SGR Repeal and Medicare Provider Payment Modernization Act

Section by Section

Sec. 1. Short Title; Table of Contents

Sec. 2. Repealing the Sustainable Growth Rate (SGR) and Improving Medicare Payment for Physicians' Services.

This section repeals the SGR to provide long-term stability to the Medicare physician fee schedule. It provides stable updates for five years and ensures no changes are made to the current payment system for four years. In 2019, it establishes a streamlined and improved incentive payment program that will focus the fee-for-service system on providing value and quality. The incentive payment program, referred to as the Merit-Based Incentive Payment System (MIPS), consolidates the three existing incentive programs, continuing the focus on quality, resource use, and meaningful electronic health record (EHR) use with which professionals are familiar, but in a cohesive program that avoids redundancies. Further, this section provides financial incentive(s) for professionals to participate in tests of alternative payment models (APMs).

Stabilizing Fee Updates

The flawed SGR mechanism is permanently repealed, averting a 21 percent SGR-induced cut scheduled for April 1, 2015. Professionals will receive an annual update of 0.5 percent in each of the years 2015 through 2019. The rates in 2019 will be maintained through 2025, while providing professionals with the opportunity to receive additional payment adjustments through the MIPS. In 2026 and subsequent years, professionals participating in APMs that meet certain criteria would receive annual updates of one percent, while all other professionals would receive annual updates of 0.5 percent.

The Medicare Payment Advisory Commission (MedPAC) is required to submit reports to Congress in 2019 evaluating the impact that the 2015-2019 updates have on beneficiary access and quality of care, with recommendations regarding further updates. Further, MedPAC will submit reports to Congress in 2017 and 2021 that assess the relationship between spending on services furnished by professionals under Medicare Part B and total expenditures under Medicare Parts A, B, and D. These reports recognize the critical role that professionals have in directing care and utilization by evaluating their impact on total program spending, including under the MIPS program.

Consolidating Current Law Programs into a unified MIPS

Payments to professionals will be adjusted based on performance in the unified MIPS starting in 2019. The MIPS streamlines and improves on the three distinct current law incentive programs:

- The Physician Quality Reporting System (PQRS) that incentivizes professionals to report on quality of care measures;
- The Value-Based Modifier (VBM) that adjusts payment based on quality and resource use in a budget-neutral manner; and
- Meaningful use of EHRs (EHR MU) that entails meeting certain requirements in the use of certified EHR systems.

Sunsetting Current Law Incentive Program Payment Implications

The payment implications associated with the current law incentive program penalties are sunset at the end of 2018, including the 2 percent penalty for failure to report PQRS quality measures and the 3 percent (increasing to 5 percent in 2019) penalty for failure to meet EHR MU requirements. The money from penalties that would have been assessed would now remain in the physician fee schedule, significantly increasing total payments compared to the current law baseline.

Professionals to Whom MIPS Applies

The MIPS will apply to: doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists beginning in 2019. Other professionals paid under the physician fee schedule may be included in the MIPS beginning in 2021, provided there are viable performance metrics available. Professionals who treat few Medicare patients, as well as professionals who receive a significant portion of their revenues from eligible APM(s) will be excluded from the MIPS.

MIPS Assessment Categories

The MIPS will assess the performance of eligible professionals in four categories: quality; resource use; EHR Meaningful Use; and clinical practice improvement activities.

1. Quality. Measures used for this performance category will be published annually in the final measures list developed under the methodology specified below. In addition to measures used in the existing quality performance programs (PQRS, VBM, EHR MU), the Secretary would solicit recommended measures and fund professional organizations and others to develop additional measures. Measures used by qualified clinical data registries may also be used to assess performance under this category.

2. Resource Use. The resource use category will include measures used in the current VBM program. The methodology that CMS is currently developing to identify resources associated with specific care episodes would be enhanced through public input and an additional process that directly engages professionals. The additional process allows professionals to report their specific role in treating the beneficiary (e.g., primary care or specialist) and the type of treatment (e.g., chronic condition, acute episode). This additional process addresses concerns that algorithms and patient attribution rules fail to accurately link the cost of services to a professional. Resource use measurement would also reflect additional research and recommendations on how to improve risk adjustment methodologies to ensure that professionals are not penalized for serving sicker or more costly patients.

