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The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)

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Summary

On April 16, 2015, President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10), as passed by the Senate on April 14, 2015, and by the House on March 26, 2015. The act repeals the sustainable growth rate (SGR) formula for calculating updates to Medicare payment rates to physicians and establishes an alternative set of annual updates. In addition, MACRA introduces a new merit-based incentive payment system and puts in place processes for developing, evaluating, and adopting alternative payment models (APMs).

The act also extends funding that was otherwise set to expire at the end of FY2015. These extensions include funding for the state Children's Health Insurance Program (CHIP) and for the Community Health Centers Fund (CHCF) for two additional years, through FY2017. For CHIP, MACRA maintains the current allotment formula, including a 23 percentage point increase in the enhanced federal medical assistance percentage (E-FMAP), which determines the federal government's share of CHIP expenditures.

In addition to repealing the SGR (Title I) and extending funding for the CHCF (Title II) and for CHIP (Title III), the act makes other health-related changes. Title II extends a number of expiring provisions in Medicare, Medicaid, and other 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 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, such as a prohibition on including Social Security numbers on beneficiaries' Medicare cards.

This report briefly summarizes each provision of MACRA. Each summary includes a brief description of prior law and an explanation of how MACRA changed prior law.

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In addition to repealing the SGR (Title I) and extending funding for the CHCF (Title II) and for CHIP (Title III), MACRA 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 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, such as a prohibition on including Social Security numbers on beneficiaries' Medicare cards.

This report provides a brief summary of each provision of MACRA. Each summary includes a brief description of current law and an explanation of how MACRA changes current law.[1]

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

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

Background

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., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative value for a service compares the work involved in performing that 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

[1] The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimated the budgetary effects of the legislation. The estimates can be found at http://www.cbo.gov/sites/default/files/cbofiles/attachments/hr2.pdf.

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 & 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 historically has provided advice and recommendations to CMS to assist in these assessments. CMS is required by statute to review the RVUs no less than every five years.[2]

In determining adjustments to RVUs used as the basis for calculating Medicare physician reimbursement under the fee schedule, the Secretary of the Department of Health and Human Services (HHS) 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 HHS Secretary 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 in aggregate 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 SGR formula was 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) were less than the cumulative spending target over the same period, the annual update was increased according to a statutory formula. However, if spending exceeded the cumulative spending target over the same period, the SGR methodology necessitated 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 grew each year. However, with the exception of 2002, when a 4.8% decrease was applied, Congress enacted a series of laws to override the reductions.

The Protecting Access to Medicare Act (PAMA; P.L. 113-93) included a provision that averted the reductions and maintained the MPFS payments at current rates through March 31, 2015. CMS actuaries estimated that, without additional congressional intervention, the statutory change in the

[2] SSA §1848(c)(2)(B)(i).

update factor would have resulted in a 21% reduction in payment rates under the MPFS, beginning 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. 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 successfully participate 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 are 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 the 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 than what evidence-based research (if available) recommends, and revise practice styles as appropriate. MIPPA (§131(c)) established such a physician feedback program. The 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 it 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 can 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 health information technology (HIT) systems by 2015 will see their Medicare payments reduced by the following amounts: 1% in 2015, 2% in 2016, and 3% in 2017 and in each subsequent year. For 2018 and beyond, if the proportion of eligible physicians who are meaningful EHR users is less than 75%, the payment reduction will be further decreased by one percentage point from the applicable amount in the previous year, although 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 pay structures, have been criticized for rewarding volume of care without incentivizing quality or improved outcomes. Although payments vary across geography by design and sometimes are 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, historically payments have not varied 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.

Since January 1, 2015, the value-based payment modifier has applied 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 (FFS) 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.

Overview

Section 101 of MACRA makes fundamental changes to the way Medicare payments to physicians are determined, how they are updated, and how they incentivize physicians. The act

- repeals the SGR methodology for determining updates to the MPFS, establishes annual fee updates in the short term, and puts in place a new method for determining updates afterward;
- establishes a merit-based incentive payment system (MIPS) to consolidate and replace several existing incentive programs;
- incentivizes the development of, and participation in, alternative payment models (APMs); and
- makes other changes to Medicare physician payment statutes.

Payment Updates

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

Beginning in 2026, there will be two update factors, one for items and services furnished by a participant in a new APM (see "Alternative Payment Models," below) and another for those who do not participate in an APM. The update factor for the APM participants will be 0.75%, and the update factor for those not participating in an APM will be 0.25%.

MedPAC will prepare reports to assist Congress in evaluating the changes. By July 1, 2017, MedPAC will 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 will include a methodology to describe the relationship between the practice and ordering patterns of physicians and other health professionals and total utilization and expenditure of healthcare services in Medicare Parts A, B, and D. The final report will be due to Congress by July 1, 2021. A second report, due no later than July 1, 2019, will examine the effect of the 2015-2019 payment updates on the efficiency, economy, and quality of care provided, determine 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.

Merit-Based Incentive Payment System

Section 101 of MACRA will create a new incentive payment system while sunsetting several existing programs on the last day of 2018. These existing programs include (1) the meaningful use incentive program for certified EHR technology, (2) the physician quality reporting system, formerly called the physician quality reporting initiative, and (3) the value-based payment modifier. The Secretary will establish a replacement program, the merit-based incentive payment system (MIPS), to accomplish the following:

- develop a methodology for assessing the total performance of each MIPS-eligible professional according to performance standards;
- use the methodology to provide for a composite performance score as for each professional for each performance period; and
- use the composite performance score of the MIPS-eligible professional to make MIPS program incentive payments to the professional for the year.

The MIPS program will 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 will change over time. Subject to the exclusions and definitions of newly eligible participants (see "Alternative Payment Models," below), only physicians, as defined under current law, and physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists—and groups that include such professionals—will be eligible for incentive payments in the first and second years of the MIPS program . The Secretary will decide which other health care professionals, in addition to those already specified, will be eligible in subsequent years.

Health care professionals excluded from the MIPS incentive payment program will include otherwise eligible professionals who (1) will be qualifying APM participants, (2) will be partial qualifying APM participants, and (3) will not exceed the low-volume-threshold measurement.

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

- *Quality*. The final quality measures under current law for existing incentive payments for quality reporting and quality of care.
- *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.
- *Clinical practice improvement activities*. The clinical practice improvement activities will be specified by the Secretary and will 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 decisionmaking 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 will give consideration to the circumstances of small practices (15 or fewer professionals) and practices located in rural areas and in health professional shortage areas.
- *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 will establish and publish in the *Federal Register* an annual list of quality measures to serve as the basis for the MIPS payment adjustment. MIPS-eligible professionals can choose from this list, which will 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 will establish MIPS performance standards and the performance period with respect to the measures and activities. The performance standards will take into account historical performance standards, improvement, and the opportunity for continued improvement. The Secretary will establish a performance period for each year in which incentive payments will be

determined, beginning with 2019; the performance period will begin and end prior to the beginning of the year in which the incentive payments will be paid.

The Secretary will 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. Using that methodology, the Secretary will determine a composite assessment (*composite performance score*) for each such professional for each performance period. As incentive, the Secretary will 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 will be based on performance on the quality measure; outcome measures will be encouraged, as feasible. The weight for the resource use category also will be 30% initially, and the clinical practice category will receive a weight of 15%. The meaningful use of certified EHR technology will receive a 25% weight. These weights will 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%, and could increase the other weights appropriately.

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

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

Professionals will be able to earn an additional MIPS adjustment 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 will vary with the amount by which the score exceeds the threshold, to be specified by the Secretary.

The performance threshold will be the mean or median (as selected by the Secretary) of the composite performance scores for all MIPS-eligible professionals; the Secretary can reassess the selection of the mean or the median every three years. The exceptional performance threshold will 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 will establish the two thresholds based on information from a period prior to the performance period, available data regarding performance on measures and activities that may be used in the four MIPS performance categories, and other factors the Secretary determines to be appropriate. Beginning with 2019, the payment received by an MIPS-eligible professional will 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 will be notified as to his or her 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 is applied. The MIPS adjustment factor(s) applies only with respect to the year involved, and the Secretary will not take such adjustments into account in making payments to an MIPS-eligible professional in a subsequent year.

The Secretary will make information regarding the performance of MIPS-eligible professionals under the MIPS program publicly available in an easily understandable format on CMS's Physician Compare website. This information will include the composite score for each MIPS-eligible professional and the performance of each MIPS-eligible professional with respect to each performance category. It could also include each eligible professional's performance on each measure or activity in the four performance categories. This information will 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 will provide an opportunity for an eligible professional to review and submit corrections for his or her information before it is made public. The Secretary will periodically post aggregate information about the MIPS program on the Physician Compare 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 will consult with stakeholders in carrying out the MIPS program, including in identifying performance category measures and activities, determining the methodologies for developing the composite score, and regarding the use of qualified clinical data registries. These consultations will 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 will 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. Priority will be given to professionals located in rural areas, health professional shortage areas, or practices with low composite scores. The guidance and assistance will be provided with respect to the performance categories or with respect to how to transition to the implementation of and participation in an alternative payment model (see "Alternative Payment Models," below).

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

To provide feedback to eligible professionals to improve performance, beginning July 1, 2017, the Secretary will make available timely (such as quarterly) confidential feedback to each MIPS-eligible professional on his or her performance with respect to the quality and resource use performance categories. Information on the clinical practice improvement activities and

meaningful EHR use categories may also be provided. The Secretary may use one or more mechanisms to provide this feedback, including a web-based portal or other mechanisms determined appropriate by the Secretary.

The Secretary may use data from periods prior to the current performance period with respect to MIPS-eligible professionals and may use rolling periods to make illustrative calculations about the performance of these professionals. This feedback would be exempt from disclosure under the Freedom of Information Act (P.L. 89-487).

Beginning July 1, 2018, the Secretary will 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 will 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 and other figures as determined appropriate by the Secretary.

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

- the methodology used to determine the amount of the MIPS adjustment factors, including for exceptional performance;
- the establishment of the performance standards and the performance period;
- the identification of performance category measures and activities and information made public or posted on the Physician Compare website of CMS; or
- 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 must submit four MIPS program evaluation reports to Congress. The first GAO report, due October 1, 2021, will (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, will examine the alignment of quality measures used in public and private programs by comparing the similarities and differences in the use of quality measures under the original Medicare FFS program under Parts A and B, the Medicare Advantage program, and private payer arrangements. It will also make recommendations on how to reduce the administrative burden involved in applying such quality measures.

