



American Medical Group Association®

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

### *Summary*

H.R. 2 (P.L. 114-10) became law on April 16, 2015. The law repeals and replaces the Medicare Sustainable Growth Rate (SGR) formula and replaces it with a value-driven payment system, in addition to making other policy modifications relating to other healthcare programs.

#### **Title I – SGR repeal and Medicare Provider Payment Modernization**

##### *Section 101. Repealing the SGR and Improving Medicare Payment for Physicians' Services*

Repeals the current SGR formula with various reforms mentioned below. During this transition, the law institutes a 0.5% payment update each year for five years through 2019. After 2019, there will be a zero percent update for the next five years. For 2026 and subsequent years, there will be a 0.75% update for Eligible Professionals (EPs) in an Alternative Payment Model (APM) and a 0.25% for EPs not in an APM.

##### Merit-Based Incentive Payment System (MIPS)

The MIPS program sunsets three existing quality incentive programs in Medicare Part B: the Physician Quality Reporting System (PQRS); the Value-Based Modifier (VBM); and Meaningful Use of electronic health records (EHR MU) on December 31, 2018.

Beginning on January 1, 2019, MIPS will assess providers on four performance categories to determine a performance score which will result in an up or down adjustment of the providers' Medicare payments. In 2019, the payment adjustment factor under MIPS will vary: positive or negative adjustments will be 4% in 2019, 5% in 2020, 7% in 2021, and 9% in all subsequent years. The performance adjustment factors included in MIPS are:

1. Quality: Quality measures will generally come from current law in PQRS for existing incentive payments for quality reporting and quality of care. Similar to the PQRS, group practices will be allowed to report quality measures.
2. Resource use: Generally, the measures of resource use under the current law in VBM will be used and the cost of part D drugs will also be included.
3. Clinical practice improvement activities: Clinical practice improvement activities will be specified by the Administration and will include at least the following subcategories:
  - a. Expanded practice access, such as urgent care and after-hours clinical advice;
  - b. Population management, such as monitoring health conditions or participation in the qualified clinical data registry;
  - c. Care coordination, such as use of remote monitoring or telehealth;
  - d. Beneficiary engagement such as the establishment of care plans for individuals with complex needs;
  - e. Patient safety and practice assessment, such as use of surgical checklists; and

- f. Participation in an APM.
4. Meaningful Use of certified EHR technology: Current law requirements for determining if an eligible professional is a meaningful EHR user.

#### Alternative Payment Models (APMs)

The law incentivizes the use of APMs such as Accountable Care Organizations (ACOs). The incentives to enroll in an APM include a 5% bonus to APM providers as well as an exclusion from the MIPS assessment and most EHR Meaningful Use requirements. For Medicare, an APM could be a model tested by the Center for Medicare and Medicaid Innovation (CMMI), an ACO under the Medicare Shared Savings Program (MSSP), a demonstration under the Health Care Quality Demonstration Program, or a demonstration required by Federal law. An “eligible APM entity” is an entity that participates in an APM that requires a certified EHR, provides payments based on quality measures similar to that found in the MIPS program and bears some “nominal” downside payment risk (unless the entity is a medical home expanded under section 1115 (c) of the Social Security Act).

In order to qualify for APM incentives, EPs must receive 25% of their Medicare payments through an APM for 2019 to 2020. For 2021 to 2022, the threshold increases to 50%, 25% of which must be Medicare payments, and the rest may come from an APM. In 2023 and beyond, 75% of payments must come from an APM, with at least 25% of that coming from Medicare. Payments made through the Veterans Affairs Administration, the Department of Defense, and State Medicaid Agencies in which no medical home or Medicaid APM is available do not qualify as APM payments for purposes of meeting the APM threshold.