3. Meaningful Use. Current EHR Meaningful Use requirements, demonstrated by use of a certified system, will continue to apply in order to receive credit in this category. To prevent duplicative reporting, professionals who report quality measures through certified EHR systems for the MIPS quality category are deemed to meet the meaningful use clinical quality measure component.

4. Clinical Practice Improvement Activities. Professionals will be assessed on their effort to engage in clinical practice improvement activities. Incorporation of this new component gives credit to professionals working to improve their practices and facilitates future participation in APMs. The menu of recognized activities will be established in collaboration with professionals. Activities must be applicable to all specialties and attainable for small practices and professionals in rural and underserved areas.

Annual List of Quality Measures Used in MIPS

Every year, the Secretary, through notice and comment rulemaking, will publish a list of quality measures to be used in the forthcoming MIPS performance period. Updates and modifications to the list of quality measures will also occur through this process. Eligible professionals will select which measures on the final list to report and be assessed on.

Eligible professional organizations and other relevant stakeholders will identify and submit quality measures to be considered for selection and to identify and submit updates to the measures already on the list. Measures may be submitted regardless of whether such measures were previously published in a proposed rule or endorsed by a consensus-based entity that holds a contract with the Centers for Medicare and Medicaid Services (CMS). Any measure selected for inclusion in such list that is not endorsed by a consensus-based entity must be evidence-based.

To the extent practicable, quality measures selected for inclusion on the final list will address all five of the following quality domains: clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention. Before including a new measure in the final list, the Secretary will submit the measure for publication in an applicable specialty-appropriate peer-reviewed journal, including the method for developing and selecting the measure.

Qualified clinical data registry measures, many of which are maintained by physician specialty organizations, and existing quality measures will not be subject to these additional requirements and will be automatically included in the first program year's final list of quality measures. These measures will remain in the MIPS program unless they are removed under the rulemaking process.

Composite Performance Score

Professionals will receive a composite performance score of 0-100 based on their performance in each of the four performance categories listed above. Professionals will only be assessed on the categories, measures, and activities that apply to them. Scoring weights for performance categories, measures, and activities may be adjusted as necessary, to account for a professional's ability to successfully report on such category measure or activity and to ensure that individuals are measured on an equitable basis.

To incentivize improved performance, professionals will also receive credit for improvement from one year to the next in the determination of their quality and resource use performance category score and may receive credit for improvement in clinical practice improvement activities.

MIPS Payment Adjustment

Each eligible professional's composite score will be compared to a performance threshold. The performance threshold will be the mean or median of the composite performance scores for all MIPS eligible professionals during a period prior to the performance period. Professionals will know what composite score they must achieve to obtain incentive payments and avoid penalties at the beginning of each performance period.

Payment adjustments will follow a linear distribution. Eligible professionals whose composite performance scores fall above the threshold will receive positive payment adjustments and eligible professionals whose composite performance scores fall below the threshold will receive negative payment adjustments.

- Negative adjustments – Negative payment adjustments will be capped at four percent in 2019, five percent in 2020, seven percent in 2021, and nine percent in 2022. Eligible professionals whose composite performance score falls between 0 and ¼ of the threshold will receive the maximum possible negative payment adjustment for the year. Professionals with composite performance scores closer to the threshold will receive proportionally smaller negative payment adjustments. These negative payment adjustments for eligible professionals whose composite performance scores fall below the threshold will fund positive payment adjustments to professionals with composite performance scores above the threshold.

- Zero adjustments – Eligible professionals whose composite performance score is at the threshold will not receive a MIPS payment adjustment.

- Positive adjustments – Eligible professionals whose composite performance scores are above the threshold will receive positive payment adjustments. Eligible professionals with higher performance scores will receive proportionally larger incentive payments up to a maximum of three times the annual cap for negative payment adjustments.