The third GAO report, due January 1, 2017, will study the role of independent risk managers. Specifically, it will 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 will 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 help with risk management and with quality improvement activities. The report also will include an analysis of any existing legal barriers to such arrangements.

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

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

MACRA makes modifications to improve quality reporting for constructing MIPS composite scores. Beginning in 2018, the existing physician feedback program will be succeeded by reports under the MIPS program and the meaningful EHR use clinical quality measure reporting requirement will be combined with the MIPS program.

Alternative Payment Models

In addition to creating the MIPS, which modifies but is still fundamentally based on FFS payment, MACRA establishes pathways for implementing new payment models that might eventually replace traditional FFS-based payment.

The term *alternative payment model* (APM) is 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 Social Security Act (SSA);
- A demonstration required by federal law.

The term *eligible alternative payment entity* means an entity that (1) 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 (see "Merit-Based Incentive Payment System", above) and (2) either 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.[3]

A *qualifying APM participant* is defined as follows:

[3] Section 204 of the TRHCA established a Medicare medical home demonstration project "to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations."

- For 2019 and 2020, an eligible professional for whom at least 25% of his or her Medicare payments are attributable to services provided through an eligible APM,
- For 2021 and 2022, an eligible professional who meets either of the following criteria:

  (a) *Medicare payment threshold*. At least 50% of Medicare payments are furnished through an eligible APM; or

  (b) *Combination all-payer and Medicare payment threshold*. At least 25% of Medicare revenue from services provided through an eligible APM and at least 50% of revenue from all payers provided through an eligible APM.

- For 2023 and in subsequent years, an eligible professional who meets either of the following criteria:

  (a) *Medicare payment threshold*. At least 75% of Medicare payments are furnished through an eligible APM; or

  (b) Combination all-payer and Medicare payment threshold. At least 25% of Medicare revenue from services provided through an eligible APM and at least 75% of revenue from all payers provided through an eligible APM.

A *partial qualifying APM participant* is defined as an eligible professional who falls short of meeting the appropriate revenue threshold to achieve a bonus payment under the qualified APM program but achieved a lower threshold, defined as follows. The Secretary will 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 will be determined by the Secretary.

To advise and evaluate the development of APMs, the act establishes an ad hoc committee called the Physician-Focused Payment Models Technical Advisory Committee. The committee will 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 will be composed of 11 members appointed by the Comptroller General, and it will include individuals with national recognition for their expertise in physician-focused payment models and related delivery of care. No more than five committee members will be providers of services, suppliers, or their representatives. Federal employees will not be allowed to be committee members. Members will 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, will be staggered, with a full term lasting three years. Vacancies will be filled in the same manner as original appointments. Committee members will serve without compensation (travel expenses would be allowed), and the committee will meet as needed.

The HHS Assistant Secretary for Planning and Evaluation will provide technical and operational support for the committee, which may be done through a contractor. The Office of the Actuary in CMS will provide actuarial assistance as needed. To establish and operate the committee, the

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

Eligible Medicare professionals will be incentivized to participate in Medicare APMs through higher payments. Beginning in 2019 and ending in 2024, eligible professionals in a qualifying APM (see "Alternative Payment Models," below) that is providing covered services will 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 will be made in a lump sum on an annual basis, as soon as practicable. These incentive payments will not be taken into account for purposes of determining actual expenditures under an APM or for purposes of determining or rebasing any benchmarks used under an APM.

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

- 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.
- 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 (SSA §1115A(b)(2)) is amended to allow for models focusing on the following:

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

MACRA also modifies the demonstration authority to add "statewide payment models" in addition to "other public sector or private sector payers" as factors for consideration.

Section 101 of MACRA requires additional studies regarding the development and testing of APMs. By July 1, 2016, the Secretary will submit to Congress a study examining the feasibility of integrating APMs in the Medicare Advantage payment system; the study will 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 Office of Inspector General (OIG), will submit a study that (1) examines 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) identifies aspects of APMs that are vulnerable to fraudulent activity; and (3) examines the implications of waivers to such laws granted in support of APMs, including under any potential expansion of APMs. The report will include recommendations for actions to be taken to reduce the vulnerability of such APMs to fraudulent activity and, as appropriate, recommendations of the OIG for changes in federal fraud prevention laws to reduce such vulnerability.

Development of New Classification Codes

MACRA aims to improve the measurement of resource use—and 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 act will require the development of (1) care episode and patient condition groups and classification codes,[4] (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.

To classify similar patients into care episode groups and patient condition groups, MACRA requires the Secretary to develop new classification codes. No later than 180 days after enactment, the Secretary will post a list of episode groups and related descriptive information as developed pursuant to the episode grouper (under prior law).[5] For 120 days after such posting, the Secretary will 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 to classify patients into care episode groups and patient condition groups. Taking into account this information, the Secretary will (1) 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 (2) assign codes to the groups.

In establishing the care episode groups, the Secretary will take into account the patient's clinical problems at the time items and services are furnished during an episode of care. These may include the patient's clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, the principal procedures or services furnished, and other factors as appropriate.

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

The Secretary will draft a list of the care episode and patient condition codes (and the criteria and characteristics assigned to the codes) and post it to the CMS website no later than 270 days after

[4] For background information, see Centers for Medicare & Medicaid Services (CMS), "Defining an Episode Logic for the Medicare Physician Resource Use Measurement Program: Background Paper for the November 10, 2009 Listening Session," at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/downloads/Defining_an_episode.pdf.

[5] CMS, *Supplemental QRURs and Episode-Based Payment Measurement,* at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Episode-Costs-and-Medicare-Episode-Grouper.html.

the end of the comment period. For 120 days after posting the list, the Secretary will 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 will 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.

The Secretary will revise the lists through rulemaking no later than November 1 of each year. The revisions may 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 facilitate the attribution of patients and episodes to physicians or applicable practitioners, the Secretary will 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 will 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

- considers himself or herself to have the primary responsibility for the general and ongoing care of the patient over extended periods of time;
- considers himself or herself to be the lead physician or practitioner and furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;
- 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;
- furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or
- furnishes items and services only as ordered by another physician or practitioner.

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

The Secretary will revise the list through rulemaking no later than November 1 of each year. The revisions may 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 will 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). To evaluate the resources used to treat patients (with respect to care episode and patient condition groups) the Secretary will, as appropriate,

- use the patient relationship codes reported on claims to attribute patients to one or more physicians and practitioners,
- 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
- 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 will (1) use the claims data experience of patients by the patient condition codes during a common period, such as 12 months, and (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 will 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. The Secretary may 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 must seek comments regarding the resource use methodology.

Section 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) of the SSA (42 U.S.C. 1395aaa-1), 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 CMS to develop quality and efficiency measures for use under the SSA through the awarding of contracts. In addition, Section 931 of the PHSA requires 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.

Section 102 of MACRA amends Section 1848 of the SSA to add a new subsection (s), "Priorities and Funding for Quality Measure Development." The Secretary will be required, not later than January 1, 2016, to come up with a draft plan for the development of quality measures under applicable provisions, as specified. The plan must address how measures used in integrated delivery systems and by private payers could be incorporated under Title XVIII; how coordination of measure development will occur; and how clinical guidelines should be used in measure development. It must consider gaps analyses; whether measures apply across health care settings; clinical practice improvement activities; and quality domains. In addition, the plan must prioritize, among other things, outcome, patient experience, care coordination, and appropriate use measures.

The Secretary will be required to accept stakeholder comments through March 1, 2016, on the draft plan and must post on the CMS website not later than May 1, 2016, an operational plan for the development of quality measures for use as specified. This plan must be updated as appropriate.

The Secretary also shall 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 must give priority to developing measures of outcomes, patient experience of care, and care coordination, among other things. The Secretary also must consider (1) whether measures

developed would be electronically specified and (2) relevant clinical practice guidelines, to the extent they exist.

The Secretary shall, no later than May 1, 2017, and annually thereafter, post on the CMS website a report on the progress made in developing quality measures for application. The reports must include the following:

- a description of the Secretary's efforts to implement the subsection;
- information about measures developed over the previous year;
- information about measures currently in development;
- a description of any updates to the plan, including newly identified gaps, as well as the inventory of measures applicable; and
- other information as the Secretary determines appropriate.

The Secretary must 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 shall provide for the transfer of $15 million, for each of fiscal years 2015 through 2019, from the SMI Trust Fund to the CMS Program Management Account. The funds will remain available through FY2022. The Paperwork Reduction Act of 1980 (44 U.S.C. 35) will not apply to information collection for measure development activities.

Section 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 will 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 also must be residing at his or her home or in a domiciliary, rest home, or assisted living facility.

Section 103 of MACRA codifies in statute existing CMS initiatives with respect to CCM services and provides other requirements for such services. This provision requires 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 requires that payment for CCM services (1) not be made to more than one applicable provider for such services, (2) not be duplicative of payment that is otherwise made by Medicare, and (3) not require that an annual wellness visit or an initial preventive physical examination be furnished as a condition of payment.

This provision also requires 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 will be directed by the Office of Rural Health Policy within HHS and the Office of Minority Health within CMS, and it will focus on encouraging participation by underserved, rural populations and racial/ethnic minority populations. No later than December 31, 2017, the Secretary will be required to submit a report to Congress on the use of CCM services by

individuals in underserved, rural populations and in racial/ethnic minority populations. The report will identify barriers to receiving CCM services and make recommendations for increasing the appropriate use of CCM services.

Section 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 SSA §1866(j)) and other eligible professionals who participate in the Physician Quality Reporting Initiative (now the Physician Quality Reporting System, or PQRS). 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 must 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 are statistically valid and reliable. The Secretary was required to consider feedback from multi-stakeholder groups (consistent with §1890(b)(7) and §1890A of the SSA) when selecting measures for use under this section and to consider the plan to transition to a value-based purchasing program for physicians (under MIPPA[6] §131) when developing and implementing the plan under this section. The Secretary was 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 was authorized to expand the information available on the Physician Compare website to other provider types (under Title XVIII) and 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 more than 9 million Part B FFS claims with information on utilization, payment (allowed amount and Medicare payment), submitted charges, and place of service, organized for more than 800,000 physicians or other noninstitutional health care providers.

Section 104 of MACRA requires 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 must 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 must include, at a minimum,

- information on the number of services furnished under Part B;
- information on submitted charges and payments for services; and

[6] Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275).

