appropriation of \$25 million for the period FY2009 through FY2013 for this demonstration, and ACA Section 4306 replaced the authorization of appropriation with a total appropriation of \$25 million for the period of FY2010 through FY2014.

While Section 4306 of the ACA funds the demonstration project, CHIPRA provides guidance on program development and implementation. Grantees may use funds to develop, implement, and evaluate multi-level (e.g., child, family, community, policy), multi-sectoral (e.g., childcare, school, community, healthcare) intervention projects, targeting communities with a high proportion of CHIP-eligible children. Authorized uses of funds include developing community educational activities that promote healthy eating behaviors; developing school-based afterhours physical activity programs; or training health professionals on how to identify and treat obese and overweight individuals.

Funding priority is granted to certain eligible entities such as those that can demonstrate having previously received funds to carry out activities that promote individual and community health; entities that carry out programs or activities consistent with goals set by *Healthy People 2010*; or entities located in medically underserved communities or areas in which the average poverty rate is at least 150 percent or higher of the average poverty rate.

Under current law, funding for the childhood obesity demonstration project expired in FY2014, and funding was not appropriated for FY2015. In 2011, CDC awarded ACA funds to grantees for the period of FY2011 through FY2015.

The provision would extend funding for the childhood obesity demonstration project through FY2017, appropriating \$10 million for the period of FY2016 through FY2017.

Sec. 305. Report of Inspector General of HHS on use of express lane option under Medicaid and CHIP.

H.R. 2 would require the Inspector General of the Department of Health and Human Services to submit a report to the House Committee on Energy and Commerce, and the Senate Committee on Finance, not later than 18 months after the date of enactment of this act. The report would include (1) data on the number of individuals enrolled in Medicaid and CHIP through the Express Lane Eligibility (ELE) state plan option, (2) assess the extent to which individuals enrolled through

ELE meet the eligibility requirements for Medicaid or CHIP, and (3) provide data on Medicaid and CHIP federal and state expenditures under ELE that is disaggregated between expenditures associated with individuals who meet the Medicaid or CHIP eligibility requirements, and those who do not.

Title IV—Offsets

Subtitle A—Medicare Beneficiary Reforms

Sec. 401. Limitation on certain medigap policies for newly eligible Medicare beneficiaries.

Medicare Supplemental Health Insurance, more commonly referred to as “Medigap”, is private health insurance that supplements Medicare coverage. It typically covers some or all of Medicare’s deductibles and coinsurance, and it also may include additional items or services not covered by Medicare, such as coverage while traveling overseas. Medigap is available to Medicare beneficiaries who are enrolled in Medicare Parts A and B. Individuals who purchase Medigap must pay a monthly premium, which is set by and paid to the insurance company selling the policy. There are 10 standardized Medigap plans with varying levels of coverage. Two of the 10 standardized plans, Plans C and F, cover Medicare Parts A and B deductibles and coinsurance in full (i.e., offer *first-dollar* coverage). In 2013, about 66% of all Medigap enrollees were covered by one of these two plans. Two other plans, D and G are similar, respectively, to Plans C and F, but do not cover Medicare Part B deductibles. (The 2015 Part B deductible is \$147.)

Three states (Massachusetts, Minnesota, and Wisconsin) offer their own state-standardized Medigap Plans under waivers.

Beginning in 2020, this H.R. 2 provision would prohibit the sale of Medigap policies that cover Part B deductibles to newly eligible Medicare beneficiaries. This includes individuals who become eligible for Medicare due to age, disability or end-stage renal disease on or after January 1, 2020. This prohibition would also apply in waiver states. Entities who sell such policies after that time would be subject to fines, and/or imprisonment of not more than five years, and/or civil money penalties of not more than \$25,000 for each prohibited act.¹⁶ For newly eligible beneficiaries, references in the law to Medigap plans C and F would be deemed as references to plans D and G.

Sec. 402. Income-related premium adjustment for parts B and D.

For the first 41 years of the Medicare program, all Part B enrollees paid the same Part B premium amounts regardless of their income. However, MMA¹⁷ required that, beginning in 2007, higher-income Part B enrollees pay higher premiums. Similarly, when the Part D program began in 2006, all enrollees in the same Part D plan paid the same premiums. The ACA subsequently imposed

¹⁶ This penalty is the same as that currently imposed on entities who knowingly sell health insurance policies to Medicare beneficiaries that duplicate existing health care coverage. (Social Security Act §1882(d)(3)(A).)

¹⁷ The MMA would have phased in the increase over five years; however, the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) shortened the phase-in period to three years.

high-income premiums for Medicare Part D prescription drug benefit enrollees beginning in 2011. CMS estimates that fewer than 5% of Medicare beneficiaries pay these higher premiums.

For Medicare Part B, standard premiums (i.e., premiums paid by enrollees who are not considered high-income) are set at 25% of average annual per capita Part B program expenditures.¹⁸ Similarly, under Part D, base premiums are set at 25.5% of expected per capita costs for basic Part D coverage.¹⁹ Adjustments are made to the Parts B and D premiums for higher-income beneficiaries, with the percentage of per capita expenditures paid by these beneficiaries increasing with income. This percentage ranges from 35% to 80% of average per capita expenditures for both Parts B and D. In 2015, individuals whose income exceeds \$85,000 (\$170,000 for a couple) are subject to higher premium amounts. (See **Table 2** below.)

The ACA also required that the income thresholds used to determine Parts B and D high-income premiums for 2011 through 2019 be frozen at the 2010 levels.²⁰ Prior to 2010, annual adjustments to these levels were based on annual changes in the consumer price index for urban consumers (CPI-U), rounded to the nearest \$1,000. However, the ACA froze the income thresholds and ranges at the 2010 level through 2019, rather than allowing them to rise with inflation.

Table 2. Current Monthly Medicare Part B Premiums and Part D Premium Adjustments

Beneficiaries who file individual tax returns with income (for couples, double the below figures):	Applicable Percentage	2015 Monthly Part B Premiums	2015 Monthly Part D Premium Adjustment
Less than or equal to \$85,000	25%	\$104.90	\$0.0
Greater than \$85,000 and less than or equal to \$107,000	35%	\$146.90	\$12.30
Greater than \$107,000 and less than or equal to \$160,000	50%	\$209.80	\$31.80
Greater than \$160,000 and less than or equal to \$214,000	65%	\$272.70	\$51.30
Greater than \$214,000	80%	\$335.70	\$70.80

Source: CMS regulation for 2015 Part B premiums: <http://www.gpo.gov/fdsys/pkg/FR-2014-10-10/pdf/2014-24248.pdf> and CMS Notice for 2015 Part D high-income adjustments: <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmarks2015.pdf>

Notes: The Part B column shows the full premium. The Part D column represents the high income adjustment which is added onto the Part D drug plan premium (which can vary among plans).

Beginning in 2018, this provision of H.R. 2 would lower the income thresholds for the top two income groups as shown in **Table 3** below. Individuals with incomes between \$133,500 and \$160,000 per year would be in the 65% applicable percentage group (instead of those with

¹⁸ In 2015, the standard monthly Part B premium is \$104.90. For additional information on Part B premiums, see CRS Report R40082, *Medicare: Part B Premiums*, by Patricia A. Davis.

¹⁹ In 2015, the base monthly Part D premium is \$33.13; however, actual premiums paid by beneficiaries may vary depending on the prescription drug plan that they select. See CRS Report R40611, *Medicare Part D Prescription Drug Benefit*, by Suzanne M. Kirchoff and Patricia A. Davis.

²⁰ Section 3402 of the ACA.

incomes between \$160,000 and \$214,000), and the income threshold for the highest group (80%) would be \$160,000 (instead of \$214,000).

Table 3. Proposed Income Thresholds for High-Income Premiums

Beneficiaries who file individual tax returns with income:	Applicable Percentage
Less than or equal to \$85,000	25%
More than \$85,000 but not more than \$107,000	35%
More than \$107,000 but not more than \$133,500	50%
More than \$133,500 but not more than \$160,000	65%
More than \$160,000	80%

Source: Section 402 of the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2)

This provision of H.R. 2 would also end the ACA freeze on the income thresholds beginning in 2018. The income thresholds would stay at the new designated levels for 2018 and 2019 (in **Table 3**). In 2020 and thereafter, the thresholds would be adjusted annually for inflation based on CPI-U.

Subtitle B—Other Offsets

Sec. 411. Medicare payment updates for post-acute providers.

Medicare payment amounts typically are updated each fiscal or calendar year to address potential yearly changes in the cost of health care items and services. The ACA reduced the annual update policy for post-acute care providers (skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and home health agencies (HHAs)) and hospices by including an adjustment to account for economy-wide productivity improvements that result in cost savings. The productivity adjustment for SNFs, IRFs, LTCHs, was implemented on October 1, 2011. The productivity adjustment for hospices was implemented on October 1, 2012 and January 1, 2015 for HHAs. The annual payment updates for SNFs, IRFs, LTCHs, HHAs and hospices may be subject to other statutory reductions (e.g., failure to report quality data) and administrative reductions (e.g., nominal case-mix growth) as well. Post-acute care providers and hospices may be subject to an update less than zero that would result in a lower payment rate than in the preceding year.