    - Additional Incentive Payment – An additional performance threshold for exceptional performance will be set at the 25th percentile of the range between the initial performance threshold and 100 (*e.g.*, if the performance threshold is a score of 60, the additional performance threshold would be a score of 70) or the 25th percentile of actual composite performance scores for MIPS eligible professionals with composite scores at or above the initial performance threshold (*i.e.*, 75 percent of professionals who receive a positive payment adjustment would receive an additional payment adjustment). Eligible professionals with composite scores above the additional performance threshold will receive an additional incentive payment. Aggregate additional incentive payments will be capped at $500 million per year for each of 2019 through 2024. Additional incentive payments will be allocated according to a linear distribution, with better performers receiving larger incentive payments. These payments will enable some professionals to receive incentive payments even if all professionals score above the initial threshold.

A professional's payment adjustment in one year will have no impact on their payment adjustment in a future year.

The Government Accountability Office (GAO) is required to evaluate the MIPS and issue a report in and 2021, including an assessment of the professional types, practice sizes, practice geography, and patient mix that are receiving MIPS payment increases and reductions.

Expanded Participation Options and Tools to Enable Success

Professionals will have the flexibility to participate in MIPS in a way that best fits their practice environment. These options include: use of EHRs, use of qualified clinical data registries maintained by physician specialty organizations, and the option to be assessed as a group, as a "virtual" group, or with an affiliated hospital or facility.

Technical assistance will be available to help practices with 15 or fewer professionals improve MIPS performance or transition to APMs. Priority will be given to practices with low MIPS scores and those in rural and underserved areas. Funding will be $20 million annually from 2016 to 2020.

Professionals will receive confidential feedback on performance in the quality and resource use categories at least quarterly, likely through a web-based portal. Professionals may also receive confidential feedback on performance through qualified clinical data registries.

Encouraging Participation in APMs

Professionals who receive a significant share of their revenues through an APM(s) that involves risk of financial losses and a quality measurement component will receive a five percent bonus each year from 2019-2024. A patient-centered medical home APM will be exempted from the downside financial risk requirement if proven to work in the Medicare population. Two tracks will be available for professionals to qualify for the bonus. The first option will be based on receiving a significant percent of Medicare revenue through an APM; the second will be based on receiving a significant percent of APM revenue combined from Medicare and other payers. The second option makes it possible for professionals to qualify for the bonus even if Medicare APM options are unavailable in their area. If no Medicaid APM is available in a state, a professional's Medicaid revenue will not be counted against the proportion of revenue in an APM. In states where Medicaid APMs are available, Medicaid medical homes will also be exempted from downside financial risk if they are proven to work in the Medicaid population.

Professionals who meet these criteria will be excluded from the MIPS assessment and most EHR meaningful use requirements.

The bonus payment for APM participation encourages professionals to consider participation and testing of new APMs, recognizes that practice changes are needed to facilitate such participation, and promotes the alignment of incentives across payers.

To make the bonus opportunity available to the greatest number of professionals, the Secretary is specifically encouraged to test APMs relevant to specialty professionals, professionals in small

practices, and those that align with private and state-based payer initiatives. Further, a Technical Advisory Committee will be established to consider physician-focused APM proposals. CMS would be required to provide a detailed response to TAC-recommended APMs. The section also requires HHS to identify potential fraud vulnerabilities in APMs.

Sec. 3. Priorities and Funding for Quality Measure Development

Measure Development Plan

Gaps in quality measurement programs will be addressed to ensure meaningful measures on which to assess professionals and funding will be provided for measure development priorities. The Secretary, with stakeholder input, is required to develop and publish a plan for the development of quality measures for use in the MIPS and in APMs, taking into account how measures from the private sector and integrated delivery systems could be utilized in the Medicare program. The plan, which must be finalized by May 1, 2016, will prioritize outcome measures, patient experience measures, care coordination measures, and measures of appropriate use of services, and consider gaps in quality measurement and applicability of measures across health care settings. The Secretary will contract with entities, which could include physician organizations, to develop priority measures and focus on measures that can be reported through an EHR.