- a unique identifier for the physician or eligible professional that is available to the public.

The information must also be made searchable by at least the following:

- specialty or type of physician or eligible professional;
- characteristics of the services furnished (e.g., volume); and
- the location of the physician or eligible professional. Beginning in 2016, this information must be integrated on the Physician Compare website.

Section 105: Expanding Availability of Medicare Data

Section 105(a), (c), and (d): 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 long have argued that the ability to access and analyze Medicare data would lead to a better understanding of the health care delivery system and an opportunity to improve patient care. Under existing law (SSA §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.

The provision in Section 105(a), (c), and (d) of MACRA expands 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 may use Medicare claims data, combined with claims data from other sources, to evaluate the performance of providers of services and suppliers, to conduct additional nonpublic analyses (as determined appropriate by the Secretary), and to provide or sell such analyses to authorized users for nonpublic use.

Any analyses provided or sold to an employer may be used only by the employer for purposes of providing health insurance to its employees and retirees. A qualified entity may 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 may provide or sell the combined data to a provider of services, a supplier, or a medical society or hospital association for nonpublic 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 in this way may 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 is prohibited from using an analysis or data provided or sold as described above for marketing purposes.

A data-use agreement is 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 must 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 is not a covered entity under the Health Insurance Portability and Accountability Act (HIPAA; P.L. 109-141) rules, the agreement shall

identify the relevant regulations, as determined by the Secretary, with which the user shall comply if it is to act in the capacity of a covered entity.

An authorized user that is provided or sold an analysis or data shall not 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 shall offer the provider or supplier an opportunity to appeal and correct errors.

In the case of a breach of a data-use agreement, the Secretary shall 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 provision would apply in the case of both an agreement between the Secretary and a qualified entity and an agreement between a qualified entity and an authorized user. Any amounts thereby collected shall be deposited in the SMI Trust Fund.

Any qualified entity that provides or sells an analysis or data as described above shall submit an annual report to the Secretary that includes the following:

- 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;
- a description of the topics and purposes of such analyses;
- 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
- other information determined appropriate by the Secretary.

Beginning July 1, 2016, the provision will also extend the availability of standard data extracts beyond the Medicare program to include Medicaid and CHIP, as the Secretary deems appropriate. In addition, any fees collected as a result of making this data available will be deposited into the CMS Program Management Account beginning July 1, 2016, instead of the SMI Trust Fund.

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

Section 601(b) of the American Taxpayer Relief Act of 2012 (ATRA; P.L. 112-240) (SSA §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 a PQRS for 2014 and subsequent years. CMS established the PQRS to reward eligible professionals for reporting specified quality data to the agency. ATRA 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. 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.[7]

Section 105(b) of MACRA requires 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 will 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 further requires 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 requires that the data be provided at a fee equal to the cost of providing such data.

Section 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 a nonparticipating 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 they 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, since 1998, physicians and certain practitioners have been able to enter into private contracts (under SSA §1861(r)) 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 dieticians and nutrition professionals. Physical and occupational therapists in independent practice and chiropractors are not allowed to opt out. However, if and when a physician or practitioner decides to enter a private contract with a Medicare patient, that physician or 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 or 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 shall 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 non-covered services.

[7] U.S. Government Accountability Office (GAO), *Clinical Data Registries: HHS Could Improve Medicare Quality and Efficiency through Key Requirements and Oversight*, GAO-14-75, December 2013, at http://www.gao.gov/assets/660/659701.pdf.

Section 106(a) of MACRA permits 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 is effective for affidavits signed on or after 60 days of enactment. The Secretary of HHS is required to make certain information on providers and practitioners in private contracts publicly available. No later than February 1, 2016, the Secretary must make information on the number and characteristics of opt-out physicians and practitioners available through a public HHS website and update the information annually. At a minimum, the website must include information about the opt-out physicians' and practitioners' (1) number, (2) professional specialty or other designation, (3) geographic distribution, (4) 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 (5) proportion (of opt-out physicians and practitioners) who billed for emergency or urgent care services.

Section 106(b): Promoting Interoperability of Electronic Health Record Systems

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 (P.L. 111-5) amended Medicare (i.e., SSA §§1814(l)(3), 1848(o), 1853(l) and (m), and 1886(n)) and Medicaid (i.e., SSA §1903(a)(3)(F) and (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 also to be able to use the information based on common standards. Although 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.

Section 106(b) of MACRA declares it a national objective to achieve widespread interoperability of certified EHR technology by December 31, 2018. The Secretary is required, in consultation with stakeholders, to establish interoperability metrics to measure progress toward achieving that objective by July 1, 2016. If the objective is not met by December 31, 2018, then the Secretary will 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 provision amends the Medicare EHR incentive program 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 have not knowingly and willfully taken any action to limit or restrict the interoperability of their certified EHR technology.

The Secretary shall, within one year of enactment, 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(c): 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.

Section 106(c) of MACRA requires GAO, within two years of enactment, to submit two reports to Congress, each with recommendations for legislative and administrative actions. GAO is permitted to combine both reports into a single document. The first report, focused on the Medicare telehealth program, will 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; (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, will 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 MPFS in order to reflect accurately the resources involved in furnishing such services.

Section 106(d): Rule of Construction Regarding Health Care Providers

Section 106(d) of MACRA provides 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 will 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

Section 201: Extension of Work Geographic Practice Cost Indices Floor

The Medicare physician fee schedule (MPFS) 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 calculating the payment rate under the MPFS. A series of bills set a temporary floor value of 1.00 on the physician work index beginning in January 2004 and continuing through March 31, 2015.

Section 201 of MACRA extends the 1.00 floor for the physician work geographic index through December 31, 2017.

Section 202: Extension of Therapy Cap Exceptions Process

Medicare beneficiaries face two annual payment limits for all Medicare-covered outpatient therapy services. Established by BBA97,[8] these limits initially applied to therapy services provided by nonhospital providers, to be applied separately for (1) physical therapy services and speech-language pathology services and (2) occupational therapy services. Initially set at $1,500 to apply beginning in 1999, these limits were suspended from 2000 to 2005. The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) 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; P.L. 112-96) 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 services received both in physicians' offices *and* in hospital outpatient departments for the first time. ATRA extended the application of the cap and threshold to therapy services furnished in a hospital outpatient department and in a critical access hospital. ATRA also 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. The Pathway for SGR Reform Act of 2013 (PSRA; P.L. 113-67) and PAMA[9] extended the therapy cap exceptions process through March 31, 2015.

Section 202 of MACRA extends the exceptions process through December 31, 2017, and requires the Secretary to implement a new medical review process for outpatient therapy services. In determining which therapy services to review, the Secretary shall identify services furnished by a therapy provider who (1) has had a high claims-denial percentage or is less compliant with applicable Medicare program requirements; (2) has a pattern of billing for therapy services that is

[8] The Balanced Budget Act of 1997 (P.L. 105-33).

[9] The Protecting Access to Medicare Act (PAMA; P.L. 113-93).

aberrant compared to peers or otherwise has questionable billing practices, such as billing medically unlikely units of services in a day; (3) is newly enrolled or has not previously furnished therapy services under the Medicare program; (4) provides services to treat a type of medical condition; or (5) is part of a group that includes another therapy provider identified by the preceding factors.

To implement this new medical review process, CMS will receive $5 million from the Federal Supplementary Medical Insurance (Medicare Part B) Trust Fund for FY2015 and FY2016, to remain available until expended. These funds shall not be used by a Medicare recovery audit contractor (RAC) for medical reviews of therapy services.

Section 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. 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.

Section 203 of MACRA extends the super rural, rural, and urban add-ons to Medicare's ambulance fee schedule until January 1, 2018.

Section 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.

The ACA temporarily relaxed the requirements for hospitals to receive increased low-volume payments, 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 reverted to the original, more stringent standards (no more than 800 total discharges, more than 25 road miles, a flat 25% increase) starting for discharges on April 1, 2015.

Section 204 of MACRA extends the more generous low-volume adjustment standards until October 1, 2017.

Section 205: Extension of the Medicare-Dependent Hospital Program

Medicare-dependent hospitals (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 their acute inpatient days or discharges are 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 expired on April 1, 2015.

Section 205 of MACRA extends the MDH program until October 1, 2017, and makes other technical conforming changes.

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

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173) 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 those who are (1) institutionalized, (2) dually eligible, or (3) living with severe or disabling chronic conditions.[10] Among other changes, ACA Section 3205 extended SNP authority through December 31, 2013, and temporarily extended authority through the end of 2012 for SNPs without contracts with state Medicaid programs to continue to operate, but not to expand their service areas.

ATRA extended SNP authority to operate through December 31, 2014. It 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.

Section 206 of MACRA extends SNP authority to operate for two additional years through December 31, 2018.

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

Section 183 of MIPPA[11] (SSA §1890) required the Secretary of HHS to have a contract with a consensus-based entity (e.g., the 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 -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 §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 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 and to review quality measures periodically and determine whether to maintain the use of a measure or to phase it out. In addition, Section 3014(a) of the ACA adds new duties for the consensus-based entity under the contract in Section 1890 of the SSA (multi-stakeholder

[10] Dual-eligible individuals are eligible for both Medicare and Medicaid.

[11] The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA; P.L. 110-275).

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 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-FY2014 from the Medicare Part A and B Trust Funds for these activities.

Section 109 of 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.

Section 207 of MACRA strikes the language in PAMA providing for $15 million for the first six months of FY2015 and replaces it with language that would provide for the transfer of $30 million for each of FY2015-FY2017 from the Medicare Part A and B Trust Funds to carry out the activities under Section 1890 and Section 1890A(a)-(d) of the SSA. These funds are required to remain available until expended.

Section 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.

PSRA extended MIPPA Section 119 authorities through the second quarter of FY2014 (March 31, 2014). It also appropriated funding at FY2013 funding levels prorated 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 million; 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 prorated for the first two quarters of FY2015 (i.e., PAMA appropriated half a year's worth of FY2015 funding).

Section 208 of MACRA extends MIPPA Section 119 authorities through FY2017. For FY2015, it provides 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 appropriates 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 increases funding for SHIPs by $5.5 million and for the Contract with the National Center for Benefits and Outreach Enrollment by $7 million for each of FY2016 and FY2017.

Table 1. Section 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: Congressional Research Service summary of Section 208 of the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10).

Section 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 the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA; P.L. 97-248). BBA97 included a provision to phase out the reasonable cost contracts; however, the phaseout 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 its 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 benchmarks.

