hfma
healthcare financial management association

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

Title 1: SGR Repeal and Medicare Provider Payment Modernization

Sec 101. Repealing the Sustainable Growth Rate and improving Medicare payment for physicians' services

Overview

- Provisions of H.R. 2 would make fundamental changes to the way Medicare payments to physicians are determined, how they are updated, and how they incentivize physicians.
- The bill would:
    - Repeal the sustainable growth rate methodology for determining updates to the Medicare Physician Fee Schedule (MPFS) and establish annual fee updates in the short term and put in place a new method for determining updates afterward;
    - Establish a merit-based incentive payment system (MIPS) to consolidate and replace several existing incentive programs;
    - Incentivize the development of, and participation, in alternative payment models (APMs); and
    - Make other changes to Medicare physician payment statutes.

Payment Updates

- For the first few years after enactment, the bill would set the annual MPFS payment updates.
    - From January 2015 through June 2015, the update would be 0.0 percent.
    - From July 2015 through December 2015, the payments would be increased by 0.5 percent.
    - In each of the next four years, 2016 through 2019, the payment increase would be 0.5 percent.
    - From 2020 through 2025, the payment update would be 0.0 percent.
- Beginning in 2026, there would be two update factors:

- One for items and services furnished by a participant in a new Alternative Payment Methodology (APM).
- One for those who do not participate in an APM.
- The update factor for the APM participants would be 0.75 percent, and the update factor for those not participating in an APM would be 0.25 percent.

Merit-Based Incentive Payment System

- Provision would create a new incentive payment system while sunsetting several existing programs on the last day of 2018, including:
    - The meaningful use incentive program for certified electronic health record (EHR) technology,
    - The quality reporting incentive program (PQRI)
    - The value-based payment modifier.
- The Secretary would establish a replacement program, the MIPS, which would accomplish the following:
    - Develop a methodology for assessing the total performance of each MIPS-eligible professional according to performance standards described below.
    - Use the methodology above to provide for a composite performance score as specified below for each professional for each performance period.
    - 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 would apply to payments for items and services furnished on or after Jan. 1, 2019.
    - Only physicians, as defined under current law, as well as physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists—including groups that included such professionals—would be eligible for MIPS program incentives in the first and second years for which the MIPS program would apply.
    - Health care professionals excluded from the MIPS incentive payment program would include otherwise eligible professionals who would:
        - be qualifying APM participants;
        - be partial qualifying APM participants; or
        - not exceed the low-volume threshold measurement.
- With the sunsetting of the incentive programs mentioned above, the MIPS program would use a new set of measures and activities under four performance categories to determine whether an individual qualified for an incentive payment.
- A composite performance score would be calculated for each MIPS-eligible professional, which would be used to determine the incentive payment.
- The Secretary would use the following performance categories to determine the composite performance score:

- ***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*** - would be specified by the Secretary and include at least the following subcategories:
  - expanded practice access, such as same-day appointments for urgent needs and after-hours access to clinician advice;
  - population management, such as monitoring health conditions of individuals to provide timely health care or participation in a qualified clinical data registry;
  - 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;
  - 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;
  - patient safety and practice assessment, such as thorough use of clinical or surgical checklists and practice assessments related to maintaining certification; and
  - participation in an alternative payment model.
- ***Meaningful use of certified EHR technology*** - The requirements established under current law for determining whether an eligible professional is a meaningful EHR user.

- The Secretary would establish MIPS performance standards and the performance period with respect to the measures and activities.
- The performance standards would take into account*:*
  - Historical performance standards, improvement, and the opportunity for continued improvement.
- The Secretary would establish a performance period for each year in which incentive payments would be determined, beginning with 2019; the performance period would begin and end prior to the beginning of the year in which the incentive payments would be paid.
- The Secretary would develop a methodology for assessing the total performance of each MIPS-eligible professional according to the performance standards, the applicable measures, and activities specified above, and determine a composite assessment (*composite performance score*) for each such professional for each performance period.
- As incentive, the Secretary would treat those eligible professionals who fail to report on an applicable measure or activity that is required as achieving the lowest potential score applicable.
- In weighting the performance categories to determine the composite performance score:
  - 30 percent of the initial score would be based on performance on the quality measure.
  - Outcome measures would be encouraged, as feasible.
  - The weight for the resource use category also would be 30 percent initially.
  - The clinical practice category would receive a weight of 15 percent.
  - The meaningful use of certified EHR technology would receive a 25 percent weight.
  - These weights would change over time.
    - For example, should the percentage of meaningful EHR users exceed 75 percent, the Secretary could reduce the weight for that category, but not below 15 percent, with the other weights increased appropriately.