#### *Section 102. Priorities and Funding for Measure Development*

By January 1, 2016, the Secretary of Health and Human Services (HHS) must draft a plan for development of quality measures to assess professionals. This plan must address the incorporation of Medicare measures used by private payers and integrated delivery systems. The Secretary of HHS must also take into account how coordination will occur across organizations while they develop measures. This plan must also take into account best practices and clinical practice guidelines that should be used for developing quality measures. Starting May 1, 2017, the Secretary of HHS will be required to post an annual report on the Centers for Medicare and Medicaid (CMS) website regarding progress attained in developing quality measures.

#### *Section 103. Encouraging Care Management for Individuals with Chronic Care Needs*

Encourages care management for individuals with chronic care needs by codifying existing CMS initiatives with respect to Chronic Care Management (CCM) services. More specifically, this law will require CMS to reimburse providers for providing CCM services. CMS has already initiated a Chronic Care Management code on January 1, 2015 through the Medicare physician fee schedule rules for 2014 and 2015.

#### *Section 104. Empowering Beneficiary Choices Through Continued Access to Information on Physicians' Services*

Requires the Secretary of HHS to publish utilization and payment data for physicians in order to educate Medicare beneficiaries. Beginning in 2016, the following information will be integrated into CMS’ Physician Compare website. At a minimum, the data will include information on the number of services provided under Part B, submitted charges and payments for such services, and a unique identifier for

the EP that is publicly available. In addition, the information will have to be searchable by characteristics of the services furnished; location of the EP; and specialty or type of EP.

*Section 105. Expanding Availability of Medicare Data*

Expands the use of Medicare data by Qualified Entities to analyze claims data.

*Section 106. Reducing Administrative Burden and Other Provisions*

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

Allows continuing renewals of any two-year period for which a physician or practitioner opts out of the Medicare claims process under a private contract.

Directs the Secretary of HHS to make publicly available, through an appropriate HHS website, information on the number and characteristics of opt-out physicians and practitioners.

*Section 106 (b)-Gainsharing Study and Report*

Requires the Secretary of HHS to consult with the HHS Office of Inspector General (OIG) to develop recommendations to Congress on potential changes to existing anti-fraud and abuse laws in order to facilitate physician-hospital gainsharing.

Importantly, section 512 of H.R. 2 narrows the circumstances under which the Civil Monetary Penalties (CMP) Law applies to gainsharing arrangements. The CMP will now only apply to arrangements that limit “medically necessary” services, a significant development that should broaden the use of beneficial gainsharing arrangements.

*Section 106 (c) - Promoting Interoperability of EHR Systems*

Establishes a national objective to achieve widespread exchange of health information through interoperable certified EHR technology, nationwide, by December 31, 2018.

Requires the Secretary of HHS to examine the feasibility of establishing one or more mechanisms to assist providers in comparing and selecting certified EHR technology products.

*Section 106 (d)-Government Accountability Office (GAO) Report of Telehealth and Remote Patient Monitoring*

Directs GAO to study specified telehealth and remote patient monitoring services.

*Section 106 (e)-Rule of Construction Regarding Healthcare Providers*

Provides that the development, recognition, or implementation of any guideline or other standard under any provision in the Affordable Care Act (ACA), Medicare, or Medicaid shall be construed to establish the standard of care or duty of care owed by a healthcare provider to a patient in any medical malpractice or medical product liability action or claim.

**Title II – Medicare and Other Health Extenders**

Subtitle A – Medicare Extenders

*Section 201. Extension of work GPCI floor*

The Medicare geographic adjustment indices, called the Geographic Practice Cost Indices (GPCIs) reflect how each geographic area compares to the national average, and are used in the calculation of Medicare payment rates. A value of 1.00 represents the average across all areas. The provision passed in H.R. 2 will extend the 1.00 floor for physician work (one of three elements used to calculate Medicare payments) through December 31, 2017. The previous extension of the physician work GPCI would have expired at the end of March 2015.