Section 209 of MACRA transitions reasonable cost plans that can no longer qualify to be cost plans into MA plans. It also allows cost plans that otherwise would qualify under the statutory requirement to voluntarily transition into MA plans.

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

- The contract is to 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."
- The organization is to be prohibited from enrolling new beneficiaries during the last year, and new enrollment during the prior year is restricted. Beneficiaries will not be allowed to enroll in the cost plan during the annual election period that applies to the last year. A beneficiary whose spouse was an enrollee under the cost contract will 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 also will 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 will not be able to enroll in the cost plan for the year prior to the last year.
- The organization offering the cost plan will be required to notify the Secretary as to whether the contract is to be converted, in whole or in part, to an MA plan for the year following the last year.
- If the organization is to convert the cost plan to an MA plan, the organization will 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.
- If a cost plan enrolls a beneficiary during the last year, the organization will be required to notify the individual that it is the last year for the contract. During the last year and the year prior to the last year, the organization will be permitted to offer an MA plan in the same area and will 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 are to be deemed to enroll in the new MA plan under certain circumstances. A beneficiary who is 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 he or she elects otherwise, but only if certain provisions apply. First, the beneficiary must have been enrolled in the reasonable cost plan in the previous year and the plan must have been extended or renewed for the last year. Second, the cost plan must have provided notice to the enrollee that it was to be converted to an MA plan. Third, the applicable MA plan must have been, in fact, converted from a cost plan and 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 must not exceed a threshold established by the Secretary.

After a cost plan converts, the subsequent MA plan is 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 is required to pay providers and suppliers not less than what would be paid under original Medicare. Beneficiaries who are eligible for the deemed enrollment process and did not have drug coverage in their reasonable cost plans are to be enrolled in an MA plan without a Part D drug benefit. Beneficiaries who had drug coverage under a cost plan are to be enrolled in an MA plan with Part D coverage. The Secretary is 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.

Section 209 of MACRA creates a special election period for beneficiaries who were deemed to enroll in a newly converted MA plan or a Medicare Advantage prescription drug (MA-PD) plan. The special election period is to last from after the last day of the annual coordinated election period (December 8) until the end of February of the first plan year for which the beneficiary is enrolled in the MA plan. Eligible beneficiaries may change their plan selections 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 may exercise this option only once. A beneficiary who develops end-stage renal disease while enrolled in a cost contract that converted to an MA contract will be eligible for the deemed enrollment process as well.

The provision requires an MA organization offering a newly converted MA plan to provide enrollees with the following information:

- 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;
- the information that the Secretary is required to send to all beneficiaries prior to the beginning of the annual, coordinated election period;
- 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;
- information about special election periods; and
- 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, MACRA requires that the plan not be treated as a new MA plan. Rather, the star rating for the converted MA plan is to be determined based on available data. To the extent that data is not available, the Secretary is required to use data from a period during which the plan was still a reasonable cost plan.

Section 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. The Benefits Improvement and Protection Act of 2000 (BIPA; P.L. 106-554) 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 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. The ACA reestablished the rural add-on at a 3% increase beginning April 1, 2010, through December 31, 2015.

Section 210 of MACRA extends 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

Section 211: Permanent Extension of the Qualifying Individual 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 the federal poverty level (FPL). BBA97 also amended the SSA to provide 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 QIs' Medicare premiums up to the federal allocation, but they receive 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 has been reauthorized and funded a number of times since it was established by BBA97. Section 201 of PAMA reauthorized the QI program through March 31, 2015, and appropriated $1.035 billion in funding.

Section 211 of MACRA permanently extends the QI program and appropriates $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 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 that otherwise would 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 Section 1931 of the SSA under two scenarios. First, states are permanently required to provide four months of TMA coverage to families who lose Medicaid eligibility under Section 1931 due to increased child *or* spousal support collections. At state option, families eligible for this four-month extension must have been receiving Medicaid under Section 1931 in at least three of the preceding six months.[12] The four-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[13] by January 1,

[12] 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 Transitional Medical Assistance (TMA).

[13] The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) created Section 36(B) of the Internal Revenue Code (IRC) to define household income, based on modified adjusted gross income (MAGI). Under the ACA, states are required to transition to a new income-counting rule based on MAGI to establish uniform standards (continued...)

2014, the extension of eligibility for individuals losing coverage under Section 1931 due to increased child support is no longer relevant, as child support is not counted as income under MAGI-based income counting methodologies.

Second, under Section 1902(e)(1) and Section 1925 of the SSA, states are required to provide TMA to families losing Section 1931 Medicaid eligibility for work-related reasons (otherwise referred to as *work-related TMA*). States originally were 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 of 1988 (FSA; P.L. 100-485) expanded state TMA requirements under Section 1925, requiring states to provide at least 6, and up to 12, months of TMA to families losing Section 1931 Medicaid eligibility due to increased hours of work or income from employment, as well as to families that 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 six-month period, a family 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.[14] Additionally, in the second six-month period, states may require families with incomes at or above 100% FPL to pay a premium for the additional coverage. ARRA[15] created an additional work-related TMA option, allowing states to provide work-related TMA for a full 12-month period rather than 2 consecutive 6-month periods.

The FSA originally authorized Section 1925 of the SSA to replace the four-month requirement in Section 1902(e)(1) through FY1998. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) extended Section 1925 thorough FY2001, and the provision continued to exist under a series of short-term extensions.

Section 212 of MACRA extends Section 1925 work-related TMA permanently, requiring states to provide at least 6, and up to 12, months of TMA coverage to families losing Section 1931 Medicaid eligibility due to increased hours of work or income from employment, as well as to families that lose eligibility due to the loss of a time-limited earned income disregard. The provision does not impact the four-month TMA coverage for individuals losing eligibility due to increased spousal support.

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

BBA97 authorized two diabetes-related programs through the PHSA[16]. The first, authorized in Section 330B of the PHSA, provides funding for the National Institutes of Health[17] to award

(...continued)

for what income to include or disregard in determining Medicaid eligibility for most nonelderly and nondisabled individuals, children under the age of 18, and adults and pregnant women under the age of 65. For more information see CRS Report R43861, *The Use of Modified Adjusted Gross Income (MAGI) in Federal Health Programs*, coordinated by (name redacted) .

[14] ARRA 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% of the federal poverty level).

[15] The American Recovery and Reinvestment Act of 2009 (P.L. 111-5).

[16] Public Health Service Act (P.L. 78-410).

[17] For more information on the National Institutes of Health, see CRS Report R41705, *The National Institutes of Health (NIH): Background and Congressional Issues*, by (name redacted) .

grants for research into the prevention and cure of Type I diabetes. The second, authorized in Section 330C of the PHSA, provides funding for the Indian Health Service (IHS)[18] 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.[19] BBA97 appropriated funding for both programs from FY1998 through FY2002; subsequent legislation extended funding years and increased amounts appropriated. Prior to MACRA, the programs' most recent extension was in PAMA, which provided $150 million for FY2015 for each program.

Section 213 of MACRA extends the annual appropriation of $150 million for each program for each of FY2016 and FY2017.

Section 214: Extension of Abstinence Education

Section 912 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA; P.L. 104-193) authorized abstinence education formula grants in Section 510 of the SSA.[20] To receive these formula grants, states must request funding when applying for Maternal and Child Health Block Grant funds authorized in Section 501 of the SSA.[21] Funds provided must be used exclusively for teaching abstinence from sexual activity outside of marriage. The program is administered by the Administration for Children and Families (ACF).

PRWORA authorized and appropriated $250 million ($50 million for each of FY1998-FY2002) for abstinence education formula grants. Subsequently, funding for this program was extended through June 30, 2009, by a series of legislation. Section 2954 of the ACA appropriated $50 million for each of FY2010-FY2014 for this program. Section 205 of PAMA extended funding for the program through FY2015. 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). Prior to MACRA, the funding designated for abstinence education grants would have expired on September 30, 2015.

Section 214 of MACRA increases and extends funding for Section 510 Abstinence Education grants to $75 million for each of fiscal years 2016 and 2017.

Section 215: Extension of Personal Responsibility Education Program

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 HHS to award grants to implement innovative youth pregnancy prevention strategies and to target services to high-risk populations. The ACA (§2953) appropriated a total of $375 million, with $75 million appropriated for each of FY2010-FY2014. The ACA required that $10 million each year be reserved for the youth pregnancy prevention

[18] For more information on the Indian Health Service (IHS), see CRS Report R43330, *The Indian Health Service (IHS): An Overview*, by (name redacted) .

[19] *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).

[20] For more information on abstinence education programs in Title V of the Social Security Act (SSA), see CRS Report RS20301, *Teenage Pregnancy Prevention: Statistics and Programs*, by (name redacted) .

[21] 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 (name redacted) .

grants. PAMA (§206) extended funding for the program through FY2015. The funds are available until expended. The program is administered by ACF. Prior to MACRA, the funding designated for PREP would have expired on September 30, 2015.

Section 215 of MACRA extends funding for PREP through FY2017 at $75 million per year.

Section 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. Section 5507 of the ACA 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. The Bipartisan Budget Act of 2013 (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, 2014, to September 30, 2014), and it provided $2.5 million for the first half of FY2015 (October 1, 2014, through March 31, 2015).

Section 216 of MACRA strikes the partial funding provided in PAMA and provides full-year funding of $5 million for FY2015. It also provides $5 million for each of FY2016 and FY2017.

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

Section 5507(a) of the ACA required the Secretary to establish a demonstration project in Section 2008 of the SSA 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 also were used to provide financial aid and other supportive services. This program is administered jointly by the HRSA and the ACF. The ACA appropriated $85 million for HPOG in each of FY2010-FY2014 ($425 million total), but it reserved a total of $15 million for a demonstration project for personal and home care aides. PAMA provided $85 million for HPOG for FY2015.

Section 217 of MACRA extends the HPOG appropriation of $85 million for each of FY2016 and FY2017.

Section 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 Section 511 of the SSA.[22] 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

[22] For more information, see CRS Report R43930, *Maternal and Infant Early Childhood Home Visiting (MIECHV) Program: Background and Funding*, by (name redacted) .

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 visitation services to Indian families. This program is administered by the HRSA and the ACF, 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 partial-year funding for Indian tribal entities (3% of the appropriation) and research and evaluation (3% of the appropriation).

Section 218 of MACRA extends the $400 million made available under PAMA through all of FY2015 (October 1, 2014, through September 30, 2015). It also provides $400 million for each of FY2016 and FY2017.