- The Secretary would be given flexibility in weighting performance categories, measures, and activities.
    - The Secretary may assign different scoring weights (including a weight of zero) for
        - each performance category based on the extent to which the category is applicable to the type of eligible professional involved, and
        - 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 would specify an MIPS program incentive payment adjustment factor for each MIPS-eligible professional for a year, which would be determined by the composite performance score of the eligible professional for the year. The application of the adjustment factors would result in differential payments reflecting the professional's composite performance score relative to an established performance threshold. Professionals with composite scores at the threshold would receive no adjustment; higher composite scores would receive higher adjustments, and composite performance scores below the threshold would lead to a negative adjustment.
- The MIPS adjustment factor (positive or negative) would be 4 percent in 2019, 5 percent in 2020, 7 percent in 2021, and 9 percent in 2022 and subsequent years.
- An additional MIPS adjustment could be earned for exceptional performance for years 2019 through 2024. Eligible professionals with a composite performance score at or above the additional performance threshold could receive an additional positive MIPS adjustment factor that would vary with the amount by which the score exceeds the threshold, to be specified by the Secretary.
- The performance threshold would be the mean or median (as selected by the Secretary) of the composite performance scores for all MIPS-eligible professionals; the Secretary could reassess the selection of the mean or the median every three years.
- The exceptional performance threshold would be determined in one of two ways:
    - The score equal to the 25th percentile of the range of possible composite scores higher than the performance threshold, or
    - 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.
- For the first two years to which the MIPS applies, the Secretary would establish the two thresholds based on:
    - Information from a period prior to the performance period,
    - Data available with respect to 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 a MIPS-eligible professional would be the amount otherwise paid (under the MPFS) multiplied by the MIPS adjustment factor expressed as a percentage.
- Information regarding the performance of MIPS-eligible professionals under the MIPS program will be available to the public on Centers for Medicare & Medicaid Services' (CMS) Physician Compare website.
- Beginning July 1, 2017, the Secretary would provide quarterly confidential feedback to each MIPS-eligible professional on the individual's performance with respect to the quality and resource-use performance categories.

- Beginning July 1, 2018, the Secretary would make available to each MIPS-eligible professional, information about items and services furnished to the professional's patients by other suppliers and providers. This information would include the following:
    - 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
    - Historical data, such as averages and other measures of the distribution if appropriate, of the total allowed charges as well as the components of the charges, as well as other figures as determined appropriate by the Secretary.

Alternative Payment Models

- In addition to creating the MIPS, which modifies but is still fundamentally based on fee-for-service (FFS) payment, this bill also would establish pathways for implementing new payment models that might eventually replace traditional FFS-based payment.
- The term *alternative payment model* (APM) would be defined to mean any of the following:
    - A model under the Center for Medicaid and Medicare Innovation (other than a health care innovation award);
    - A Medicare shared savings program accountable care organization;
    - A demonstration under Section 1866C of the Social Security Act (SSA);
    - A demonstration required by federal law.
- The term *eligible alternative payment entity* would mean an entity that:
    - Participates in an APM that requires participants to use certified EHR technology and provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in the MIPS program established above, and
    - Bears financial risk for monetary losses under the APM that are in excess of a nominal amount or is a medical home expanded under Section 1115(c) of the SSA.
- A *qualifying APM participant* would mean the following:
    - For 2019 and 2020, an eligible professional for whom the Secretary determines that at least 25 percent of payments for Medicare-covered professional services furnished by a professional during the most recent period for which data are available (which could be less than a year) were attributable to services furnished to Medicare beneficiaries through an entity eligible for participation in an eligible APM.
    - For 2021 and 2022, an eligible professional who meets either of the following criteria:
        a. *Medicare payment threshold* - At least 50 percent of Medicare payments for covered professional services during the most recent period for which data are available were furnished to Medicare beneficiaries through an eligible APM; or
        b. *Combination all-payer and Medicare payment threshold* - Satisfies conditions on:
            I. The amount of Medicare payments made under qualified APMs and
            II. Payments made by other payers under arrangements in which quality measures, EHR technology, and other conditions apply.
    - For 2023 and in subsequent years, an eligible professional as described above, but meeting a criteria of 75 percent for (a) and a similarly higher condition for (b).
- A partial qualifying APM participant would be defined as an eligible professional who would fail to meet the appropriate revenue threshold to achieve a bonus payment under the qualified