For FY2015, CMS administratively determined the annual Medicare payment update, after application of the productivity adjustment, to be 2.0% for SNFs, 2.2% for IRFs, 1.1% for LTCHs, and 2.1% for hospices. These payment rates may be subject to other administrative reductions as well. For CY2015, CMS administratively determined the annual Medicare payment update, after application of the productivity adjustment, to be 2.1% for HHAs; however, after application of the rebasing reduction required by the ACA, the net Medicare payment update for HHAs is 0%. HHAs may be subject to other payment reductions as well. CMS has not yet proposed payment rate updates for these providers for rate-setting years 2016 and later.

H.R. 2 requires Medicare payment updates for SNFs, IRFs, LTCHs, and hospices to be 1% for FY2018 and 1% for HHAs for CY2018, after application of the productivity adjustment.

Sec. 412. Delay of reduction to Medicaid DSH allotments.

The Medicaid statute requires states to make disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income patients.²¹ The federal government provides each state an annual DSH allotment, which is the maximum amount of federal matching funds that each state can claim for Medicaid DSH payments. The ACA included a provision directing the Secretary to make aggregate reductions in Medicaid DSH allotments in specified annual amounts for FY2014 through FY2020. Since the ACA, a number of laws have amended the ACA Medicaid DSH reductions by eliminating the reductions for FY2014 through FY2016, changing the reduction amounts, and extending the reductions through FY2024.

This provision would further amend the Medicaid DSH reductions by pushing the Medicaid DSH reductions out one year (i.e., eliminating the FY2017 reductions and extending the reductions to FY2025) and increasing the aggregate reduction amounts from \$35.1 billion to \$43.0 billion. Specifically, under this provision, the annual aggregate reductions to the Medicaid DSH allotments would equal to \$2.0 billion in FY2018, \$3.0 billion in FY2019, \$4.0 billion in FY2020, \$5.0 billion in FY2021, \$6.0 billion in FY2022, \$7.0 billion in FY2023, \$8.0 billion in FY2024, and \$8.0 billion in FY2025. In FY2026, states' DSH allotments would rebound to their pre-reduced levels with the annual inflation adjustments for FY2018 through FY2025.

Sec. 413. Levy on delinquent providers.

Under the Federal Payment Levy Program, the Internal Revenue Service and the Department of the Treasury may collect overdue taxes through a continuous levy on certain federal payments, including Medicare fee-for-service payments. The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) required that CMS fully implement the requirements of the federal levy program. For outstanding tax debts, the federal levy program authorizes the government to reduce the payment owed to providers or suppliers by 15%, or by the exact amount of the tax owed if it is less than 15% of the payment. The maximum levy is increased to 100% for payments to government contractors and to 30% for payments due to Medicare providers and suppliers under SSA title XVIII.

This provision of H.R. 2 would increase the percentage of Medicare provider and supplier payments subject to continuous federal levy from 30% to 100%. This provision would be applicable to payments made 180 days after enactment of this law.

Sec. 414. Adjustments to inpatient hospital payment rates.

CMS modified its patient classification system and introduced Medicare severity-diagnosis related groups (MS-DRGs) into the Medicare IPPS starting for discharges in FY2008. In the FY2008 IPPS rule, CMS established prospective budget neutrality reductions of -1.2% in FY2008, -1.8% in FY2009 and -1.8% in FY2010, because of anticipated increases in measured

²¹ For more information about Medicaid DSH payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*, by Alison Mitchell.

severity of illness that would be attributable to documentation or coding improvements (DCI) associated with the new MS-DRGs.

The TMA, Abstinence Education, and QI Programs Extension Act of 2007 (P.L. 110-90) halved the CMS' planned DCI reductions in FY2008 and FY2009, but permitted retrospective offsets to IPPS rate increases in FY2010, FY2011, and FY2012 to account for DCI payment increases in FY2008 and FY2009 above these amounts that were established through a retrospective claims evaluation. The law did not address the additional -1.8% decrease originally established by CMS for FY2010; CMS did not implement that DCI adjustment.

The American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240) prevented CMS from fully recouping past overpayments related to DCI changes in FY2008 and FY2009. ATRA required CMS to establish additional base rate reductions which would recoup overpayments associated with DCI in FY2008, FY2009 and FY2010. CMS was directed to reduce the base rates in FY2014 through FY2017 to offset \$11 billion in increased DCI payments from FY2008 through FY2013 that had not yet been recovered. This required adjustment did not affect the Secretary's authority to apply a prospective adjustment for DCI with respect to FY2010 discharges.

CMS implemented a schedule of a cumulative -0.8% reduction in each year from FY2014 to FY2017 (or an -0.8% reduction in FY2014; -1.6% reduction in FY2015; -2.4% reduction in FY2016 and -3.2% reduction in FY2017). In FY2018, CMS is expected to restore the cumulative -3.2% DCI reduction to the hospital base rate.

H.R. 2 would remove the authority to retroactively recoup DCI payment increases from FY2010. CMS would be directed to increase base rates +0.5 percentage points each year from FY2018 through FY2023 (for a total increase of +3.0 percentage points) instead of the anticipated increase of +3.2 percentage points in FY2018. CMS would be prohibited from recouping the additional -0.55 percentage point reduction in base rates to account for DCI payment increases in FY2010.

Title V—Miscellaneous

Subtitle A—Protecting the Integrity of Medicare

Sec. 501. Prohibition of inclusion of Social Security account numbers on Medicare cards.

Beneficiaries' Social Security Numbers (SSNs) are displayed on their Medicare cards. CMS uses the SSN to assign each beneficiary a health insurance claim number which is required to document Medicare eligibility and most other administrative activities, including performance analysis and program integrity. With increasing identity theft, however, the display and use of the SSN on Medicare cards has raised the program's and beneficiaries' vulnerability to fraud. Thieves could steal the information from Medicare cards to commit identity theft and it makes beneficiaries more vulnerable to data breaches—the unauthorized disclosure of a beneficiary's personally identifiable information.²² CMS has proposed different options to remove SSNs from beneficiary identification cards which ranged in cost from \$254 million to \$316 million.²³

²² GAO, *Medicare: CMS Needs an Approach and a Reliable Cost Estimate for Removing Social Security Numbers from* (continued...)

H.R. 2 would require the Secretary to collaborate with the Commissioner of Social Security to establish cost-effective procedures to ensure that Medicare beneficiaries' SSNs (or a derivative) are not displayed, coded, or embedded on Medicare cards. To implement removal of beneficiary SSNs from Medicare cards, \$320 million would be transferred from the Medicare Trust Funds to following accounts:

- to the CMS Program Management Account; \$65 million in FY2015 (available through FY2018), \$53 million in FY2016 and \$53 million in FY2017 (available through FY2018), and \$48 million in FY2018 (available until expended).
- to the Social Security Administration Limitation on Administration Account; \$27 million in FY2015 (available until FY2018), \$22 million in FY2016 and \$22 million in FY2017 (available through FY2018), and \$27 million in FY2018 (available until expended).
- to the Railroad Retirement Board Limitation on Administration Account; \$3 million in FY2015 (available until expended).

The Secretary would be required to set an effective date for removal of SSNs that was not later than four years after the date of enactment of H.R. 2, but otherwise could specify an effective date.

Sec. 502. Preventing wrongful Medicare payments for items and services furnished to incarcerated individuals, individuals not lawfully present, and deceased individuals.

Medicare law and regulations generally prohibit payment for services for incarcerated beneficiaries.²⁴ However, there is an exception to this prohibition if state or local law requires incarcerated beneficiaries to repay the cost of medical services received while they are incarcerated and state or local governments enforce the requirement. Although there is a claim processing mechanism that allows CMS's contractors to identify provider claims that meet the exception requirements, data on incarcerated individuals is not always available before a claim is paid.²⁵ CMS's systems also are not always capable of identifying claims for incarcerated beneficiaries after they were paid so that overpayments could be recovered.

Medicare Part D sponsors submit claims information to CMS for each drug they dispense. CMS has processes that prevent Part D sponsors from paying claims that have dates of service more than 32 days after a beneficiary's death. OIG found that CMS's policies allow Part D sponsors to pay for HIV drugs for deceased Medicare beneficiaries.²⁶

(...continued)

Medicare Cards (GAO-12-831), August 2012.

²³ CMS, SSN Removal from Medicare Card, Cost Analysis Summary, May 10, 2013.

²⁴ Incarcerated individuals include "... individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, on medical furlough, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule."

²⁵ OIG, *Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries Who Received Services During 2009 Through 2011* (A-07-12-01113), January 2013.

²⁶ OIG, *Medicare Paid for HIV Drugs for Deceased Beneficiaries* (OEI-02-11-00172), October 2014.