Section 219: Tennessee Disproportionate Share Hospital Allotment for FY2015-FY2025

The Medicaid statute requires states to make disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income patients.[23] Although 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. Most 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 prior law, Tennessee was the only state without a Medicaid DSH allotment for FY2014 and subsequent years.

Section 219 of MACRA provides a Medicaid DSH allotment to Tennessee in the amount of $53.1 million for each fiscal year from FY2015 through FY2025.

Section 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 must 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 (e.g., 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

[23] For more information about Medicaid disproportionate share hospital payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*, by (name redacted).

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 nonmedical costs.[24]

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. PAMA Section 211 delayed the effective date of the beneficiary liability settlement amendment from October 1, 2014, until October 1, 2016.

Section 220 of MACRA extends the effective date of the beneficiary liability settlements from October 1, 2016, until October 1, 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), which provided mandatory funding for federal health centers authorized in Section 330 of the PHSA.[25] 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, Section 10503 of the ACA (as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, §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.[26] Specifically, the CHCF provided $1.5 billion for the NHSC from FY2011through 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.

Section 5508 of the ACA created Section 340H of the PHSA, which required the Secretary 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. The section also appropriated $230 million in direct and indirect GME payments for the period of FY2011-FY2015.

Section 221 of MACRA extends 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. It also provides $60 million for each of FY2016 and FY2017 to support direct and indirect GME payments to teaching health centers. In addition, this section applies an existing restriction on the use of funds for abortions (included in the Consolidated and Further Continuing Appropriations Act, 2015 [P.L. 113-235], which provided appropriations for

[24] Arkansas Dept. of Health and Human Services v. Ahlborn and Wos v. E.M.A.

[25] For more information on health centers, see CRS Report R43937, *Federal Health Centers: An Overview*, by (name redacted) .

[26] 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 (name redacted) .

FY2015) to funds appropriated by this act to health centers, the NHSC, and qualified teaching health centers for FY2016 and FY2017. [27]

Title III—CHIP

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

Section 301(a): Funding

Prior to passage of MACRA, CHIP was funded through FY2015 with appropriated amounts specified in statute.[28] Since CHIP was first established in 1997, it has been funded through subsequent legislation. 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 and the ACA provided federal CHIP funding for FY2014 and FY2015.

For FY2014 and FY2015, the annual appropriation amounts were $19.1 billion and $21.1 billion, respectively. Prior to MACRA, the FY2015 appropriation was the combination of semiannual appropriations of $2.85 billion from Section 2104(a) of the SSA plus a one-time appropriation of $15.36 billion from Section 108 of CHIPRA, which was to be provided for the first six months of the fiscal year and remain available until expended.

Section 301(a) of MACRA extends 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 is structured as it was for FY2015, with semiannual appropriations of $2.85 billion plus a one-time appropriation (see "Section 301(b)(3): One-Time Appropriation for FY2017") in the amount of $14.70 billion.

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[27] Specifically, § §506 and 507 of P.L. 113-235 state that

> (a) 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 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. §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.

[28] For more information about CHIP financing, see CRS Report R43949, *Federal Financing for the State Children's Health Insurance Program (CHIP)*, by (name redacted).

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. Allotments are the federal funds allocated to each state for the federal share of its 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 (see "Section 301(d): Child Enrollment Contingency Fund") from the previous year, adjusted for growth in per capita National Health Expenditures and child population 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 based on 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). This figure is adjusted using the same growth factor as the even-year formula (i.e., growth in per capita National Health Expenditures and child population in the state). Because the odd-year formula is based on states' actual use of CHIP funds, it is called the *rebasing year*, and a state's CHIP allotment can either increase or decrease depending on that state's CHIP expenditures in the previous year.

Under prior law, FY2015 was the last year CHIP allotments were authorized. Section 301(b)(1) and (2) of MACRA authorizes 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 HHS using a set formula, and it varies by state. By statute, the E-FMAP (or federal matching rate) can range from 65% to 85%. In FY2015, the E-FMAP ranged 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 provision increases the statutory range of the E-FMAP rate to 88% through 100%. With this 23 percentage point increase, the federal share of CHIP is significantly higher, which means states are expected to spend through their allotments faster when the 23 percentage point E-FMAP increase is in effect.

Section 301(b)(1)(B)(ii) of MACRA includes a special rule for the FY2016 allotments to account for the 23 percentage point increase in the E-FMAP that began in FY2016. Under this provision, the FY2016 allotments are each state's FY2015 *allotment* (including Child Enrollment Contingency Fund payments and redistribution funds), but the allotments are determined as if the 23 percentage point increase in the E-FMAP were in place for FY2015. Then, that amount is adjusted using the same growth factor as the even- and odd-year formulas (i.e., growth in per capita National Health Expenditures and child population in the state).

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

State CHIP allotment funds are provided annually, and the funds are available to states for two years. After two years, any unused state CHIP allotment funds are redistributed to states with funding shortfalls. Although FY2017 is the last year for which federal CHIP funding is provided under MACRA, 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 MACRA includes a provision that reduces 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

Prior to MACRA, when FY2015 was the last year federal CHIP funding was available, CHIP allotments for the first half of FY2015 were available from the appropriation amount provided in Section 2104(a)(18)(A) of the SSA in addition to the FY2015 one-time appropriation provided for in Section 108 of CHIPRA (see "Section 301(b)(3): One-Time Appropriation for FY2017"). 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 the SSA.

In FY2015, the full-year amount for state allotments was 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 MACRA makes the allotment formula for FY2017 the same as the formula was for FY2015 prior to MACRA. For FY2017, funding for the first half of the year is available from Section 2104(a)(20)(A) of the SSA and from the FY2017 one-time appropriation provided for in Section 301(b)(3) of MACRA. Funding for the second half of the year is provided in Section 2104(a)(20)(B) of the SSA.

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

Prior to MACRA, when FY2015 was the last year federal CHIP funding was available, a one-time appropriation in the amount of $15.4 billion was provided for allotments for the first six months of FY2015 in addition to the semiannual appropriations provided in Section 2104(a)(18)(A) of the SSA. The funds from the one-time appropriation were to remain available until expended.

Section 108 of CHIPRA provided a one-time appropriation for FY2013 (which was the last year of federal CHIP funding provided in 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 the ACA) by amending Section 108 of CHIPRA.

Section 301(b)(3) of MACRA provides a one-time appropriation in the amount of $14.7 billion for FY2017. This funding will accompany the allotments for the first half of FY2017, and the funding will remain available until expended. In addition, rather than amend Section 108 of CHIPRA (as was done in the ACA for the FY2015 one-time appropriation), MACRA 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 provision is referred to as the *qualifying state* option, and FY2015 is the last year in which the qualifying state option was authorized under prior law.

Section 301(c) of MACRA extends 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. It 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 to be 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. This payment will be 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 MACRA extends the funding mechanism for the Child Enrollment Contingency Fund and payments from the fund through FY2017.

Section 302: Extension of "Express Lane" Eligibility

CHIPRA created a state plan option for "Express Lane" eligibility through September 30, 2013. Under this option, states are permitted to rely on a finding from specified "Express Lane" agencies (e.g., those that administer programs such as TANF, Medicaid, CHIP, and the Supplemental Nutrition Assistance Program) for

- determinations of whether a child has met one or more of the eligibility requirements necessary to determine his or her initial eligibility for Medicaid or CHIP,
- eligibility redeterminations, or
- renewal of eligibility coverage under Medicaid or CHIP.

This provision was extended through subsequent legislation. Under prior law, authority for Express Lane eligibility determinations would have expired after September 30, 2015.

Section 302 of MACRA extends authority for Express Lane eligibility determinations through September 30, 2017.

Section 303: Extension of Outreach and Enrollment Program

CHIPRA authorized $100 million in outreach and enrollment grants for FY2009-FY2013 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. Of the total allocation, 10% is directed to a national 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 also are targeted to proposals that address cultural and linguistic barriers to enrollment. The ACA appropriated $140 million for FY2009-FY2015 for outreach and enrollment grants. Under prior law, authority for outreach and enrollment grants would have expired after September 30, 2015.

Section 303 of MACRA authorizes $40 million for fiscal years 2016 and 2017 for outreach and enrollment grants.

Section 304: Extension of Certain Programs and Demonstration Projects

Section 304(a): Childhood Obesity Demonstration Project

Section 401(a) of CHIPRA required the Secretary of HHS to conduct a Childhood Obesity Demonstration Project by awarding grants to eligible entities (e.g., community-based organizations, federally qualified health centers, universities, and colleges) to carry out individual programs. CHIPRA authorized the appropriation of $25 million for the period FY2009 through FY2013 for this demonstration, and Section 4306 of the ACA 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 multilevel (e.g., child, family, community, policy), multisectoral (e.g., child care, school, community, health care) 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 after-hours physical activity programs; and training health professionals on how to identify and treat obese and overweight individuals.

Funding priority is granted to certain eligible entities. These entities include those that can demonstrate having previously received funds to carry out activities that promote individual and community health; those that carry out programs or activities consistent with goals set by Healthy People 2010;[29] or those located in medically underserved communities or areas in which the average poverty rate is at least 150% of the average poverty rate in the state involved.

Under prior law, funding for the Childhood Obesity Demonstration Project expired in FY2014, and funding was not appropriated for FY2015. In 2011, the Centers for Disease Control and Prevention awarded ACA funds to grantees for the period of FY2011 through FY2015.

Section 304(a) of MACRA extends funding for the Childhood Obesity Demonstration Project through FY2017, appropriating $10 million for the period of FY2016 through FY2017.

[29] Healthy People 2010 is a national health promotion and disease prevention initiative launched by the Centers for Disease Control and Prevention in 2000. Healthy People 2010 consisted of various objectives with targets to be achieved by the year 2010, including reducing obesity.