APM program but had achieved a lower threshold. The Secretary would select one of the following low-volume threshold measurements to determine the above exclusion for the performance period:
    - A minimum number of Medicare beneficiaries who are treated by the eligible professional;
    - A minimum number of items and services furnished by the professional; or
    - A minimum amount of allowed charges billed by the professional.
- In each case, the minimum number would be determined by the Secretary.
- To advise and evaluate the development of APMs, the bill would establish an ad hoc committee to be known as the Physician-Focused Payment Models Technical Advisory Committee.
    - The committee would provide comments and recommendations to the Secretary as to whether the APMs meet the criteria (to be established by the Secretary) for assessing physician-focused payment models.
    - The committee would be composed of 11 members appointed by the Comptroller General, and it would include individuals with national recognition for their expertise in physician-focused payment models and related delivery of care.
    - No more than five members of the committee would be providers of services or suppliers or their representatives.
    - The HHS Assistant Secretary for Planning and Evaluation would provide technical and operational support for the committee, which could be by use of a contractor.
    - To establish and operate the committee, the Secretary would transfer amounts as necessary from the Supplemental Medical Insurance Trust Fund, not to exceed $5 million for each fiscal year, beginning in 2015.
- Eligible Medicare professionals would be incentivized to participate in Medicare APMs through higher payments.
- Beginning in 2019 and ending in 2024, eligible professionals in a qualifying APM providing covered services would receive payment for the services provided that year as well as an amount equal to 5 percent of the estimated aggregate payment amounts for covered professional services for the preceding year.
    - The incentive payment would be made in a lump sum on an annual basis, as soon as practicable. These incentive payments would not be taken into account for purposes of determining actual expenditures under an APM or for purposes of determining or rebasing any benchmarks used under the APM.
- To encourage the development and testing of certain APMs, demonstration project authority regarding the testing of models (§1115A(b)(2) of the SSA) is amended to allow for models focusing:
    - Primarily on physicians' services, with particular focus on such services furnished by physicians who are not primary care practitioners,
    - On practices of 15 or fewer professionals,
    - On risk-based models for small physician practices that may involve two-sided risk and prospective patient assignment, and that examine risk-adjusted decreases in mortality rates, hospital readmissions rates, and other relevant and appropriate clinical measures, and
    - Primarily on Medicaid, working in conjunction with the CMS and CHIP Services
- The demonstration authority is also modified to add "statewide payment models," in addition to "other public sector or private sector payers" as factors for consideration.

- The provision would require additional studies regarding the development and testing of APMs.
    - By July 1, 2016, the Secretary would submit to Congress a study examining the feasibility of integrating APMs in the Medicare Advantage payment system
    - The study would include the feasibility of including a value-based modifier and whether such a modifier should be budget neutral.

Development of New Classification Codes

- 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 bill would require the development of:
    - Care episode and patient condition groups and classification codes,
    - Patient relationship categories and codes to facilitate the attribution of patients and episodes to physicians or applicable practitioners,
    - Expanded claims to gather more information for resource use measurement, and
    - A methodology for resource use analysis.
- To classify similar patients into care episode groups and patient condition groups, the Secretary would be required to develop new classification codes.
    - The Secretary would post a list of episode groups and related descriptive information as developed pursuant to the episode grouper (under current law).
- The Secretary would accept suggestions from physician specialty societies, applicable practitioner organizations, and other stakeholders for episode groups in addition to those posted, as well as specific clinical criteria and patient characteristics in order to classify patients into care episode groups and patient condition groups. Taking into account this information, the Secretary would:
    - 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
    - Assign codes to the groups.
- In establishing the care episode groups, the Secretary would take into account:
    - The patient's clinical problems at the time items and services are furnished during an episode of care, such as the patient's clinical conditions or diagnoses;
    - Whether or not inpatient hospitalization occurs; and
    - The principal procedures or services furnished, and other factors as appropriate.
- In establishing the patient condition groups, the Secretary would take into account the patient's clinical problems at the time items and services are furnished during an episode of care, such as:
    - The patient's clinical conditions or diagnoses,
    - Whether inpatient hospitalization occurs,
    - The principal procedures or services furnished, and
    - Other factors as appropriate.
- The Secretary would draft a list of the care episode and patient condition codes (and the criteria and characteristics assigned to the codes) on the CMS website no later than 270 days after the end of the comment period.
- No later than 270 days after the end of the comment period, the Secretary would post an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to the codes) on the CMS website.