Federal law prohibits unlawfully present aliens from receiving public benefits, including health benefits. CMS prohibited contractors from paying Part A and B claims for unlawful aliens, but OIG found that some Part D claims were paid for unlawfully present individuals.²⁷ OIG noted that CMS and Part D plans did not have internal controls to identify and disenroll unlawful aliens and automatically reject Part D claims for those individuals.

H.R. 2 would amend the Social Security Act to require the Secretary to establish policies and claims edits that would prevent improper Medicare payments for incarcerated individuals, unlawfully present aliens, and deceased individuals. This provision also would require the OIG to submit a report to Congress on the procedures and maintenance of the process to ensure that Medicare did not make improper payments for incarcerated individuals, unlawfully present aliens, and deceased individuals. OIG would be required to submit an initial report within 18 months of the date of enactment of this law and periodically thereafter as determined necessary by the OIG.

Sec. 503. Consideration of measures regarding Medicare beneficiary smart cards.

Medicare beneficiaries' SSNs are displayed on their Medicare cards, exposing individuals to increased risk of identity theft and potential unauthorized disclosure of personal health information. Beneficiaries' SSN is referred to as the Health Insurance Claim Number (HICN) and is used for identification as well as for processing Medicare fee-for-service (FFS) claims and for other administrative activities.²⁸ Inclusion of individuals' SSNs on identification cards used to be a common practice, but in response to federal and state laws restricting using SSNs as identifiers, most organizations have abandoned that approach. CMS has proposed different options to remove SSNs from beneficiary identification cards which ranged in cost from \$254 million to \$316 million.²⁹ In reviewing different methodologies to remove SSNs from Medicare cards, CMS officials have ruled out some options, such as embedding the number in smart cards or magnetic strips, because they were determined to be too costly, technically infeasible, or burdensome to providers and beneficiaries.³⁰

H.R. 2 would enable the Secretary to assess whether it is cost effective and technologically viable to use electronic Medicare cards. Electronic cards might include smart card technology, including an embedded and secure integrated circuit chip.³¹ If the Secretary considers the feasibility of using smart card technology, then the Secretary would be required to submit a report outlining the Secretary's consideration of electronic Medicare cards to the House Committees on Ways and Means, and Energy and Commerce, and the Senate Committee on Finance.

²⁷ OIG, *Medicare Improperly Paid Millions of Dollars for Prescription Drugs Provided to Unlawfully Present Beneficiaries During 2009 through 2011* (A-07-12-06038), October 2013.

²⁸ Under Medicare Parts C and D, private health plans provide services to beneficiaries. Most health plans issue their own identification cards to beneficiaries which do not contain SSNs. HICN are 10- or 11-digits including the 9-digit SSN and a beneficiary identifier assigned to the beneficiary and other dependents.

²⁹ CMS, *SSN Removal from Medicare Card, Cost Analysis Summary*, May 10, 2013.

³⁰ GAO, *Medicare Information Technology: Centers for Medicare & Medicaid Services Needs to Pursue a Solution for Removing Social Security Numbers from Cards* (GAO-13-761), September 2013.

³¹ As presented by a GAO report required by the conference report to accompany the Consolidated Appropriations Act, 2014 (P.L. 113-76).

Sec. 504. Modifying Medicare durable medical equipment face-to-face encounter documentation requirement.

Medicare covers certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) under Part B of the program if they are medically reasonable and necessary and prescribed by a physician. At least two places in the Medicare statutes either require that a face-to-face evaluation of a beneficiary be conducted as a condition for payment, or give the Secretary authority to require such evaluations as a condition for payment. Specifically, the Secretary is statutorily prohibited from paying for a power wheelchair unless a physician, physician assistant, nurse practitioner, or clinical nurse specialist has conducted a face-to-face examination of the beneficiary and written a prescription. For power wheelchairs, each of the specified medical providers is able to perform and document the face-to-face examination. A separate provision of statute not pertaining to power wheelchairs gives the Secretary authority to require that payment be made for items and services only if a physician has communicated to the supplier a written order for the item prior to delivery of the item (WOPD). The ACA specified that only physicians were able to document a face-to-face encounter for such WOPD items, regardless of whether a physician, physician assistant, nurse practitioner, or clinical nurse specialist had conducted the face-to-face encounter.

H.R. 2 would authorize a physician, physician assistant, nurse practitioner, or clinical nurse specialist to document the face-to-face encounters that they themselves conduct. This would make the requirement similar to the face-to-face requirement for power wheelchairs under Medicare. H.R. 2 would allow the Secretary to implement this section through program instructions or otherwise.

Sec. 505. Reducing improper Medicare payments.

CMS relies on a variety of contractors to help administer the Medicare program, including Medicare Administrative Contractors (MACs) for FFS (Parts A and B) Medicare. MACs process Medicare claims, and serve as the primary operational contact between the FFS program, and Medicare's approximate 1.5 million health care providers and suppliers. Within their geographic service areas, each MAC is required to educate providers and their staffs about the fundamentals of the program, policies and procedures, new initiatives, and other significant changes. MACs also identify potential improper payment issues through analyses of provider inquiries, claim submission errors, medical review data, Comprehensive Error Rate Testing (CERT) data, and the Recovery Audit Program data.

In addition to MACs, CMS also relies on other contractors that support program integrity activities, such as Recovery Audit Contractors (RACs). Unlike other Medicare contractors, RACs are compensated on a contingency fee basis—their only payment is a percentage of the amount of each improper payment they identify, regardless of whether the claim was an overpayment or underpayment. RAC contingency fees vary depending on the contractor, the type of claim, and the Part of Medicare. Overpayments identified by RACs are recouped by MACs and the amount of recouped funds less contingency fees paid to RACs and expenses for administering the RAC program are returned to the Medicare Trust Funds. RACs must return contingency fees when overpayments are overturned on appeals filed by Medicare providers and suppliers. In its annual

FFS RAC program report to Congress, CMS reported that Part A and B RACs returned over \$3.0 billion to the Medicare Trust Funds for FY2013.³²

To identify improper payments, RACs use three types of review: automated, semi-automated, and complex reviews. Automated reviews rely solely on computer system “edits” that review the claim’s coded information. Semi-automated reviews also rely on system edits and data analysis to identify coding and other errors, but RACs also may review additional documentation offered by providers to substantiate the claim information. In complex reviews, licensed medical professionals manually review claim information and related documentation, including medical records copies requested from providers. RAC coders and clinicians look to verify that provided services and supplies were covered by Medicare and were reasonable and medically necessary.

In FFS Medicare, RACs focus primarily on post-payment claim review and identification of overpayments to be recouped by MACs, although they also indirectly provide insight to CMS and other Medicare contractors on topics for provider education and outreach and identification of fraud and abuse vulnerabilities.

RAC overpayment decisions that are appealed by providers affect the amount identified by RACs and the amount returned to the Medicare Trust Funds. The Medicare FFS appeals process has four levels. If providers appeal a large number of corrected RAC claims and these claims are eventually overturned in providers’ favor, then RAC corrections initially reported in annual reports overstate the success of the program. In addition, these appeals increase CMS’s cost of administering the RAC program, since CMS must compensate MACs for their work in resolving appeals. Furthermore, appeals are costly for providers, although those costs are not borne by Medicare. The Medicare appeals process can take two years or more to resolve appealed claims (counting all appeal levels) and even longer if providers are unsuccessful and pursue their cases in District Court.

H.R. 2 would amend the SSA by adding a new requirement for MACs to implement an improper payment outreach and education program. Each MAC would be required to have an improper payment outreach and education program to provide outreach, education, training, and technical assistance activities to providers and suppliers in their geographic service areas. MACs would be required to provide these services on a regular basis. The information that would be provided by MACs under the improper payment outreach and education program would include information the Secretary determined to be appropriate which may include the following:

- a list of each provider’s and supplier’s most frequent and expensive payment errors over the last quarter;
- specific instructions on how to correct or avoid these errors in the future;
- notice of all new audit topics that the Secretary has approved for RACs;
- specific instructions to prevent future issues related to new RAC procedures approved by the Secretary; and
- other information the Secretary determined would be appropriate.

³² CMS, *Recovery Auditing in Medicare and Medicaid for Fiscal Year 2013*, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2013-Report-To-Congress.pdf>.

MACs would be required under the outreach and education program to give priority to activities that would reduce Medicare improper payments that are one of the following:

- are for items or services that have the highest rate of improper payment;
- are for items and services that have the greatest total dollar amount of improper payments;
- are due to clear misapplication or misinterpretation of Medicare policies;
- are clearly due to common and inadvertent clerical or administrative errors; or
- are due to other error types the Secretary determined could be prevented through activities under the outreach and education program.