*Section 202. Extension of Therapy Cap Exceptions Process*

This provision extends the current therapy cap exceptions process through December 31, 2017, which sets an annual threshold of \$3,700, including physician offices and hospital outpatient department visits, unless a patient is eligible for an exception to this amount due to medical necessity. The provision also requires the Secretary of HHS to implement a new medical review process for outpatient therapy services. Under the review process, the Secretary can use certain characteristics to target review such as 1) a high claims denial percentage, 2) a pattern of billing for therapy services that is aberrant compared to peers, or other questionable billing practices, 3) is newly enrolled, 4) provides therapy to treat a type of medical condition, or 5) is part of a group that includes another therapy provider identified by the preceding factors.

*Section 203. Extension of Ambulance Add-Ons*

H.R. 2 extends the super rural, rural, and urban add-ons to the Medicare ambulance fee schedule until January 1, 2018. "Super rural" are counties with the lowest population densities.

*Section 204. Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-Volume Hospitals*

This provision extends the current policy in the Inpatient Prospective Payment System until October 1, 2017.

*Section 205. Extension of the Medicare-Dependent Hospital (MDH) Program*

MDH's are small rural hospitals with a high percentage of patients who are Medicare beneficiaries. These entities receive higher payments under the Inpatient Prospective Payment System. H.R. 2 extends the MDH program until October 1, 2017 and makes other conforming changes.

*Section 206. Extension for Specialized Medicare Advantage Plans for Special Needs Individuals*

Medicare Advantage (MA) Special Needs Plans (SNP) can target enrollment to one or more types of special needs beneficiaries to include those who are institutionalized, dually eligible for both Medicare and Medicaid, and individuals with severe chronic conditions, and individuals who are disabled. H.R. 2 extends SNP authority to continue through December 31, 2018.

*Section 207. Extension of Funding for Quality Measure Endorsement, Input, and Election*

Through its Measure Applications Partnership the National Quality Forum has been convening a multi-stakeholder group to discuss the selection of quality measures for use in Medicare and other federal healthcare programs. Since FY 2009, this program has continued to receive funding from the Medicare Part A and B Trust Funds to carry out activities under section 1890 of the Social Security Act. H.R. 2 provides for \$30 million for each of FY 2015 through fiscal year 2017 to continue its activities.

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

Section 119 of Medicare Improvements for Patients and Providers Act (P.L. 110-275) allocated funding for low-income Medicare beneficiary outreach and education activities through several programs, including Aging and Disability Resource Centers, the Administration on Aging, Area Agencies on Aging, and others.

H.R. 2 extends these authorities through FY 2017.

*Section 209. Extension and Transition of Reasonable Cost Reimbursement Contracts*

Reasonable cost plans (known as “cost plans”) are Medicare managed care plans that are reimbursed by Medicare for the actual cost of providing services to enrollees. Phase-out of these plans has been delayed over the years due to Congressional action, however, H.R. 2 will transition cost plans into Medicare Advantage plans.

*Section 210. Extension of Home Health Rural Add-On*

Medicare provides increased payment under the home health prospective payment system for home health providers who provide care to beneficiaries in rural areas. Over the years, Congress has provided add-on payments at various rates, and H.R. 2 extends the rural add-on at a 3% increase for home health care provided to beneficiaries in rural areas from January 1, 2016, when the current add-on expires, through December 31, 2017.

Subtitle B—Other Health Extenders

*Section 211. Permanent Extension of the Qualifying Individual Program*

The Balanced Budget Act of 1997 (BBA) required payments Medicare Part B premiums for a group of low-income Medicare beneficiaries known as Qualified Individuals (QIs) who have incomes between 120% and 135% of the federal poverty level. H.R. 2 permanently extends the QI program and appropriates \$535 million for the remainder of FY 2015 (April 1-December 31, 2015) and \$980 million for CY 2016. Funding for subsequent years will 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.

*Section 212. Permanent Extension of Transitional Medical Assistance*

Medicaid requires states to continue Medicaid benefits for certain low-income families who would otherwise lose their coverage due to increases in income or child support. H.R. 2 permanently extends transitional medical assistance (TMA) or 6 and up to 12 months for families losing Medicaid eligibility due to increased hours of work or income from employment, as well as families who lose eligibility due to the loss of a time-limited income earning period. The provision will not affect the current 4-month TMA coverage for individuals who become ineligible for Medicaid due to increased spousal support.