- The Secretary would revise the lists through rulemaking no later than Nov. 1 of each year.
- To develop patient relationship categories and codes to facilitate the attribution of patients and episodes to physicians or applicable practitioners, the Secretary would develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time an item or service is furnished.
- These patient relationship categories would include different relationships of the physician or practitioner to the patient (and the codes could reflect combinations of such categories).
- Examples of such relationship categories might include a physician or practitioner who:
    - Considers himself or herself to have the primary responsibility for the general and ongoing care for 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.

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

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

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

- Section 10331 of the Affordable Care Act (ACA) required the Secretary to develop, by Jan. 1, 2011, a Physician Compare website with information about physicians enrolled in Medicare (under §1866(j) of the SSA) and other eligible professionals who participate in the Physician Quality Reporting Initiative (now the Physician Quality Reporting System).
- The Secretary was required, by Jan. 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).
- The Secretary is required to consider the feedback from the multi-stakeholder groups when selecting measures for use under this section, and must consider the plan to transition to a value-based purchasing program for physicians (under §131 of MIPPA) when developing and implementing the plan.

- The Secretary is required to report to Congress, not later than Jan. 1, 2015, on the Physician Compare website.
- At any time before the submission of this report, the Secretary is authorized to expand the information available on the Physician Compare website to other provider types and establish, at any time not later than Jan. 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).

Title II—Medicare and Other Health Extenders

Subtitle A. Medicare Extenders

Section 201: Extension of Work Geographic Practice Cost Indices Floor

- The MPFS is adjusted geographically to reflect differences in the cost of resources needed to produce physician services, including their work, practice expense, and medical malpractice insurance. The geographic adjustments are Geographic Practice Cost Indices that reflect how each area compares to the national average in a "market basket" of goods.
- 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.
- This provision of H.R. 2 extends the 1.00 floor for the physician work geographic index through Dec. 31, 2017.

Section 202: Extension of Therapy Cap Exceptions Process

- 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 Oct. 1, 2012.
    - However, this increased amount applied to therapy services received both in physicians' offices *and* in hospital outpatient departments for the first time.
- The American Taxpayer Relief Act of 2012 (ATRA) extended the application of the cap and threshold to therapy services furnished in a hospital outpatient department and in a critical access hospital (CAH).
    - It 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 and the Protecting Access to Medicare Act 0f 2014 extended the therapy cap exceptions process through March 31, 2015.
- This provision in H.R. 2 would extend the exceptions process through Dec. 31, 2017, and require the Secretary to implement a new medical review process for outpatient therapy services.
- In determining which therapy services to review, the Secretary could identify services furnished by a therapy provider who:
    - Has had a high claims-denial percentage or is less compliant with applicable Medicare program requirements;
    - Has a pattern of billing for therapy services that is aberrant compared to peers or otherwise has questionable billing practices, such as billing medically unlikely units of services in a day;

- Is newly enrolled or has not previously furnished therapy services under the Medicare program;
- Provides services to treat a type of medical condition; or
- Is part of a group that includes another therapy provider identified by the preceding factors

Section 205: Extension of the Medicare-Dependent Hospital [MDH] Program

- MDHs have no more than 100 beds and at least 60 percent of acute inpatient days or discharges attributable to Medicare in FY87 or in two of the three most recently audited cost reporting periods. MDHs receive special treatment, including higher payments, under Medicare's inpatient prospective payment system.
- The MDH special payment status will expire by April 1, 2015. H.R. 2 would extend the MDH program until Oct. 1, 2017 and would make other technical conforming changes.

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.
- 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 percent 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.
- Beginning in 2020, the H.R. 2 provision would prohibit the sale of Medigap policies that cover Part B deductibles to newly eligible Medicare beneficiaries. This includes individuals who become eligible for Medicare due to age, disability, or end-stage renal disease on or after Jan. 1, 2020. This prohibition would also apply in waiver states.