Annual Report

By May 1, 2017, and annually thereafter, the Secretary is required to report on the progress made in developing quality measures. The report will include descriptions of the number of measures developed, including the name and type of each measure. The report will also include descriptions of the measures under development, including an estimated timeline for completion of such measures, as well as quality areas being considered for future measure development.

Funding

Funding will be $15 million annually in 2015 to 2019 for professional quality measure development. The funding will remain available through fiscal year 2022.

Sec. 4. Encouraging Care Management for Individuals with Chronic Care Needs

In order to encourage the management of care for individuals with chronic conditions, at least one payment code for care management services will be established for professionals treating such individuals. In order to prevent duplicative payments, only one professional or group practice will receive payment for these services provided to an individual during a specified period. Payment for these codes will be budget-neutral within the physician fee schedule. Finally, payments for chronic care management would not require that an annual wellness visit or an initial preventive physician examination be furnished as a condition of payment.

Sec. 5. Empowering Beneficiary Choices through Access to Information on Physician Services

Beginning with 2015, in addition to the quality and resource use information that would be posted through the MIPS, the Secretary is required to publish utilization and payment data for physicians and

professionals, as appropriate. With emphasis on the services a professional most commonly furnishes, such information will include the number of services furnished and submitted charges and payments for such services and will be searchable by at least the eligible professional's name, location, and services furnished. The Secretary will integrate this information on the Physician Compare website starting in 2016.

Sec. 6. Expanding Claims Data Availability to Improve Care

Qualified Entities

Consistent with relevant privacy and security laws, entities that currently receive Medicare data for public reporting purposes (qualified entities, "QEs") will be permitted to provide or sell non-public analyses and claims data to physicians, other professionals, providers, medical societies, and hospital associations to assist them in their quality improvement activities or in developing APMs. Any data or analyses must be de-identified, though the provider accessing the data or analysis can receive identifiable information on the services furnished to his or her patient. QEs will be permitted to provide or sell non-public analyses to health insurers (who provide claims data to the QE) and self-insured employers (only for purposes of providing health insurance to their employees or retirees). Providers identified in such analyses will have an opportunity to review and submit corrections before the QE provides or sells the analysis to other entities.

To ensure the privacy, security, and appropriate use of Medicare claims information, QEs must: have a data use agreement with providers and entities to which they provide data; and be subject to an assessment for breach of such agreement. Further, providers and entities receiving data and analyses are prohibited from re-disclosing them or using them for marketing.

QEs that provide or sell analyses or data shall provide an annual report to the Secretary that provides an accounting of: 1) the analyses provided or sold, including the number of analyses and purchasers, the amount of fees received, and the topics and purposes of the analyses; and 2) a list entities that were provided or sold data, the uses of that data, and the fees received by the QE for such data. The claims data available to QEs will also include Medicaid/CHIP data.

Qualified Clinical Data Registries

Consistent with relevant privacy and security laws, the Secretary is required to make data available, for a fee that covers the cost of preparing the data, to requesting qualified clinical data registries to support quality improvement and patient safety activities. Providers identified in public reports will have an opportunity to review and submit corrections.

Sec. 7. Reducing Administrative Burden and Other Provisions

Rule of Construction

Provides that the development, recognition, or implementation of any guideline or other standard under any Federal health care provision, including Medicare, cannot be construed to establish the standard of care or duty of care owed by a health care professional to a patient in any medical malpractice or medical product liability action or claim. This ensures that MIPS participation cannot be used in

liability cases. This provision would not preempt any state or common law governing medical professional or medical product liability actions or claims. This provision is intended to reaffirm existing law with respect to medical malpractice and medical products cases.

Other Provisions

- Allows professionals who opt-out of Medicare to automatically renew at the end of each two-year cycle.
- Requires regular reporting of opt-out physician characteristics.
- Requires that Electronic Health Records (EHR) be interoperable by 2018 and prohibits providers from deliberately blocking information sharing with other EHR vendor products.
- Requires the Secretary to issue a report recommending how a permanent physician-hospital gainsharing program can best be established.
- Requires GAO to report on barriers to expanded use of telemedicine and remote patient monitoring.