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

The federal government provides funding for the National Institutes of Health (NIH) to award grants for research into the prevention and cure of Type I diabetes, in addition to providing funding for the Indian Health Service (IHS) to award grants for services related to the prevention and treatment of diabetes for

American Indians and Alaska Natives who receive services through IHS-funded facilities. H.R. 2 extends annual appropriations of \$150 million for each program for each of FY 2016 and FY 2017.

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

Enacted in the ACA, the Family-to-Family Health Information Centers program is administered by the Health Resources and Services Administration (HRSA) to provide grants to family-staffed organizations that provide health care information and resources to families of children with special health care needs. H.R. 2 will provide funding for this program of \$5 million for FY 2015 and provide \$5 million for each of FY 2016 and FY 2017.

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

H.R. 2 extends funding to this program, which is run jointly by HRSA and the Administration for Children and Families, to provide grants to states, territories, and tribes for the support of evidence-based early childhood home visiting programs. The programs support in-home visits made by health or social service professionals with at-risk families. H.R. 2 provides \$400 million through the remainder of FY 2015, in addition to providing \$400 million for each of FY 2016 and FY 2017.

*Section 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 provides mandatory funding for federal health centers located in medically underserved areas. These centers provide primary care, dental care, and other health and supportive services to individuals regardless of their ability to pay for them. Another provision in the ACA requires the Secretary of HHS to make direct and indirect Graduate Medical Education (GME) payments to qualified teaching health centers which are community-based outpatient facilities that train medical residents. H.R. 2 extends the CHCF, providing \$3.6 billion for health centers and \$310 million to the National Health Services Corp, which provides scholarships and loan repayments for medical professionals who agree to work in health professional shortage areas upon graduation. These funds will continue the FY 2015 funding level and will apply to both FY 2016 and FY 2017.

**Title III – CHIP**

*Section 301. 2-Year Extension of the Children’s Health Insurance Program (CHIP)*

This section contains an extension of CHIP funding for two additional fiscal years, \$19.3 billion in FY 2016, and \$20.4 billion in FY 2017.

**Title IV – Offsets**

Subtitle A – Medicare Beneficiary Reforms

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

This section prohibits the sale of a Medicare supplemental (Medigap) policy covering the Part B deductible to a newly eligible Medicare beneficiary starting on January 1, 2020.

*Section 402. Income-Related Premium Adjustment for Parts B and D*

This section adjusts income thresholds for Medicare part B beneficiaries to determine their respective premiums. For those with a modified adjusted gross income between \$133,500 and \$160,000, the share of Part B expenditures that beneficiary premiums are calculated to cover will be 65% in 2018. For those with a modified adjusted gross income between \$133,500 and \$160,000, the share of Part B expenditures that beneficiary premiums are calculated to cover will be 65% starting in 2018, up from 50% in 2015. For those with a modified adjusted gross income between \$160,000 and \$214,000, the share of Part B expenditures that beneficiary premiums are calculated to cover will be 80% in 2018, up from 65% in 2015. The standard Part B premium is calculated to cover 25% of Part B expenditures.

This section also maintains the freeze on adjustments to the income-related premium income thresholds for inflation through 2019.

#### Subtitle B – Other Offsets

##### *Section 411. Medicare Payment Updates for Post-Acute Providers*

This section decreases the Medicare market-basket update for Post-Acute Care providers to 1% for FY 2018.

##### *Section 412. Delay of Reduction to DSH Allotments*

This section delays Medicaid DSH cuts as required under the ACA to FY 2017. But, the law also extends Medicaid DSH cuts into FY 2025.

##### *Section 413. Levy on Delinquent providers*

Currently, the U.S. Treasury Department is allowed to impose a levy of 30% of payments to Medicare services who fail to pay some or all of the taxes due to the government. This provision will increase Treasury's levy authority to 100% of payments to Medicare providers.