To assist MACs in conducting the improper payment outreach and education program, the Secretary would be required to supply to each MAC a complete list of the types of improper payments identified by RACs for the providers and suppliers in the MACs region. The list of services identified by RACs and provided to each MAC would be supplied on a time frame determined appropriate by the Secretary, which may be quarterly. The list of improper payments identified by RACs that the Secretary would be required to supply to each MAC would include information such as the following:

- providers and suppliers that have the highest improper payment rates;
- providers and suppliers that have the greatest total dollar amounts of improper payments;
- items and services furnished in each MAC's service region that have the highest improper payment rates;
- items and services furnished in each MAC's service region that are responsible for the greatest total improper payment amounts; and
- other information the Secretary determines would be helpful to MACs in carrying out the outreach and education program.

MACs would be required to ensure that all provider and supplier communications related to the improper payment outreach and education programs complied with communication requirements identified in SSA §1874A(g), Communications with Beneficiaries, Providers, and Suppliers.

The SSA would also be amended at §1893(h) to authorize the Secretary to retain a portion of annual RAC overpayment recoveries which would be available, subject to certain limitations (see below), to the CMS program management account for carrying out the activities of the following sections:

- SSA §1833(z), Incentive Payments for Participation in Eligible Alternative Payment Models;
- SSA §1834(1)(16), Prior Authorization for Repetitive Scheduled Non-Emergent Ambulance Transports;
- SSA §1874A(a)(4)(G), Additional Functions;³³

³³ The additional functions that might be required of MACs, include activities to support the Medicare Integrity (continued...)

- Medicare Access and CHIP Reauthorization Act of 2015, §514(b); and
- implementing strategies (such as claim processing edits) to help reduce Medicare payment error rates.

The amounts retained from RAC overpayment recoveries would be limited to 15% of RAC recoveries and would remain available until expended. The Secretary would be prohibited from using the funds retained from RAC overpayment recoveries for technology-related infrastructure, capital investments, or information systems, except for uses that supported claims processing (including edits) or system functionality for detecting fraud. In addition, in retaining an additional portion of RAC overpayment recoveries, contingency fee payments to RACs would not be reduced.

Sec. 506. Improving senior Medicare patrol and fraud reporting rewards.

Section 203(b) of HIPAA established an Incentive Reward Program to collect information on Medicare fraud and abuse. The program encourages individuals to report to the HHS Secretary information on those who engage in certain violations under the SSA, including those who engage in fraud and abuse against the Medicare program. If an individual reports information that serves as the basis for collection they may be paid a portion of the amount collected.

Section 411 of the OAA authorizes the Senior Medicare Patrol program funds projects that educate older Americans and their families to recognize and report Medicare fraud. The program engages volunteers to conduct outreach and education to Medicare beneficiaries about suspected fraud, errors, or abuse. The program also receives beneficiary complaints regarding suspected fraud or abuse and makes determinations about such complaints, which may result in referrals to the appropriate state and federal agencies for further investigation.

H.R. 2 would require the HHS Secretary to develop a plan to revise the Incentive Reward Program to encourage greater individual participation in the reporting of Medicare fraud and abuse. Such a plan would include recommendations for ways to enhance rewards for individuals reporting under the program and ways to extend the program to Medicaid. The plan would also include recommendations for the use of Senior Medicare Patrols to conduct a public awareness and education campaign to encourage participation in the revised incentive program. It would require the HHS Secretary to submit the plan to Congress no later than 180 days after enactment.

Sec. 507. Requiring valid prescriber National Provider Identifiers on pharmacy claims.

To administer the Medicare Part D outpatient prescription drug benefit, CMS contracts with private companies, called plan sponsors that provide benefits through drug plans. Medicare Part D drug plans provide Part D benefits to enrollees by contracting with pharmacies that fill prescriptions and submit claims and other data to CMS. CMS uses these data to monitor and administer the Part D benefit. Part D drug plans submit prescription drug data to CMS in an electronic, prescription drug event (PDE), record. The PDE contains drug cost and payment as

(...continued)

Program under SSA section 1893.

well as other data, including the identification number of the provider who wrote the prescription, the enrollee, the pharmacy that filled the prescription, and drug information. CMS uses or requires Part D plans to use some of the PDE data, such as pharmacy and prescriber identifiers, to validate claims, monitor quality, and conduct program integrity and other oversight activities. There are several possible numbers that can be used to uniquely identify prescribers, including the national provider identifier (NPI), the Drug Enforcement Administration (DEA) registration number, state license numbers, and the unique provider identification number. CMS is transitioning to using the NPI to identify all participating Medicare providers. CMS recommended that Part D plan sponsors prepare and review reports of physician drug prescribing patterns to identify potential prescriber fraud.³⁴ CMS, however, does not have system edits to check the prescriber identification data included in PDEs.³⁵ CMS does not require the prescriber identifier and other qualifying fields to be completed on certain non-standard format Part D claims, such as claims filed by beneficiaries and paper claims. In a June 2010 report, OIG found that there were a number of Part D claims with invalid prescriber identifiers and these claims accounted for \$1.2 billion in Medicare Part D expenditures. OIG also reported that CMS and Part D plans did not have adequate procedures to detect invalid prescriber identifiers.

Beginning with Medicare Part D plan year (calendar year) 2016, H.R. 2 would require the Secretary to ensure that PDEs included the NPI to identify the prescribing provider and that the NPI is checked to determine that it is a valid number. In addition, the Secretary would also establish procedures to ensure that when a Part D claim is denied because of the NPI requirements, beneficiaries would be informed of the denial reason at the point of service. Moreover, OIG would be required to prepare a report to Congress by January 1, 2018 on the effectiveness of the procedures to require valid NPIs on all Part D drug claims.

Sec. 508. Option to receive Medicare Summary Notice electronically.

The Medicare contractor that processes claims mails a Medicare Summary Notice (MSN) that identifies the health care services each beneficiary received during the previous quarter. MSNs are not bills, but they contain information about provider charges, the amount Medicare paid, and the amount for which beneficiaries were responsible. Medicare beneficiaries enrolled in (FFS) Medicare may view e-MSNs online and can print their MSNs from their own computer.³⁶

H.R. 2 would require the Secretary, beginning January 1, 2017, to establish a process whereby beneficiaries may opt to receive MSNs electronically. If beneficiaries opt to receive the MSN electronically, they would not also receive mailed MSNs. The provision gives the Secretary discretion to limit the number of elections beneficiaries may exercise, but not for the Secretary to limit the number of elections to less than one. The Secretary would be required to ensure in the most cost-effective manner that beginning January 1, 2017 beneficiaries received clear notification of the option to receive e-MSN statements, which may be distributed with mailed MSNs. Moreover, the Secretary would be required to apply an option similar to electronic MSN notices to other HHS areas and to provide MSNs or other notices on a more frequent basis than otherwise required.

³⁴ CMS, *Medicare Prescription Drug Benefit Manual*, Chapter 9, Compliance Program Guidelines, Section 50, Elements of an Effective Compliance Program at <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf>.

³⁵ OIG, *Invalid Prescriber Identifiers on Medicare Part D Drug Claims* (OEI-03-09-00140), June 2010.

³⁶ For more information see <https://www.mymedicare.gov/>.

Sec. 509. Renewal of MAC contracts.

CMS administers the Medicare program through contracts with private entities, such as Medicare Administrative Contractors (MACs). MACs help CMS run Medicare's day-to-day operations by paying FFS claims, enrolling providers, handling provider customer service, providing education and outreach, administering appeals, operating toll-free call centers, and other activities. In addition, MACs conduct some program integrity activities, including prepayment and post-payment claims review, audits of hospitals and other institutional providers, and recoupment of overpayments. MACs also implement local coverage determinations (LCD) in their jurisdictions.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) required the Secretary to implement Medicare FFS contracting reform by 2011. Contracting reform was designed to improve Medicare's administrative services to beneficiaries and health care providers through the use of new contracting tools including competition and performance incentives. CMS initiated a first round of Parts A and B FFS contractor reform by awarding contracts to 15 Parts A and B MACs (A/B MACs) and four DME MACs between 2005 and 2010.³⁷ In 2010, CMS announced that it intended to further consolidate the 15 combined Parts A/B MAC contracts to 10 contract areas during a second round of MAC contract awards.³⁸ By February 2014, CMS had reduced the number of A/B MAC contract areas to 12 by combining contract areas when the contracts were re-competed. CMS also announced that it would postpone further Part A/B MAC contract area consolidation for up to five years.³⁹

MAC performance is an important CMS management activity given the breadth of activities these contractors play in administering Medicare Parts A and B and the size of the contracts awarded to MACs. In a retrospective study OIG found that over a five year contracting period, CMS awarded \$4.3 billion in contracts to 16 MACs.⁴⁰ Several CMS divisions within the Medicare Contractor Management Group have some responsibility in assessing performance, conducting oversight, and monitoring MAC activities. Under Medicare law MAC contracts are awarded for a base year with four option years.⁴¹ CMS has discretion whether or not to exercise the option to renew MAC contracts for the option years.⁴² In a 2013 report, OIG noted that the time period for re-competing MAC contracts might be better managed if it was longer. CMS could delay re-competing MAC contracts with successful contractors, while using the time saved from the successful contract re-compete contract cycles to spend more time replacing under-performing MACs.⁴³

H.R. 2 would amend the SSA to extend the time period under which MAC contracts must be offered with the application of competitive procedures running for ten years rather than the

³⁷ CMS began the acquisition process in November 2005. The first round of Medicare administrative contractor (MAC) procurements included all procurements completed or in progress of as of September 1, 2010.