Section 304(b): Extension of Certain Programs and Demonstration Projects—Pediatric Quality Measures Program

Under current law, the Secretary was required to identify and publish an initial core set of pediatric quality measures by no later than January 1, 2010. The Secretary, not later than January 1, 2011, and every three years thereafter, also is required to submit a report to Congress on pediatric quality measures, including, the quality of children's health care under Medicaid and CHIP. Section 401(b) of CHIPRA required that a Pediatric Quality Measures Program (PQMP) be established by January 1, 2011;[30] this program is required to identify pediatric measure gaps and development priorities, award grants and contracts to develop measures, and revise and strengthen the core measure set, among other things. States are required to submit reports to the Secretary annually to include information about state-specific child health quality measures applied by the state, among other things. The Secretary was required to collect, analyze, and make publicly available the information reported by states by not later than September 30, 2010, and annually thereafter. The Secretary also was required, between FY2009 and FY2013, to award no more than 10 grants to states for demonstration projects to evaluate ideas to improve the quality of children's health care. In addition, the Secretary, not later than January 1, 2010, was required to establish a program to encourage the development and dissemination of a model electronic health record (EHR) for children. The Institute of Medicine (IOM) was required to develop a report on the measurement of child health status and quality by no later than July 1, 2010.

Funding for these activities was appropriated in the amount of $45 million for each of FY2009-FY2013. Section 210 of PAMA[31] extended funding for only the PQMP for FY2014 by requiring that $15 million of the $60 million appropriated for adult health quality measures under Section 1139B(e) of the SSA for FY2014 be used to carry out Section 1139A(b). The appropriation in Section 1139A(i) for funding to carry out Section 1139A (except for 1139A(e), the Childhood Obesity Demonstration Project) expired in FY2013; the funding designated to carry out Section 1139A(b) expired in FY2014.

Section 304(b) of MACRA appropriates $20 million for the period FY2016-FY2017 for the purposes of carrying out Section 1139A. This funding is specifically excluded from being used to carry out the activities under Section 1139A(e), the Childhood Obesity Demonstration Project; Section 1139A(f), the development of a model electronic health record for children; and Section 1139A(g), the IOM study of pediatric health quality.

Section 305: Report of Inspector General of HHS on Use of Express Lane Option Under Medicaid and CHIP

Section 305 of MACRA requires the Inspector General of the Department of HHS 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 must (1) include data on the number of individuals enrolled in Medicaid and CHIP through the Express Lane Eligibility state plan option, (2) assess the extent to which individuals enrolled through the Express Lane Eligibility option meet the eligibility requirements for Medicaid or CHIP, and (3) provide data on Medicaid and CHIP federal and state expenditures under Express Lane Eligibility that is

[30] SSA §1139A(b).

[31] The Protecting Access to Medicare Act (PAMA; P.L. 113-93).

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

Section 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, Section 401 of MACRA will prohibit the sale of Medigap policies that cover Part B deductibles to newly eligible Medicare beneficiaries. This category includes individuals who become eligible for Medicare due to age, disability, or end-stage renal disease on or after January 1, 2020. The prohibition also applies in waiver states. Entities that sell such policies after that time will be subject to fines, imprisonment of not more than five years, and/or civil money penalties of not more than $25,000 for each prohibited act.[32] For newly eligible beneficiaries, references in the law to Medigap plans C and F will be deemed as references to plans D and G.

Section 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, the MMA[33] 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 high-income premiums for Medicare Part D prescription drug benefit enrollees beginning in 2011. In 2015, about 5.6% of Part B enrollees pay these higher premiums.

[32] 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)).

[33] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173) 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.

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.[34] Under Part D, base premiums are set at 25.5% of expected per capita costs for basic Part D coverage.[35] 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.[36] 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. In other words, the income categories shown in **Table 2** were to remain the same for years 2010 through 2019. This meant that over time, as income—including Social Security benefits—increased with inflation, a greater proportion of Medicare enrollees would pay the high-income premiums. Beginning in 2020, the income thresholds were to revert to the levels they would have reached had they been indexed for inflation since 2007, thereby reducing the proportion of beneficiaries who would be subject to higher premiums. Additionally, beginning in 2020, thresholds were to be adjusted annually again by changes in the CPI-U.

Table 2. Monthly Medicare Part B Premiums and Part D Premium Adjustments in 2015

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

Sources: Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), "Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2015," 79 *Federal Register* 61314, at http://www.gpo.gov/fdsys/pkg/FR-2014-10-10/pdf/2014-24248.pdf and CMS, "Annual Release of Part D National Average Bid Amount and Other Part C & D Bid Information," July 31, 2014, at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmarks2015.pdf.

[34] 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 (name redacted) .

[35] 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 (name redacted) and (name redacted) .

[36] ACA §3402.

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

Beginning in 2018, Section 402 of MACRA will 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 will be in the 65% applicable percentage group (instead of those with incomes between $160,000 and $214,000), and the income threshold for the highest group (80%) will be $160,000 (instead of $214,000).

Table 3. Income Thresholds for High-Income Premiums Starting in 2018

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 (P.L. 114-10).

Under this provision, the income thresholds will stay at the current levels (in **Table 2**) through 2017 and will be at the new designated levels for 2018 and 2019 (shown in **Table 3**). For years 2020 and thereafter, the thresholds will be adjusted annually for inflation based on the CPI-U. However, unlike prior law, the adjustments will be based on the new (2018 and 2019) threshold levels rather than on what the levels would have been without a freeze.

Subtitle B. Other Offsets

Section 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), 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, and LTCHs was implemented on October 1, 2011. The productivity adjustment for hospices was implemented on October 1, 2012, and the adjustment for HHAs was implemented on January 1, 2015. 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 beyond.

Section 411 of MACRA requires Medicare payment updates for SNFs, IRFs, LTCHs, and hospices to be 1% for FY2018 and payment updates for HHAs to be 1% for CY2018, after application of the productivity adjustment.

Section 412: Delay of Reduction to Medicaid Disproportionate Share Hospital Allotments

The Medicaid statute requires states to make disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income patients.[37] 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.

Section 412 of MACRA will 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 will be $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 will rebound to their pre-reduced levels, with the annual inflation adjustments for FY2018 through FY2025.

Section 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 (FFS) payments. MIPPA[38] 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 was increased to 100% for payments to government contractors and to 30% for payments to Medicare providers and suppliers under Title XVIII of the SSA.

Section 413 of MACRA increases the percentage of Medicare provider and supplier payments subject to continuous federal levy from 30% to 100%. This provision is applicable to payments made 180 days after enactment.

Section 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 Inpatient Prospective Payment System (IPPS)

[37] For more information about Medicaid disproportionate share hospital payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*, by (name redacted).

[38] The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA; P.L. 110-275).

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 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 CMS's planned DCI reductions in FY2008 and FY2009, but it 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.

ATRA[39] prevented CMS from fully recouping past overpayments related to DCI changes in FY2008 and FY2009. ATRA required CMS to establish additional base-rate reductions that 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 was expected to restore the cumulative 3.2% DCI reduction to the hospital base rate.

Section 414 of MACRA removes the authority to retroactively recoup DCI payment increases from FY2010. CMS was directed to increase base rates by 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 is 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

Section 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 increased the program's and beneficiaries' vulnerability to fraud. Thieves could steal the information from Medicare cards to commit identity theft, and beneficiaries are more vulnerable to data breaches—the unauthorized disclosure of a beneficiary's personally identifiable information.[40] CMS has proposed different options to remove SSNs from

[39] The American Taxpayer Relief Act of 2012 (P.L. 112-240).

[40] GAO, *Medicare: CMS Needs an Approach and a Reliable Cost Estimate for Removing Social Security Numbers from Medicare Cards*, GAO-12-831, August 2012.

beneficiary identification cards. These options have ranged in cost from $254 million to $316 million.[41]

Section 501 of MACRA requires 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 will be transferred from the Medicare Trust Funds to the following accounts:

- 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).
- 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).
- Railroad Retirement Board Limitation on Administration Account—$3 million in FY2015 (available until expended).

The Secretary must set an effective date for removal of SSNs that is no later than four years after the date of enactment of MACRA.

Section 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.[42] 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 incarcerated and state or local governments enforce the requirement. Although a claim processing mechanism 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.[43] In addition, CMS's systems are not always capable of identifying claims for incarcerated beneficiaries after they were paid so that overpayments could be recovered.

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 the HHS Office of Inspector General (OIG) found that some Part D claims were paid for unlawfully present individuals.[44] OIG noted that CMS and Part D plans did not have internal controls to

[41] CMS, *SSN Removal from Medicare Card: Cost Analysis Summary*, May 10, 2013, at http://waysandmeans.house.gov/uploadedfiles/ssn_removal_revised_report_final_5-10-2013.pdf.

[42] In 42 C.F.R. §411.4(b) individuals who are in custody 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."

[43] U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), *Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries Who Received Services During 2009 Through 2011*, A-07-12-01113, January 2013.

[44] HHS, 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.

identify and disenroll unlawful aliens and to automatically reject Part D claims for those individuals.

Medicare Part D sponsors submit claims information to CMS for each drug they dispense. CMS has processes in place that prevent Part D sponsors from paying claims that have dates of service more than 32 days after a beneficiary's death. The OIG found that CMS's policies allow Part D sponsors to pay for HIV drugs for deceased Medicare beneficiaries.[45]

Section 502 of MACRA amends the SSA to require the Secretary to establish policies and claims edits that will prevent improper Medicare payments for incarcerated individuals, unlawfully present aliens, and deceased individuals. This provision also requires 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 is 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.

Section 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. A beneficiary's SSN is referred to as the health insurance claim number and is used for identification, for processing Medicare FFS claims, and for other administrative activities.[46] Including individuals' SSNs on identification cards used to be a common practice, but in response to federal and state laws restricting the use of SSNs as identifiers, most organizations have abandoned that approach. CMS has proposed different options to remove SSNs from beneficiary identification cards. These options have ranged in cost from $254 million to $316 million.[47] 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 these options have been determined to be too costly, technically infeasible, or burdensome to providers and beneficiaries.[48]

Section 503 of MACRA enables the Secretary to assess whether it is cost-effective and technologically viable to use electronic Medicare cards. Electronic cards might include smart-card technology, such as an embedded and secure integrated circuit chip.[49] If the Secretary considers the feasibility of using smart-card technology, then the Secretary is required to submit a report outlining the Secretary's consideration of this matter to the House Committees on Ways and Means and Energy and Commerce and to the Senate Committee on Finance.

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[45] HHS, OIG, *Medicare Paid for HIV Drugs for Deceased Beneficiaries*, OEI-02-11-00172, October 2014.

[46] Under Medicare Parts C and D, private health plans provide services to beneficiaries. Most health plans issue their own identification cards to beneficiaries that do not contain Social Security numbers (SSNs). Health insurance claim numbers are 10- or 11-digits, and they include the 9-digit SSN and a beneficiary identifier assigned to the beneficiary and other dependents.