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

- *The Monthly Medicare Part B and Part D Premiums for 2015 are listed below:*

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

Beneficiaries Who File Individual Tax Returns with Income (for couples, double the below figures):	Applicable Percentage	2015 Monthly Part B Premiums	2015 Monthly Part D Premium Adjustment
Less Than or Equal to $85,000	25%	$104.90	$0.0
Greater Than $85,000 and Less Than or Equal to $107,000	35%	$146.90	$12.30
Greater Than $107,000 and Less Than or Equal to $160,000	50%	$209.80	$31.80
Greater Than $160,000 and Less Than or Equal to $214,000	65%	$272.70	$51.30
Greater Than $214,000	80%	$335.70	$70.80

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

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

- Beginning in 2018, this provision of H.R. 2 would lower the income thresholds for the top two income groups as shown in **Table 3** below. Individuals with incomes between $133,500 and $160,000 per year would be in the 65 percent applicable percentage group (instead of those with incomes between $160,000 and $214,000), and the income threshold for the highest group (80 percent) would be $160,000 (instead of $214,000).

Table 3. Proposed Income Thresholds for High-Income Premiums

Beneficiaries Who File Individual Tax Returns with Income:	Applicable Percentage
Less Than or Equal to $85,000	25%
More Than $85,000 but Not More Than $107,000	35%
More Than $107,000 but Not More Than $133,500	50%
More Than $133,500 but Not More Than $160,000	65%
More Than $160,000	80%

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

- Under this provision of H.R. 2, the income thresholds would stay at the current levels (in **Table 2** above) through 2017 and would be at the new designated levels for 2018 and 2019 (shown in **Table 3**). For years 2020 and thereafter, the thresholds would be adjusted annually for inflation based on the consumer price index for all urban consumers.

- However, unlike current law, the adjustments would be based on the new (2018) threshold levels rather than being based on what the levels would have been without a freeze.

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

- The ACA included a provision directing the Secretary to make aggregate reductions in Medicaid disproportionate care (DSH) allotments in specified annual amounts for FY14 through FY20.
- Since the ACA, a number of laws have amended the ACA Medicaid DSH reductions by eliminating the reductions for FY14 through FY16, changing the reduction amounts and extending the reductions through FY24.
- This provision would further amend the Medicaid DSH reductions by pushing the Medicaid DSH reductions out one year (i.e., eliminating the FY17 reductions and extending the reductions to FY25) and increasing the aggregate reduction amounts from $35.1 billion to $43 billion.
- Under this provision, the annual aggregate reductions to the Medicaid DSH allotments would equal to:
    - $2.0 billion in FY18
    - $3.0 billion in FY19
    - $4.0 billion in FY20
    - $5.0 billion in FY21
    - $6.0 billion in FY22
    - $7.0 billion in FY23
    - $8.0 billion in FY24
    - $8.0 billion in FY25
- In FY26, states' DSH allotments would rebound to their pre-reduced levels with the annual inflation adjustments for FY18 through FY25.

Section 414: Adjustments to Inpatient Hospital Payment Rates

- H.R. 2 would remove the authority to retroactively recoup documentation or coding improvements (DCI) payment increases from FY10.
- CMS would be directed to increase base rates +0.5 percentage points each year from FY18 through FY23 (for a total increase of +3.0 percentage points) instead of the anticipated increase of +3.2 percentage points in FY18.
- CMS would be prohibited from recouping the additional 0.55 percentage point reduction in base rates to account for DCI payment increases in FY10.

Title V—Miscellaneous

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.
- CMS delayed enforcement of certain aspects of the policy until Sept. 30, 2014.
- Medicare's recovery audit contractors (RACs) did not conduct patient status reviews assessing the medical necessity of short inpatient stays with dates of service between Oct. 1, 2013, and Sep.t 30, 2014.
- The Medicare administrative contractors (MACs) will monitor hospitals' compliance with the new regulations under a probe-and-educate program.
    - These reviews are intended to be instructional and are limited to a sample of 10 claims to 25 claims per hospital.
- The Protecting Access to Medicare Act of 2014 (PAMA) permits the MACs to conduct the probe-and-educate program for claims from Oct. 1, 2014, through March 31, 2015.
- PAMA would not permit post-payment RAC audits for claims with dates of admission from Oct. 1, 2013, through March 31, 2015, unless there is evidence of systematic gaming, fraud, abuse, or delays in the provision of care.
- H.R. 2 would extend the MAC's probe-and-educate program for claims through FY15. Postpayment RAC audits would not be permitted with dates of admission through Sept. 30, 2015.

More Information

Read more about *H.R.2: The Medicare Access and CHIP Reauthorization Act of 2015*.