³⁸ For more information, see <http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Vision-of-Future-Fee-for-Service-Medicare-Environment.html>.

³⁹ *CMS to Delay Further Medicare Administrative Contractor (MAC) Jurisdiction Consolidations*, March 19, 2014, at <http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/RFI-Announcement-AB-MAC-March-2014.pdf>.

⁴⁰ OIG, *Medicare Administrative Contractors' Performance* (OEI-03-11-00740), January 2014.

⁴¹ SSA §1874A(b)(1)(B).

⁴² Effective September 3, 2014, the CMS contracting officer can exercise options only after determining the contractor's performance on the contract was acceptable (received satisfactory ratings), 78 *Federal Register* 46783, August 1, 2013.

⁴³ OIG, *Medicare Administrative Contractors' Performance* (OEI-03-11-00740), January 2014.

current five-year period. This change would be applicable to new MAC contracts as well as contracts in effect as of the date of enactment of H.R. 2. In addition, the Secretary would be required, to the extent possible without compromising the MAC contracting process, to make available to the public the performance of each MAC with respect to performance requirements and measurement standards.

Sec. 510. Study on pathway for incentives to States for State participation in medicaid data match program.

CMS initiated the Medicare-Medicaid Data Match Program as a pilot program in 2001.⁴⁴ Medi-Medi was intended to help CMS and states identify overpayments and fraud that affected both Medicare and Medicaid. Based on comparative Medicare and Medicaid data, CMS investigated atypical billing patterns that may not have been evident when analyzing the data from each program separately. If problems were identified, CMS, through a contractor, coordinated with states (for Medicaid) and providers (for Medicare) to recover federal overpayments.

The Medi-Medi pilot was funded mostly by CMS with some addition support from the Federal Bureau of Investigation (FBI). California was the only state in the original pilot in 2001. In 2005, CMS was allocated \$19 million from Health Care Fraud and Abuse Control (HCFAC) funds to continue the California Medi-Medi pilot and expand it to eight other states.⁴⁵ In 2006, Section 6034 of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) required the Secretary to expand the Medi-Medi program nationwide and established dedicated funding (\$12 million in FY2006, rising to \$60 million annually in FY2010 and every year thereafter).

In a 2012 report, OIG found that the Medi-Medi program had produced limited results and few fraud referrals.⁴⁶ During 2007 and 2008, CMS had Medi-Medi projects in 10 states, which produced about 66 fraud referrals to law enforcement, and 27 cases were accepted.⁴⁷ OIG also found that state Medicaid programs received less benefit from the Medi-Medi program than Medicare received.

H.R. 2 would require the Secretary to study and, as appropriate, specify incentives for states to work with the Secretary in conducting the Medi-Medi Data Match program. The Secretary would be authorized to use the limited waiver authority available in the Medi-Medi Data Match program to specify those state incentives.⁴⁸

⁴⁴ CMS founded the California Medicare and Medicaid Data Analysis Center (CMMDAC) on September 28, 2001 to show proof of concept for dual Medicare-Medicaid data analysis. CMMDAC was established to demonstrate the value of comparative Medicare-Medicaid claims data analysis for the detection, prosecution, and elimination of aberrant practices, Medicaid Alliance for Program Safeguards, May 2005.

⁴⁵ Texas, Illinois, Pennsylvania, North Carolina, New Jersey, Ohio, and Washington had agreed to participate in the Medi-Medi pilot in 2005.

⁴⁶ OIG, *The Medicare-Medicaid (Medi-Medi) Data Match Program* (OEI-09-08-00370), April 2012.

⁴⁷ In 2008, the following 10 states were participating in the Medi-Medi program: California, Florida, Illinois, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Texas, and Washington.

⁴⁸ Under the Medi-Medi program, the Secretary has authority to waive only such requirements of SSA title XVIII, and titles XI and XIX as are necessary to carry out the Medi-Medi program (SSA §1893(g)(2)).

Sec. 511. Guidance on application of Common Rule to clinical data registries.

The Physician Quality Reporting System (PQRS) was established by CMS to reward eligible professionals for reporting specified quality data to the agency. Section 601(b) of the American Taxpayer Relief Act of 2012 (SSA Sec. 1848(m)(3)(E)) required the Secretary of HHS to deem those eligible professionals who satisfactorily participate in a “qualified clinical data registry” as having met the quality reporting requirements for PQRS for 2014 and subsequent years. The section also required the Secretary to establish requirements for a qualified clinical data registry and in so doing to consider, among other things, whether an entity has mechanisms in place to ensure transparency and to support quality improvement initiatives for participants. Measures used in the qualified clinical data registries may be endorsed by the National Quality Forum (NQF). These measures are not subject to the process for measure selection being carried out by multi-stakeholder groups under SSA Section 1890A. In defining the requirements for the qualified clinical data registries, the Secretary was required to consult with interested parties and establish a process to determine whether the requirements have been met. GAO was required to conduct a study on the potential of clinical data registries to improve the quality and efficiency of care in the Medicare program, including through payment incentives. As required by statute, GAO submitted a report to Congress on this study in December 2013.⁴⁹

Subpart A of 45 CFR 46 (the Common Rule) outlines the basic HHS policy for the protection of human research subjects carried out using federal funding, as specified, including requirements for Institutional Review Board composition and review, and informed consent, among other things.

This provision of H.R. 2 would require the Secretary, not later than one year after enactment, to issue a clarification or modification with respect to the application of the Common Rule (specifically, Subpart A of 45 CFR 46) for the protection of human research subjects to activities involving clinical data registries, including qualified clinical data registries.

Sec. 512. Eliminating certain civil money penalties; gainsharing study and report.

Under Section 1128A of the SSA, OIG is authorized to impose civil penalties and assessments on individuals and entities that engage in improper conduct with respect to federal health programs, including the imposition of penalties for knowingly presenting or causing to be presented to a federal or state employee or agent certain false or fraudulent claims.⁵⁰ These penalties might also be applicable to certain payments made to physicians to reduce or limit services. The section 1128A penalties include fines up to \$10,000 for each item or service found to be fraudulently claimed, and up to \$50,000 under certain additional circumstances, as well as treble damages.

H.R. 2 would amend section 1128A of the SSA to enable hospitals and critical access hospitals to compensate physicians for reducing medically unnecessary services provided to beneficiaries of

⁴⁹ GAO, “Clinical Data Registries: HHS Could Improve Medicare Quality and Efficiency through Key Requirements and Oversight,” December 2013, <http://www.gao.gov/assets/660/659701.pdf>.

⁵⁰ 42 U.S.C. §1320a-7a. Civil penalties do not apply to beneficiaries under this provision. Under 42 U.S.C. §1320a-7a(i)(5), a beneficiary is defined as an individual who is eligible to receive items or services for which payment may be made under a federal health care program, but excludes any providers, suppliers, or practitioners. However, it may be noted that beneficiaries still may be subject to criminal penalties under 42 U.S.C. §1320a-7b.

federal health programs without being subject to civil monetary penalties. This provision would be effective on the date of enactment of H.R. 2.

In addition, the Secretary, in consultation with OIG, would be required within 12 months after the enactment of H.R. 2 to study and submit a report to Congress that identifies options for amending existing SSA titles XI and XVIII that provide exceptions, safe harbors, or other narrowly targeted fraud and abuse provisions. The intent of the study and report would be to identify gainsharing arrangements or other similar arrangements between physicians and hospitals that otherwise would be subject to civil monetary penalties and to improve care while reducing waste and increasing efficiency. The report to Congress would be required to include the following:

- consideration of whether gainsharing provisions should apply to ownership interests, compensation arrangements, and other relationships;
- description of how the recommendations address accountability, transparency, and quality, including how best to limit inducements to stint on care, discharge patients prematurely, or otherwise reduce or limit medically necessary care; and
- consideration of whether a portion of any savings generated by gainsharing and other arrangements (as compared to an historic benchmark or other metric specified by the Secretary to determine the effect of delivery and payment system changes on Medicare expenditures) should accrue to the Medicare program.

Sec. 513. Modification of Medicare home health surety bond condition of participation requirement.

Medicare covers part-time or intermittent home health services under both Parts A and B.⁵¹ Home health services include skilled nursing services, physical and occupational therapy, speech therapy, medical social services, and home health aide services. Home health service providers consistently have been associated with high improper payment rates and other vulnerabilities.⁵² CMS has sometimes been unable to collect home health agency improper payments. BBA97 required the Secretary to impose surety bonds on Medicare home health agencies. Regulations promulgated in 1998 set the surety bond amount at the greater of \$50,000 or 15% of the annual amount paid in Medicare claims. Those regulations are pending. Congressional oversight agencies such as OIG and GAO recommended that CMS require surety bonds that would help to improve overpayment recoveries from home health agencies.