[47] CMS, *SSN Removal from Medicare Card: Cost Analysis Summary*, May 10, 2013, at http://waysandmeans.house.gov/uploadedfiles/ssn_removal_revised_report_final_5-10-2013.pdf.

[48] GAO, *Medicare Information Technology: Centers for Medicare and Medicaid Services Needs to Pursue a Solution for Removing Social Security Numbers from Cards*, GAO-13-761, September 2013.

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

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

Medicare covers certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) under Part B if the DMEPOS are medically reasonable and necessary and are 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 prior to delivery (WOPD) of the item. 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.

Section 504 of MACRA authorizes a physician, physician assistant, nurse practitioner, or clinical nurse specialist to document the face-to-face encounters that they themselves conduct. This provision makes the requirement similar to the face-to-face requirement for power wheelchairs. MACRA allows the Secretary to implement this section through program instructions or otherwise.

Section 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 approximately 1.5 million health care providers and suppliers. Each MAC is required to educate providers and their staffs within its geographic service area 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 data, and Recovery Audit Program data.

In addition to MACs, CMS 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 an 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 Parts A and B RACs returned more than $3.0 billion to the Medicare Trust Funds for FY2013.[50]

[50] CMS, *Recovery Auditing in Medicare and Medicaid for Fiscal Year 2013*, at http://www.cms.gov/Research-(continued...)

To identify improper payments, RACs use three types of review: automated, semiautomated, and complex. Automated reviews rely solely on computer system "edits" that review the claim's coded information. Semiautomated 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 that they 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. They also indirectly provide insight to CMS and other Medicare contractors on topics for provider education and outreach and for 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, because 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 it can take even longer if providers are unsuccessful and pursue their cases in District Court.

Section 505 of MACRA amends the SSA by adding a new requirement for MACs to implement an improper payment outreach and education program. Each MAC must have such a program to provide outreach, education, training, and technical assistance activities to providers and suppliers in its geographic service area. MACs must provide these services on a regular basis. The information provided by MACs under the improper payment outreach and education program shall 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.

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

- for items or services that have the highest rate of improper payment;

(...continued)

Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2013-Report-To-Congress.pdf.

- for items and services that have the greatest total dollar amount of improper payments;
- due to clear misapplication or misinterpretation of Medicare policies;
- clearly due to common and inadvertent clerical or administrative errors; or
- 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 shall supply to each MAC a complete list of the types of improper payments identified by RACs for the providers and suppliers in the MAC's 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 shall supply to each MAC should 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 are required to ensure that all provider and supplier communications related to the improper payment outreach and education programs comply with communication requirements identified in Section 1874A(g) of the SSA, Communications with Beneficiaries, Providers, and Suppliers.

Section 1893(h) of the SSA also is amended to authorize the Secretary to retain a portion of annual RAC overpayment recoveries. These overpayment recoveries 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 Section 1833(z), Incentive Payments for Participation in Eligible Alternative Payment Models;
- SSA Section 1834(1)(16), Prior Authorization for Repetitive Scheduled Non-Emergent Ambulance Transports;
- SSA Section 1874A(a)(4)(G), Additional Functions;[51]
- MACRA, Section 514(b); and
- implementing strategies (such as claim processing edits) to help reduce Medicare payment error rates.

The amounts retained from RAC overpayment recoveries are limited to 15% of RAC recoveries and will remain available until expended. The Secretary is prohibited from using the funds retained from RAC overpayment recoveries for technology-related infrastructure, capital

[51] The additional functions that might be required of Medicare administrative contractors include activities to support the Medicare Integrity Program under SSA §1893.

investments, or information systems, except for uses that support 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 should not be reduced.

Section 506: Improving Senior Medicare Patrol and Fraud Reporting Rewards

Section 203(b) of HIPAA[52] established an incentive reward program to collect information on Medicare fraud and abuse. The program encourages individuals to report to the 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, he or she may be paid a portion of the amount collected.

Section 411 of the Older Americans Act (OAA; P.L. 89-73, as amended) authorized the Senior Medicare Patrol program, which 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.

Section 506 of MACRA requires the Secretary to develop a plan to revise the incentive reward program to encourage greater individual participation in the reporting of Medicare fraud and abuse. The plan will include recommendations for ways to enhance rewards for individuals reporting under the program and ways to extend the program to Medicaid. It also will 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. MACRA requires the Secretary to submit the plan to Congress no later than 180 days after enactment.

Section 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 information as 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. Several possible numbers can be used to uniquely identify prescribers, including the national provider identifier (NPI), the Drug Enforcement Administration registration number, state license numbers, and the unique provider identification number. CMS is transitioning to using the NPI to identify all participating Medicare providers.

[52] The Health Insurance Portability and Accountability Act of 1996 (P.L. 109-141).

CMS recommended that Part D plan sponsors prepare and review reports of physician drug prescribing patterns to identify potential prescriber fraud.[53] CMS, however, does not have system edits to check the prescriber identification data included in PDEs.[54] CMS does not require the prescriber identifier and other qualifying fields to be completed on certain nonstandard format Part D claims, such as claims filed by beneficiaries and paper claims. In a June 2010 report, OIG found a number of Part D claims with invalid prescriber identifiers. 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, Section 507 of MACRA requires the Secretary to ensure that PDEs include NPI to identify the prescribing provider and that the NPI is checked to determine that it is a valid number. In addition, the Secretary will establish procedures to ensure that when a Part D claim is denied because of the NPI requirements, beneficiaries are informed of the denial reason at the point of service. Moreover, OIG must 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.

Section 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 electronic MSNs (e-MSNs) online and can print their MSNs from their own computers.[55]

Section 508 of MACRA requires the Secretary, beginning January 1, 2017, to establish a process whereby beneficiaries may opt to receive MSNs electronically. If beneficiaries opt to receive their MSNs electronically, they will not also receive MSNs through the mail. This provision gives the Secretary discretion to limit the number of elections beneficiaries may exercise but not to limit the number of elections to less than one. The Secretary must ensure in the most cost-effective manner that, beginning January 1, 2017, beneficiaries receive clear notification of the option to receive e-MSN statements. These notifications may be distributed with mailed MSNs. Moreover, the Secretary must apply an option similar to e-MSN notices to other HHS areas and must provide MSNs or other notices on a more frequent basis than otherwise required.

Section 509: Renewal of Medicare Administrative Contractor Contracts

CMS administers the Medicare program through contracts with private entities, such as 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, and operating toll-free call centers, among 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 in their jurisdictions.

[53] 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.

[54] HHS, OIG, *Invalid Prescriber Identifiers on Medicare Part D Drug Claims*, OEI-03-09-00140, June 2010.

[55] For more information, see https://www.mymedicare.gov/.

The MMA[56] 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 durable medical equipment MACs between 2005 and 2010.[57] 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.[58] 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.[59]

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 them. In a retrospective study, OIG found that over a five-year contracting period, CMS awarded $4.3 billion in contracts to 16 MACs.[60] 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.[61] CMS has discretion as to whether or not to exercise the option to renew MAC contracts for the option years. In a 2013 report, OIG noted that the time period for re-competing MAC contracts might be better managed if it were longer. CMS could delay re-competing MAC contracts with successful contractors and use the time saved from the successful contract re-compete cycles to spend more time replacing underperforming MACs.[62]

Section 509 of MACRA amends the SSA to extend the time period under which MAC contracts must be offered, with the application of competitive procedures running for 10 years rather than 5 years. This change will be applicable to new MAC contracts as well as contracts in effect as of the date of MACRA's enactment. In addition, the Secretary is 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.

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

CMS initiated the Medicare-Medicaid Data Match Program, known as Medi-Medi, as a pilot in 2001.[63] Medi-Medi was intended to help CMS and states identify overpayments and fraud that

[56] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173).

[57] 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.

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

[59] CMS, *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.

[60] HHS, OIG, *Medicare Administrative Contractors' Performance*, OEI-03-11-00740, January 2014.

[61] SSA §1874A(b)(1)(B).

[62] HHS, OIG, *Medicare Administrative Contractors' Performance*, OEI-03-11-00740, January 2014.

[63] S.Rept. 114-104, July 30, 2015, p. 3, at https://www.congress.gov/114/crpt/srpt104/CRPT-114srpt104.pdf. 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 (continued...)

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 additional support from the Federal Bureau of Investigation. California was the only state in the original pilot. In 2005, CMS was allocated $19 million from Health Care Fraud and Abuse Control funds to continue the California Medi-Medi pilot and expand it to other states.[64] 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.[65] During 2007 and 2008, CMS had Medi-Medi projects in 10 states. These projects produced about 66 fraud referrals to law enforcement, and 27 cases were accepted.[66] OIG also found that state Medicaid programs received less benefit from the Medi-Medi program than Medicare.

Section 510 of MACRA requires 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 is authorized to use the limited waiver authority available in the Medi-Medi Data Match program to specify those state incentives.[67]

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

CMS established the Physician Quality Reporting System (PQRS) to reward eligible professionals for reporting specified quality data to the agency. Section 601(b) of ATRA (SSA §1848(m)(3)(E)) required the Secretary 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 Section 1890A of the SSA.

(...continued)

practices, Medicaid Alliance for Program Safeguards, May 2005.

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

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

[66] 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.

[67] Under the Medi-Medi program, the Secretary has the authority to waive only those requirements of SSA Title XVIII, Title XI, and Title XIX as are necessary to carry out the Medi-Medi program (SSA §1893(g)(2)).

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.[68]

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

Section 511 of MACRA requires 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 C.F.R. 46) for the protection of human research subjects in activities involving clinical data registries, including qualified clinical data registries.

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

Under Section 1128A of the SSA, the 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.[69] These penalties also might 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.

Section 512 of MACRA amends Section 1128A of the SSA to enable hospitals and critical access hospitals to compensate physicians for reducing medically unnecessary services provided to beneficiaries of federal health programs without being subject to civil monetary penalties. This provision is effective on the date of enactment of MACRA.

In addition, MACRA requires the Secretary, in consultation with the OIG, to study and submit a report to Congress within 12 months of the act's enactment that identifies options for amending existing SSA Titles XI and XVIII. These titles provide exceptions, safe harbors, or other narrowly targeted fraud and abuse provisions. The intent of the study and report is to identify gainsharing 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 must include the following:

- consideration of whether gainsharing provisions should apply to ownership interests, compensation arrangements, and other relationships;

[68] GAO, "Clinical Data Registries: HHS Could Improve Medicare Quality and Efficiency through Key Requirements and Oversight," December 2013, at http://www.gao.gov/assets/660/659701.pdf.