##### *Section 414. Adjustments to Inpatient Hospital Payment Rates*

As dictated by the American Taxpayer Relief Act of 2012, CMS was required to retrospectively recoup \$11 billion in overpayments to hospitals. Subsequently, instead of receiving a one-time 3.2% payment increase schedule to occur in FY 2018, this provision will phase-in at 0.5% the increase over 6 years starting in FY 2018.

### **Title V – Miscellaneous**

#### Subtitle A – Protecting the Integrity of Medicare

##### *Section 501. Prohibition of Inclusion of Social Security Account Numbers on Medicare Cards*

This section prohibits the display of a beneficiary's Social Security number on Medicare cards. New Medicare cards issued from HHS must not have a beneficiary's Social Security number (or derivative thereof). HHS must implement this provision within 4 years from the date of enactment. Three-hundred twenty million dollars will be made available from the Medicare Trust Funds to implement this section.

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

Requires HHS to establish procedures to ensure payment is not made for items and services for an individual who is incarcerated, not lawfully present in the United States who is ineligible for coverage, or deceased. The HHS-OIG must submit a report to Congress on this provision within 18 months.

*Section 503. Consideration of Measures Regarding Medicare Beneficiary Smart Cards*

To the extent that it is viable and cost effective, HHS is required consider smart card and electronic card technology for use by Medicare beneficiaries, providers and suppliers. If HHS considers using this technology they must report to the Congressional Committees of jurisdiction.

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

In addition to physicians, this provision permits physician assistants, practitioners, or specialists to have a face-to-face encounter for coverage of Durable Medical Equipment. This provision allows HHS to implement this provision without formal rulemaking.

*Section 505. Reducing Improper Medicare Payments*

Requires Medicare Administrative Contractors (MACs) to provide suppliers and providers a quarterly list of the most expensive payment errors and how to correct or avoid those errors. MACs must also provide notice of new topics for Recovery Audit Contractor (RAC) audits and how to avoid issues related to the audits.

This section instructs MACs to give priority to services and items that have the highest rate of improper payments and are due to misapplication, misinterpretation, or administrative errors.

*Section 506. Improving Senior Medicare Patrol and Fraud Reporting Rewards*

HHS shall submit a report to Congress within 180 days on encouraging greater participation by individuals to report fraud and abuse in the Medicare program.

*Section 507. Requiring Valid Prescriber National Provider Identifiers on Pharmacy Claims*

Beginning in plan year 2016, HHS shall require claims for Part D or Medicare Advantage Prescription Drug Plans (MA-PD) to include a valid prescriber National Provider Identifier (NPI). HHS shall establish procedures for determining NPI validity, in consultation with appropriate stakeholders. Beneficiaries are to be notified for reasons for denial. The HHS-OIG is required to submit a report to Congress on the effectiveness of the provision by January 1, 2018.

*Section 508. Option to Receive Medicare Summary Notice Electronically*

Starting in 2016, Medicare beneficiaries may elect to receive Medicare's explanation of benefits electronically. The beneficiary may be allowed to revoke their electronic election at least once, but HHS may limit the number of elections. HHS does not have to provide beneficiaries notice of the electronic option until 2017.

*Section 509. Renewal of MAC Contracts*

Medicare Administrative Contractor (MAC) contracts, entered into after enactment of the legislation, are lengthened from 5 to 10 years. The provision requires HHS to make MAC performance public if making public does not compromise renewing or entering into new contracts.

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

Requires HHS to study potential incentives for states to work with the Administration on coordinating activities to protect government spending under both the Medicare and Medicaid programs.

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

Within one year of enactment, HHS must clarify or modify the application of the Common Rule to clinical data registries, including qualified clinical data registries. The issue is whether the Common Rule protecting human research applies to data registries.

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

Narrows the circumstances under which the Civil Monetary Penalties (CMP) Law applies to gainsharing arrangements. The CMP will now only apply to arrangements that limit “medically necessary” services, a significant development that should broaden the use of beneficial gainsharing arrangements.