H.R. 2 would authorize the Secretary to require Medicare home health agencies to post a surety bond in a form specified by the Secretary of at least \$50,000 or an amount commensurate with the volume of payments to the home health agency.

⁵¹ For more information on Medicare home health services, see CRS Report R42998, *Medicare Home Health Benefit Primer: Benefit Basics and Issues*, by Scott R. Talaga.

⁵² HHS, Office of Inspector General, *Surety Bonds Remain an Unused Tool to Protect Medicare from Home Health Overpayments* (OEI-03-12-00070), September 2012.

Sec. 514. Oversight of Medicare coverage of manual manipulation of the spine to correct subluxation.

Medicare covers medically necessary chiropractic services, which are limited to certain manual (use of hands) spinal manipulation treatments to correct subluxations.⁵³ When submitting payment claims, chiropractors must indicate that their services were for acute/corrective treatment (AT) by attaching a modifier to their claims.⁵⁴ According to CMS guidance, chiropractors also must be able to provide certain specific documents to support claims for their services. When further improvement cannot reasonably be expected from continuing care, the services are considered maintenance therapy, which is not medically necessary and therefore not payable under Medicare.

In a 2009 study, GAO found that CMS's efforts to stop payments for uncovered chiropractic maintenance therapy were unsuccessful.⁵⁵ CMS, supported by MACs and program integrity contractors, has used a variety of initiatives including provider education, system edits (caps), and focused medical review, but continues to identify a high number of improper payments for chiropractic services that are maintenance treatments.

H.R. 2 would require the Secretary to establish a medical review process applicable to certain chiropractic manipulation treatments to correct spinal subluxation provided to Medicare beneficiaries.⁵⁶ This medical review process would be applicable to the following types of chiropractic claims submitted after December 31, 2016:

- for services provided by a chiropractor who had aberrant billing patterns in comparison to peers; and
- for services by a chiropractor who in a prior period had a claim denial percentage in the 85th percentile or greater after adjusting for claims denials that were overturned on appeal.

The medical review that would be required by this provision would consist of prior authorization of claims furnished by an individual chiropractor that were part of an episode of treatment that included more than 12 services, based on a justification for treatment such as a diagnosis code.

The Secretary would be authorized to end the prior authorization medical review if the Secretary determines the chiropractor has a low denial rate under prior authorization, but the Secretary may reapply prior authorization medical review if it is determined to be appropriate since the time the prior authorization was lifted. Chiropractors would be permitted to request prior authorization medical review for their services before the chiropractor furnishes the 12th treatment during an episode of care.

⁵³ CMS, *Medicare Benefit Policy Manual*, Chapter 15, Subluxation May be Demonstrated by X-Ray or Physician's Exam, §240.1.2, defines subluxation as "A motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact."

⁵⁴ Medicare does not cover maintenance chiropractic care. If no further improvement in a beneficiary's condition can be expected, then continuing, maintenance, chiropractic care would not be covered by Medicare.

⁵⁵ OIG, *Inappropriate Medicare Payments for Chiropractic Services* (OEI-07-07-00390), May 2009.

⁵⁶ CMS defines medical review as the collection of information and clinical review of medical records by Medicare Contractors to ensure that payment is made only for services that meet all Medicare coverage, coding, and medical necessity requirements, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/>.

The Secretary also would be authorized to use pre-payment or post-payment review of chiropractic services that were not subject to prior authorization medical review. The Secretary has discretion to not use prior authorization medical review in cases where fraud may be suspected. When chiropractor claims were subject to prior authorization medical review, the Secretary would be authorized to make a determination as to whether the services would meet the medical necessity requirements prior to the service being furnished.⁵⁷ The Secretary is prohibited from paying chiropractor claims subject to the prior authorization medical review unless the claims were determined to meet the medical necessity requirements. Chiropractors subject to the prior authorization medical review would be authorized to submit information to support the services they propose to provide by fax, mail, or electronic means. The Secretary would be required to facilitate the receipt of electronic documentation as soon as practicable. For chiropractor claims subject to the prior authorization medical review, the Secretary would be required to make a determination as to the medical necessity of services within 14 days of receipt of the medical documentation or the services could be provided without prior authorization.

When payment for chiropractic services was denied as a result of pre-payment or post-payment review—applied to claims not subject to prior authorization medical review—beneficiaries payment liability would be limited as stipulated in section 1879 of the SSA.

The Secretary would be authorized to contract with MACs or any other Medicare contractors other than Recovery Audit Contractors.

The Secretary would be required under this provision to apply the prior authorization medical review in a manner that would allow chiropractors to obtain authorization to provide multiple services at a single time rather than on a service-by-service basis.

Chiropractic services subject to prior authorization medical review also could be denied for failing to meet other applicable requirements.

The Secretary is authorized to implement the requirements for prior authorization medical review under this section by publishing an interim final rule with comment period. This provision would be exempt from the Federal Information Policy requirements under Chapter 35 of Title 44 of the United States Code.

The Secretary would be required to consult with stakeholders, including the American Chiropractic Association and MAC representatives to develop educational and training programs to improve the ability of chiropractors to provide documentation that would demonstrate that these services are reasonable and necessary. The Secretary would be required to make the educational and training programs available by January 1, 2016.

The Secretary would be authorized to use funds recovered by Recovery Audit Contractors and authorized for use by section 506(b) of H.R. 2 to implement this provision.

GAO would be required to conduct a study on the effectiveness of prior authorization medical review process of services furnished as manual manipulation treatments for subluxation of the spine. The GAO study would be required to include an analysis of the aggregate data on (1) the number of individuals, chiropractors, and claims for services subject to prior authorization

⁵⁷ Medicare's general medical necessity requirements are available at SSA §1862(a)(1)A).

medical review; (2) the number of prior authorization medical reviews conducted. In addition, the GAO report would be required to include an analysis of the outcome of the prior authorization medical review conducted.

Within four years after the date of enactment, GAO would be required to submit a report to Congress containing the results of its study on the prior authorization medical review of chiropractic services. The report would include recommendations for legislation and administrative action applicable to the process for prior authorization of chiropractic medical review as determined appropriate by GAO.

Sec. 515. National expansion of prior authorization model for repetitive scheduled non-emergent ambulance transport.

Medicare covers ambulance services, including non-emergent transportation, when furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. CMS has defined a repetitive ambulance service as medically necessary ambulance transportation that is furnished in 3 round trips or more during a 10-day period, or at least once per week for at least 3 weeks.

Section 1115A of the SSA establishes the Center for Medicare and Medicaid Innovation (CMMI) and authorizes the testing of innovative payment and service delivery models to reduce expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and CHIP beneficiaries. After evaluation, the scope and duration of the innovated payment and service delivery models that meet certain criteria can be expanded through rulemaking. Budget neutrality is not required as a condition for testing a new payment or service delivery model. However, the design or implementation of a model will be modified or terminated, unless the Office of the Actuary in CMS certifies after testing has begun, that that model is expected (1) to improve quality of care without increasing spending, (2) reduce spending without reducing the quality of care, or, (3) improve the quality of care and reduce spending. There has been \$15 billion in funding appropriated from FY2010 through FY2019 to implement new payment models.

CMS recently implemented a three year prior authorization model for repetitive scheduled non-emergent ambulance transport in New Jersey, Pennsylvania and South Carolina under the statutory authority at 1115A of the SSA. Ambulance suppliers (or beneficiaries) began submitting prior authorization requests on December 1, 2014 for transports occurring on or after December 15, 2014.

H.R. 2 would extend the prior authorization payment model for repetitive non-emergent transports to transports in Delaware, the District of Columbia, Maryland, New Jersey, Pennsylvania, North Carolina, South Carolina, West Virginia and Virginia starting no later than January 1, 2016. The funding in 1115A of the SSA would be allocated to carry out this expansion.

The prior authorization model would be expanded to all states if deemed appropriate by the Secretary. The RAC recovery funds established in 1893(h)(10) of the SSA elsewhere in the legislation would be used to carry out this provision. The expansions of the prior authorization model would be required to meet the budget neutrality requirements under Section 1115A.

Sec. 516. Repealing duplicative Medicare secondary payor provision.

Under Medicare Secondary Payer (MSP) laws, Medicare pays the medical bills of beneficiaries covered by certain group health plans and other types of insurance such as liability insurance, only after the other insurer has made the first, or primary, payment.⁵⁸ A provision of MSP law, Section 1862(b)(5) of the SSA (42 U.S.C. Section 1395y(b)(5)), requires employers to provide certain information regarding employees or spouses of employees who may be Medicare eligible and may have received group health benefits. The statute includes fines for employers that willfully and repeatedly decline to report the information of up to \$1,000 for each individual for which a request for information has been made.

Subsequent legislation, Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007, (P.L. 110-173, MMSEA) included additional requirements for group health plans to provide information to HHS regarding the health insurance status of employees, as well as judgments, payments, or settlements involving Medicare beneficiaries. The information is used prospectively to determine whether Medicare is a primary or a secondary payer and retrospectively to collect reimbursement for erroneous payments and conditional payments.