[69] 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. The definition 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.

- 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 a 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.

Section 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.[70] 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.[71] CMS sometimes has been unable to collect home health agency improper payments. BBA97[72] 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.

Section 513 of MACRA authorizes 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.

Section 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.[73] When submitting payment claims, chiropractors must indicate that their services were for acute or corrective treatment by attaching a modifier to their claims.[74] 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.

[70] For more information on Medicare home health services, see CRS Report R42998, *Medicare Home Health Benefit Primer: Benefit Basics and Issues*, by (name redacted)

[71] HHS, OIG, *Surety Bonds Remain an Unused Tool to Protect Medicare from Home Health Overpayments*, OEI-03-12-00070, September 2012.

[72] The Balanced Budget Act of 1997 (BBA97; P.L. 105-33).

[73] 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."

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

In a 2009 study, GAO found that CMS's efforts to stop payments not covered by Medicare for chiropractic maintenance therapy were unsuccessful.[75] 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 it continues to identify a high number of improper payments for chiropractic services that are maintenance treatments.

Section 514 of MACRA requires the Secretary to establish a medical review process applicable to certain chiropractic manipulation treatments to correct spinal subluxation provided to Medicare beneficiaries.[76] This medical review process is applicable to the following types of chiropractic claims submitted after December 31, 2016:

- services provided by a chiropractor who had aberrant billing patterns in comparison to peers; and
- 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 is required by this provision consists 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.

MACRA authorizes the Secretary to end the prior-authorization medical review if the Secretary determines that the chiropractor has a low denial rate under prior authorization. The Secretary may reapply prior-authorization medical review after having lifted it if doing so is determined to be appropriate. A chiropractor may request prior-authorization medical review for his or her services before he or she furnishes the 12th treatment during an episode of care.

It also authorizes the Secretary to use prepayment or post-payment review of chiropractic services that were not subject to prior-authorization medical review. The Secretary has discretion not to use prior-authorization medical review in cases where fraud may be suspected. When payment for chiropractic services is denied as a result of prepayment or post-payment review—applied to claims not subject to prior-authorization medical review—beneficiary payment liability is limited, as stipulated in Section 1879 of the SSA.

When chiropractor claims are subject to prior-authorization medical review, the Secretary is authorized to determine whether the services meet Medicare's medical necessity requirements prior to the service being furnished.[77] The Secretary is prohibited from paying chiropractor claims subject to the prior-authorization medical review unless the claims are determined to meet these medical-necessity requirements. Chiropractors subject to the prior-authorization medical review are authorized to submit information to support the services they propose to provide by fax, mail, or electronic means. The Secretary must facilitate the receipt of electronic documentation as soon as practicable. For chiropractor claims subject to the prior-authorization medical review, the Secretary is required to make a determination as to the medical necessity of services within 14

[75] HHS, OIG, *Inappropriate Medicare Payments for Chiropractic Services*, OEI-07-07-00390, May 2009, at https://oig.hhs.gov/oei/reports/oei-07-07-00390.pdf.

[76] 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. See CMS, "Medical Review and Education," June 24, 2014, at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/.

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

days of receipt of the medical documentation or the services may be provided without prior authorization.

Section 514 of MACRA authorizes the Secretary to contract with MACs or any other Medicare contractors other than RACs. In addition, it requires the Secretary to apply the prior-authorization medical review in a manner that allows chiropractors to obtain authorization to provide multiple services at a single time rather than on a service-by-service basis. The provision also stipulates that chiropractic services subject to prior-authorization medical review may 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 is exempt from the Federal Information Policy requirements under Title 44, Chapter 35, of the *United States Code*.

MACRA requires the Secretary 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 demonstrating that these services are reasonable and necessary. The Secretary must make the educational and training programs available by January 1, 2016.

The Secretary is authorized to use funds recovered by RACs and authorized for use by Section 506(b) of MACRA to implement this provision.

MACRA also requires GAO to conduct a study on the effectiveness of the prior-authorization medical review process for services furnished as manual manipulation treatments for subluxation of the spine. The GAO study must include an analysis of the aggregate data on (1) the number of individuals, chiropractors, and claims for services subject to prior-authorization medical review and (2) the number of prior-authorization medical reviews conducted. In addition, the GAO report must include an analysis of the outcome of the prior-authorization medical review conducted.

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

Section 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 three round trips or more during a 10-day period or at least once per week for at least three weeks.

Section 1115A of the SSA establishes the Center for Medicare and Medicaid Innovation 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 CMS Office of the Actuary certifies after testing has begun 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. A total of $15 billion in funding has been 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 in Section 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.

Section 515 of MACRA extends 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 Section 1115A of the SSA is allocated to carry out this expansion.

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

Section 516: Repealing Duplicative Medicare Secondary Payer 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.[78] 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 (MMSEA; P.L. 110-173), 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 and conditional payments.

Section 516 of MACRA eliminates 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 takes effect on the date of enactment and applies to information required on or after January 1, 2016.

Section 517: Plan for Expanding Data in Annual Comprehensive Error Rate Testing 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

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

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 Parts 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 as well as 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 the claims 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 a claim, the claim is counted as either a total or partial improper payment. Improper payments 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%.[79]

Section 517 of MACRA requires the Secretary to submit a report to the Senate Committee on Finance and the House Committees on Energy and Commerce and Ways and Means by June 30, 2015, that includes the following information:

- 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 CERT rates greater than 20%.

Section 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 Section 1898 of the SSA, among other changes, to 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.

Section 518 of MACRA amends Section 1898(b)(1) of the SSA to eliminate the $195 million appropriated for the Medicare Improvement Fund to be available during and after FY2020.

Section 519: Rule of Construction

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

[79] HHS, *Department of Health and Human Services Agency Financial Report*: *FY2014*, November 2014, p. 23, at http://www.hhs.gov/afr/fy2014-mda.pdf.

Subtitle B. Other Provisions

Section 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 two-midnight-rule policy until September 30, 2014. Specifically, Medicare's 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. 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 claims to 25 claims per hospital. PAMA[80] 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.

Section 521 of MACRA extends the MAC's probe-and-educate program for claims through FY2015. Post-payment RAC 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

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. The 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. Each supplier must

[80] The Protecting Access to Medicare Act (PAMA; P.L. 113-93).

- meet financial standards;
- meet quality requirements;
- 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
- adhere to other criteria to ascertain whether the supplier's bids are bona fide and whether the supplier can provide the items based on the bids submitted.

CMS arrays the composite bids of all suppliers that pass the non-price competition criteria from lowest to highest. It 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. More than 90% of suppliers that 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. For the other 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.

Section 522 of MACRA adds 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.

MACRA also requires 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 will be required to provide proof of the bid bonds to the Secretary. The bonds will be required to be between $50,000 and $100,000 for each competitive bidding area in which the supplier competes. If a supplier is 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, then the bond submitted by the supplier is required to be forfeited; the Secretary is then required to collect on the bond. In all other circumstances, the bond must 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 to report the results of the study to Congress not later than six months after the first contracts subject to this requirement are awarded.

Section 523: Payment for Global Surgical Packages

Under the Medicare physician fee schedule (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: (1) 0-day global codes include the surgical procedure and the preoperative and postoperative physicians' services on the day of the procedure, including visits related to the service; (2) 10-day global codes include these services as well as visits related to the procedure during the 10 days following

the procedure; and (3) 90-day global codes include the same services as the 0-day global codes plus the preoperative services furnished 1 day prior to the procedure and postoperative 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 preoperative and postoperative periods outside of the day of the surgical procedure.

Section 523 of MACRA prohibits the implementation of this rule regarding global surgical packages and requires 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 collected should 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 it should be reported on claims at the end of the global period or in another manner specified by the Secretary. CMS will 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 will reassess the value of the information collected every four years and may discontinue the data collection if adequate information on valuing surgical services is 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 will use the information gathered together with other available data to improve the accuracy of the valuation of surgical services under the MPFS. The Secretary may delay 5% of the 10- or 90-day global payment as an incentive for physicians to report the required information. The HHS Inspector General will audit a sample of the information reported to verify its accuracy.

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

Counties with National Forest System lands managed by the U.S. Forest Service and with certain Bureau of Land Management lands historically have received a percentage of agency revenues, primarily from timber sales.[81] 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; P.L. 106-393)[82] as a temporary, optional program of payments based in part on historic rather than current revenues.[83]

[81] 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 (name redacted)

[82] 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 (name redacted)

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

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, which was made in February 2015, was significantly lower than the previous years' SRS payments.

Section 524 of MACRA reauthorizes 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, will take into account the revenue-sharing payment that already has been disbursed to the counties.

Section 525: Exclusion from PAYGO Scorecards

MACRA 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*). Both statutory and Senate PAYGO are budget-enforcement mechanisms created 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 5-year and 10-year periods. When legislation affecting direct spending or revenue is enacted, the projected net budgetary effect of the legislation must 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 does, the President must issue a sequestration order that implements across-the-board cuts to nonexempt programs in an amount sufficient to remedy the projected deficit increase.[84] Section 525 of MACRA directs that the measure's projected budgetary effects not be recorded on OMB's scorecards and therefore not be factored into OMB's annual evaluation of the budgetary effects of enacted direct spending and revenue legislation.

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 6-year or an 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.[85] Section 525 of MACRA directs that the measure's budgetary effects not be recorded on the Senate PAYGO scorecard and therefore not affect the scorecard's balance.

[84] For more information on statutory PAYGO, see CRS Report R41157, *The Statutory Pay-As-You-Go Act of 2010: Summary and Legislative History*, by (name redacted)

[85] For more information on the Senate PAYGO rule, see CRS Report RL31943, *Budget Enforcement Procedures: The Senate Pay-As-You-Go (PAYGO) Rule*, by (name redacted)

Appendix. List of Abbreviations

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

ACF: Administration for Children and Families

ADRC: Aging and Disability Resource Center

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

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

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

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

CHIP: Children's Health Insurance Program

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

CMS: Centers for Medicare & Medicaid Services

CPI-U: Consumer price index for all urban consumers

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

HHA: Home health agency

HHS: Department of Health & Human Services

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

HPOG: Health profession opportunity grants

LTCH: Long-term care hospital

MA: Medicare Advantage

MAC: Medicare administrative contractor

MACRA: Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10)

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 and Community Self-Determination Act of 2000 (P.L. 106-393)

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

WOPD: Written order prior to delivery

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