Requires an HHS-OIG report to Congress on gainsharing arrangements and options for amendment fraud and abuse laws.

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

Makes several changes to the surety bond requirement for home health agencies, including a \$50,000 minimum surety bond, but HHS will determine if the amount of the surety bond is commensurate to the volume of payments.

*Section 514. Oversight of Medicare Coverage of Manual Manipulation of the Spine to Correct a Subluxation*

HHS must implement a medical review of chiropractic services furnished on or after January 1, 2017 with a focus on chiropractors that have aberrant billing patterns compared to peers and have a denial percentage in the 85<sup>th</sup> percentile. This provision also establishes a prior authorization process for 12 or more of these services. HHS at their discretion may end prior authorization if the chiropractor has a low denial rate. HHS has the option to reapply prior authorization.

Allows HHS to use pre and post payment reviews.

HHS can establish the medical review process through interim final rulemaking and HHS is to develop (in consultation with stakeholders) education and training materials to make available to chiropractors.

Within four years the Government Accountability Office must report to Congress on the medical review process.

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

In 2016, expands the CMMI model to test prior authorization for repetitive scheduled non-emergent ambulance transport to Delaware, D.C., Maryland, North Carolina, West Virginia, and Virginia. In 2017, HHS must expand the model nationwide but it must not reduce quality of care, deny or limit coverage or increase spending.

*Section 516. Repealing Duplicative Medicare Secondary Payor Provision*

In 2016 this provision repeals a duplicative reporting requirement that requires employers to submit information about employees or spouses that may be Medicare eligible and may be receiving group health benefits. There is still a similar requirement, but current law is duplicative so it eliminates one of the provisions.

*Section 517. Plan for Expanding Data in Annual CERT Report*

By June 30, 2015 HHS shall submit to the Senate Finance Committee, the House Ways and Means Committee and the House Energy and Commerce Committee a plan for including services where the error rate is above 20% and the fee schedule amount is above \$250 in the Comprehensive Error Rate Testing Program.

*Section 518. Removing Funds for Medicare Improvement Fund Added by IMPACT Act of 2014*

Removes \$195 million from the Medicare Improvement Fund that was a part of the Improving Medicare Post-Acute Care Transformation Act (IMPACT Act).

*Section 519. Rule of Construction*

Clarifies that CMS may use notice and comment periods to carry out provisions of Subtitle A of the SGR bill.

Subtitle B—Other provisions

*Section 521. Extension of Two-Midnight Protecting Access to Medicare Act Rules on Certain Medical Review Activities*

This provision extends the moratorium on post payment RAC audits relating to the Two Midnight Rule for six months. These audits will not be permitted with dates of admission through September 30, 2015.

*Section 522. Requiring Bid Surety Bonds and State Licensure for Entities Submitting Bids under the Medicare DMEPOS Competitive Acquisition Program*

Durable medical equipment suppliers submitting bids under the Medicare competitive bidding program must meet State licensure requirements. For rounds of competitive bidding beginning in 2017, bidding entities must receive a bid between \$50,000 and \$100,000 for each area a bid is submitted. To discourage low bids and suppliers from rejecting contracts bid bonds will be forfeited to HHS if the entity rejects the contract.

Requires a GAO study on this requirement's impact on small suppliers.

*Section 523. Payment for Global Surgical Packages*

Prohibits CMS from implementing the 2015 physician fee schedule final rule provision that would have eliminated global surgical bundles. Requires HHS to collect data from a sample of physicians on services in global surgical packages to value these services, and transfers \$2 million from the Medicare Trust Fund for the data collection effort.

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

Extends funding for the Secure Rural Schools program for Fiscal Years 2014 and 2015. This program aids counties hit by losses in timber revenues.

*Section 525. Exclusion from PAYGO Scorecards*

Excludes H.R. 2 from PAYGO (Pay-As-You-Go) scorecards. The bill is not fully offset, meaning that the cost of the bill will not be recorded on the scorecards that the Office of Management and Budget uses to analyze costs and savings.