This provision would eliminate the original reporting requirements under Section 1862(b)(5) for information required to be provided on or after July 1, 2016 to avoid duplication of reporting requirements. The amendment would take effect on the date of enactment and would apply to information required on or after January 1, 2016.

Sec. 517. Plan for expanding data in annual CERT report.

CMS implemented the Comprehensive Error Rate Testing (CERT) program to measure improper payments in the Medicare FFS program. CERT was designed to comply with the Improper Payments Information Act (IPIA, P.L. 107-300), as amended by the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA, P.L. 112-248). A CERT contractor selects a stratified random sample of approximately 40,000 Medicare Part A and B claims submitted and processed by MACs during each reporting period. The sample size was selected to enable CMS to calculate a national improper payment rate and contractor- and service-specific improper payment rates. After selecting the sampled claims, CMS's CERT contractor collects supporting documentation for each claim. The sampled claims and the supporting documentation are reviewed by an independent medical review contractor to determine if they were properly paid under Medicare coverage, coding, and billing rules. If these criteria are not met or the provider fails to submit medical records to support the claim, the claim is counted as either a total or partial improper payment and the improper payment may be recouped (for overpayments) or reimbursed (for underpayments). CMS then calculates an annual Medicare FFS improper payment rate. The Medicare FFS improper payment rate in FY2014 was 12.7% and the rate in FY2013 was 10.1%.⁵⁹

H.R. 2 would require the Secretary to submit a report to the Senate Committee on Finance and the House of Representatives Committees on Energy and Commerce and Ways and Means by June 30, 2015 that includes the following information:

⁵⁸ See CRS Report RL 33587, *Medicare Secondary Payer, Coordination of Benefits* by Suzanne Kirchhoff.

⁵⁹ *Department of Health and Human Services Agency Financial Report, FY2014*, page 23, <http://www.hhs.gov/afr/fy2014-mda.pdf>.

- a plan for including in the annual CERT program, data on services (or service groupings; other than medical visits) paid under the Medicare FFS physician fee schedule where the fee schedule amount was greater than \$250 and where the CERT rate for those services or service groupings also exceeded 20%; and
- to the extent practicable by June 30, 2015, specific examples of services or service groupings that had physician fee schedule payment amounts over \$250 and had CERT rates greater than 20%.

Sec. 518. Removing funds for Medicare Improvement Fund added by IMPACT Act of 2014.

A provision in the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT, P.L. 113-185) amended SSA §1898 to, among other changes, convert the Transitional Fund for Sustainable Growth Rate Reform to the Medicare Improvement Fund. IMPACT also appropriated \$195 million to the fund to be available during and after FY2020.

H.R. 2 would amend the SSA §1898(b)(1) to eliminate the \$195 million appropriated for the Medicare Improvement Fund to be available during and after FY2020.

Sec. 519. Rule of construction.

Except as explicitly noted in H.R. 2 Subtitle A—Protecting the Integrity of Medicare—including amendments made by Subtitle A, H.R. 2 would not prevent the use of notice and comment rulemaking in the implementation of Subtitle A's provisions and amendments.

Subtitle B—Other Provisions

Sec. 521. Extension of two-midnight PAMA rules on certain medical review activities.

In August 2013, CMS established a policy regarding the determination of a medically necessary short inpatient stay. Under that policy, inpatient admissions are presumed to be medically appropriate if a physician expects a beneficiary's treatment to require a two-night hospital stay and admits the patient under that assumption. With this two midnight rule, CMS thought that hospitals would have fewer incentives to provide outpatient observation services to beneficiaries. These outpatient stays have higher out-of-pocket expenses for beneficiaries and do not count toward the three-day inpatient requirement for Medicare skilled nursing facility (SNF) coverage. CMS delayed enforcement of certain aspects of this policy until September 30, 2014. Specifically, Medicare's recovery audit contractors (RACs) did not conduct patient status reviews assessing the medical necessity of short inpatient stays with dates of service between October 1, 2013 and September 30, 2014. The Medicare administrative contractors (MACs) will monitor hospitals' compliance with the new regulations under a probe and educate program. These reviews are intended to be instructional and are limited to a sample of 10 to 25 claims per hospital. The Protecting Access to Medicare Act (PAMA; P.L. 113-93) permits the MACs to conduct the probe and educate program for claims from October 1, 2014 through March 31, 2015. PAMA would not permit post payment RAC audits for claims with dates of admission from October 1, 2013

through March 31, 2015 unless there is evidence of systematic gaming, fraud, abuse, or delays in the provision of care.

H.R. 2 would extend the MAC's probe and educate program for claims through FY2015. Post payment RAC audits would not be permitted with dates of admission through September 30, 2015.

Sec. 522. Requiring bid surety bonds and State licensure for entities submitting bids under the Medicare DMEPOS competitive acquisition program.

Medicare generally pays for most durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) on the basis of fee schedules. Fee schedules are statutorily determined formulas used to set payment amounts for equipment. Over time, the Medicare fee schedules for DMEPOS have resulted in payment amounts that are higher than amounts paid by other payers. MMA required the Secretary to establish a Competitive Acquisition Program (Competitive Bidding) to replace the Medicare fee schedules in the selected areas where competitive bidding takes place. Under competitive bidding, payments for specified pieces of equipment in specified areas are determined by the bids of winning suppliers. A bid represent the price at which a supplier is willing to provide equipment to Medicare beneficiaries. Suppliers bid on all of the items within a category of DMEPOS, such as hospital beds and supplies, or oxygen equipment and supplies. A supplier's bid for each item in a category is then weighted by national usage of the item and added together to create the supplier's "composite bid" for the category.

Suppliers compete based on price (i.e., their composite bid) only after meeting other specified competition criteria including the following: a supplier must meet financial standards; the supplier must meet quality requirements; each supplier must meet any relevant state licensure requirements under a statutory requirement pertaining to all Medicare DMEPOS suppliers inside and outside of the competitive bidding program, as well as regulatory requirements about the timing of when state licensure requirements need to be met for suppliers competing in a competitive bidding program; and each supplier must adhere to other criteria to ascertain whether their bids are bona fide and whether the supplier can provide the items based on the bids submitted.

For all suppliers that pass the non-price competition criteria, CMS arrays their composite bids from lowest to highest, and offers contracts to the suppliers with the lowest bids until enough suppliers have been offered contracts to more than supply the market. Suppliers can accept or reject the contract offers without penalty. Over 90% of suppliers who are offered Medicare contracts accept them.

The Medicare price or "single payment amount" for a competitively bid item is set at the median (or middle) bid for that item among all winning suppliers. This means that for half of the winning suppliers, the single payment amount will be less than the bid they submitted for that item, and for half of the suppliers, the single payment amount will be greater than their bid for that item.

Some have expressed concern that, since there is no penalty for rejecting a contract offer under the competitive bidding program, suppliers have an incentive to place low bids and then reject the contract when the single payment amounts (based in part on their own bids) are lower than they would prefer.

H.R. 2 would add specifically to the competitive acquisition statutes the requirement that suppliers meet applicable state licensure as an additional condition for being awarded a contract under the competitive bidding program.

H.R. 2 would require suppliers bidding for contracts that are to begin not earlier than January 1, 2017 and not later than January 1, 2019, to obtain bid bonds. The suppliers would be required to provide proof of the bid bonds to the Secretary. The bonds would be required to be between \$50,000 and \$100,000 for each competitive bidding area the supplier competes in. If a supplier were to be offered a contract for a category of DMEPOS in an area, the supplier's composite bid for the category was less than the median composite bid, and the supplier rejected the contract, the bond submitted by the supplier would be forfeited; and the Secretary would then be required to collect on the bond. In all other circumstances, the bond would be required to be returned to the suppliers within 90 days of the announcement of the winning suppliers. The Comptroller General is required to evaluate the effect of the bid bond requirement on the participation of small suppliers and report the results of the study to Congress not later than six months after the date the first contracts subject to this requirement are awarded.

Sec. 523. Payment for global surgical packages.

Under the MPFS, physicians receive a global payment for surgical services that covers preoperative and postoperative care provided immediately before and after the surgical procedure during the "global period." There are three global packages: (i) 0-day global codes include the surgical procedure and the pre-operative and post-operative physicians' services on the day of the procedure, including visits related to the service; (ii) 10-day global codes include these services as well as visits related to the procedure during the 10 days following the procedure; and (iii) 90-day global codes include the same services as the 0-day global codes plus the pre-operative services furnished one day prior to the procedure and post-operative services during the 90 days immediately following the day of the procedure.

Because the payment rates and global packages were defined and based on data collected many years ago, the accuracy of the payments is uncertain and unlikely to reflect changes in standards of practice and newer technology. In the 2015 Medicare Physician Fee Schedule Final Rule, CMS proposed to redefine bundles by transitioning to 0-day global codes over several years and eliminating all 10- and 90-day global codes; medically reasonable and necessary visits would be billed and paid separately during the pre- and post-operative periods outside of the day of the surgical procedure.

H.R. 2 would prohibit the implementation of this rule regarding global surgical packages and require the Secretary to collect data on services included in global surgical packages from a representative sample of physicians for the purpose of valuing surgical services, beginning no later than January 1, 2017. The information would include the number and level of medical visits and other items and services related to the surgery and furnished during the global services period, as appropriate, and would be reported on claims at the end of the global period or in another manner specified by the Secretary. CMS would receive \$2 million from the Medicare Part B Trust Fund for FY2015 to implement this initiative, with funds to remain available until expended. The Secretary would reassess the value of the information collected every four years and could discontinue the data collection if adequate information on valuing surgical services were to be available from other sources such as qualified clinical data registries, surgical logs, billing systems or other practice or facility records, and electronic health records.

Beginning with 2019, the Secretary would use the information reported above together with other available data to improve the accuracy of valuation of surgical services under the Medicare physician fee schedule. The Secretary could delay 5% of the 10- or 90- day global payment as an incentive for physicians to report the required information. The HHS Inspector General would audit a sample of the information reported to verify the accuracy of the information.

Sec. 524. Extension of Secure Rural Schools and Community Self-Determination Act of 2000.

Counties with national forest lands managed by the United States Forest Service and with certain Bureau of Land Management lands have historically received a percentage of agency revenues, primarily from timber sales.⁶⁰ However, timber sales declined substantially beginning in the 1990s, which led to significantly reduced payments to the counties. Thus, Congress enacted the Secure Rural Schools and Community Self-Determination Act of 2000 (SRS)⁶¹ as a temporary, optional program of payments based in part on historic rather than current revenues.⁶² Authorization of mandatory spending for SRS payments originally expired at the end of FY2006, but the program was extended through FY2013 by several reauthorizations. SRS payments are disbursed after the end of each fiscal year, so the FY2013 SRS payment—the last authorized payment—was made in FY2014. County payments have returned to the revenue-based system that was in place before SRS. The FY2014 payment to counties—made in February 2015—was significantly lower than the previous years’ SRS payments.

This provision would reauthorize mandatory spending for SRS payments for two years, at 95% of the funding level for the preceding fiscal year. The FY2014 payment, to be made within 45 days of enactment, would take into account the revenue-sharing payment that has already been disbursed to the counties.

Sec. 525. Exclusion from PAYGO scorecards.

As has been the case with other enacted “doc fix” legislation, H.R. 4302 includes a provision preventing the bill’s budgetary effects from being recorded on scorecards associated with statutory PAYGO and Senate PAYGO (PAYGO is often used interchangeably with the term “pay-as-you-go”).⁶³ Both statutory and Senate PAYGO are budget enforcement mechanisms created

⁶⁰ Act of May 23, 1908, 16 U.S.C. §500 (directing that 25% of the gross revenue generated on national forest system lands is returned to the counties containing those lands for the “benefit of public schools and public roads.”), and the Act of August 28, 1937, ch. 876, 43 U.S.C. §§1181a-1181j (directing that 50% of the revenue generated on certain lands in Oregon is returned to the counties containing those lands, to be used for any governmental purpose. For more information see CRS Report R42951, *The Oregon and California Railroad Lands (O&C Lands): Issues for Congress*, by Katie Hoover).

⁶¹ P.L. 106-393, 16 U.S.C. §§7101-7153. For more information, see CRS Report R41303, *Reauthorizing the Secure Rural Schools and Community Self-Determination Act of 2000*, by Katie Hoover.

⁶² The payment formula to determine a county’s payment is based half on the revenues generated between FY1986-FY1999 and half on the proportion of agency land within the county, with an adjustment factor based on relative county income.

⁶³ For example, the last three enacted “doc fix” bills, the Protecting Access to Medicare Act of 2014 (P.L. 113-93), the Pathway for SGR Reform Act of 2013 (P.L. 113-67), and the American Taxpayer Relief Act (P.L. 112-240), included the same provision.

with the goal of preventing new direct spending and revenue legislation from resulting in a projected net deficit increase.

In the case of statutory PAYGO, the Office of Management and Budget (OMB) maintains two PAYGO scorecards, covering rolling five-year and ten-year periods. When legislation affecting direct spending or revenue is enacted, the projected net budgetary effect of the legislation is required to be recorded on the scorecards. At the end of a congressional session, OMB determines if the projected budgetary effects of all legislation recorded on the PAYGO scorecards will result in a net deficit increase for either time period. If it has, the President must issue a sequestration order that implements across-the-board cuts to non-exempt programs in an amount sufficient to remedy the projected deficit increase.⁶⁴ Section 525 of H.R. 2 directs that the measure's projected budgetary effects not be recorded on OMB's scorecards, and therefore will not be factored into OMB's annual evaluation of the budgetary effects of enacted direct spending and revenue legislation. It may be worth noting that when statutory PAYGO was enacted in February of 2010, it pre-emptively exempted from the PAYGO scorecard, specified budgetary effects of certain "current policy" legislation, one of which was Medicare physician payments. This exemption, however, remained in effect only through 2011.

In the case of Senate PAYGO, the rule prohibits consideration in the Senate of direct spending or revenue legislation that would increase the deficit over either a six or 11 year period. A scorecard is maintained in the Senate that records the budgetary effects of such legislation. This scorecard, also referred to as a ledger, allows for the budgetary effects of any deficit reduction legislation enacted since the beginning of the calendar year to be used as an offset in the consideration of subsequent direct spending or revenue legislation.⁶⁵ Section 525 of H.R. 2 directs that the measure's budgetary effects would not be recorded on the Senate PAYGO scorecard, and therefore would not affect the scorecard's current balance.

⁶⁴ For more information on statutory PAYGO, see CRS Report R41157, *The Statutory Pay-As-You-Go Act of 2010: Summary and Legislative History*, by Bill Heniff Jr.

⁶⁵ For more information on the Senate PAYGO rule, see CRS Report RL31943, *Budget Enforcement Procedures: Senate Pay-As-You-Go (PAYGO) Rule*, by Bill Heniff Jr.

Appendix. List of Abbreviations

ACA: The Patient Protection and Affordable Care Act (P.L. 111-148, as amended)

ADRC: Aging and Disability Resource Center

ARRA: The American Recovery and Reinvestment Act of 2009 (P.L. 111-5)

ATRA: The American Taxpayer Relief Act of 2012 (P.L. 112-240)

BBA97: The Balanced Budget Act of 1997 (P.L. 105-33)

BIPA: Benefits Improvement and Protection Act of 2000 (P.L. 106-554)

CAH: Critical access hospital

CERT: Comprehensive error rate testing

CHIP: State Children’s Health Insurance Program

CHIPRA: Children’s Health Insurance Program Reauthorization Act (P.L. 111-3)

CMMI: Center for Medicare and Medicaid Innovation

CMS: Centers for Medicare & Medicaid Services

CPI-U: Consumer price index for all urban consumers

DEA: Drug Enforcement Agency

DME: Durable medical equipment

DMEPOS: Durable medical equipment, prosthetics, orthotics, and supplies

DRA: Deficit Reduction Act of 2005 (P.L. 109-171)

DSH: Disproportionate share hospital

FFS: Fee-for-service

FPL: Federal poverty level

FSA: The Family Support Act of 1988 (P.L. 100-485)

GAO: Government Accountability Office

GPCI: Geographic practice cost index

HCFAC: Health care fraud and abuse control

HHHA: Home health agency

HHS: Department of Health & Human Services

HIPAA: Health Insurance Portability and Accountability Act of 1996 (P.L. 109-141)

LTCH: Long-term care hospital

MA: Medicare Advantage

MAC: Medicare administrative contractor

MAGI: Modified adjusted gross income

MA-PD: Medicare Advantage plans with a prescription drug component

MedPAC: Medicare Payment Advisory Commission

MCTRJCA: Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96)

MIECHV: Maternal, infant, and early childhood home visiting

MIPPA: Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275)

MMA: Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173)

MMEA: Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309)

MMSEA: Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173)

NPI: National provider identifier

OAA: Older Americans Act (P.L. 89-73, as amended)

OIG: The Department of Health and Human Services Office of Inspector General

OMB: Office of Management and Budget

PAMA: Protecting Access to Medicare Act of 2014 (P.L. 113-93)

PAYGO: Pay-as-you-go

PDE: Prescription drug event

PHSA: Public Health Service Act (P.L. 78-410)

PREP: Personal responsibility education program

PRWORA: Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193)

PSRA: Pathway for SGR Reform Act of 2013 (P.L. 113-67)

QI: Qualifying Individual

RAC: Recovery audit contractor

SGR: Sustainable growth rate

SNF: Skilled nursing facility

SRS: Secure Rural Schools

SSA: Social Security Act

TEFRA: Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248)

TRHCA: Tax Relief and Health Care Act of 2006 (P.L. 109-432)

TMA: Transitional medical assistance

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