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

TITLE I—SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION

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

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

TITLE II—MEDICARE AND OTHER HEALTH EXTENDERS

Subtitle A—Medicare Extenders

Sec. 201. Extension of work Geographic Practice Cost Index (GPCI) floor. Boosts payments for the work component of physician fees in areas where labor cost is lower than the national average. The provision extends the existing 1.0 floor on the "physician work" cost index until January 1, 2018.

Sec. 202. Extension of therapy cap exceptions process. The Medicare program currently limits ("caps") the amount of annual per-patient therapy expenditures. Congress created an exceptions process in 2006 that allows patients to exceed the cap based on medical necessity. This provision extends the therapy cap exceptions process until January 1, 2018 and reforms the process of medical manual review to help support the integrity of the Medicare program.

Sec. 203. Extension of ambulance add-ons. Extends the add-on payment for ground ambulance services, including in super-rural areas until January 1, 2018.

Sec. 204. Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals. This provision extends Medicare Low-Volume hospital payments. The Centers for Medicare and Medicaid Services (CMS) has traditionally provided an additional payment to hospitals for the higher costs associated with operating a hospital with a low volume of discharges. This provision extends special add-on payments until October 1, 2017.

Sec. 205. Extension of the Medicare-dependent hospital (MDH) program. MDHs are rural hospitals with no more than 100 beds that serve a high percentage of Medicare beneficiaries. MDHs are paid based on a blend of current prospective payment system rates and costs. This provision extends special payments to MDHs until October 1, 2017.

Sec. 206. Extension for specialized Medicare Advantage (MA) plans for special needs individuals. MA special needs plans (SNPs) are plans that may limit enrollment to certain populations, such as beneficiaries dually eligible for both Medicare and Medicaid or those suffering from certain chronic conditions. This provision extends authority for SNPs through December 31, 2018.

Sec. 207. Extension of funding for quality measure endorsement, input, and selection. Funds the National Quality Forum's (NQF) review, endorsement and maintenance of quality and resource use measures, as well as the NQF and Secretary regarding the pre-rulemaking process and measure dissemination and review activities. The provision provides funding for each of fiscal years 2016 and 2017.

Sec. 208. Extension of funding outreach and assistance for low-income programs. Provides additional funding for outreach and education activities for Medicare beneficiaries through September 30, 2017, including State Health Insurance Programs, Area Agencies on Aging, Aging and Disability Centers, and the National Center for Benefits Outreach and Enrollment.

Sec. 209. Transition and Extension of Medicare reasonable cost contracts. This provision would allow for a smooth transition policy for cost plans that no longer meet statutory requirements to operate under Medicare in their service area. This policy outlines rules and beneficiary protections for cost plans to transition to Medicare Advantage plans.

Sec. 210. Medicare Home Health Rural Add-On. This policy extends a three percent add-on to payments made for home health services provided to patients in rural areas through January 1, 2018.

Subtitle B—Other Health Extenders

Sec. 211. Permanent extension of the qualifying individual (QI) program. This program assists low-income Medicare beneficiaries with incomes between 120 percent and 135 percent of poverty (currently between $14,124 - $15,890 a year) in covering the cost of their Medicare Part B premium. This provision makes the QI program permanent.

Sec. 212. Permanent extension of transitional medical assistance (TMA). TMA allows low-income families to maintain their Medicaid coverage for up to one year as they transition from welfare to work. This provision extends TMA permanently.

Sec. 213. Extension of special diabetes program for type I diabetes and for Indians. Extends both the Type I Diabetes and Type II Indian Health Service programs through fiscal year 2017.

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

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

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

Sec. 217. Extension of health workforce demonstration project for low-income individuals. Extends this program at the current funding level, which provides funding to help low-income individuals obtain education and training in high-demand, well-paid, health care jobs, through fiscal year 2017.

Sec. 218. Extension of maternal, infant, and early childhood home visiting programs. Extends the Maternal, Infant, and Early Childhood Home Visiting Program funding through fiscal year 2017. This program provides states, territories, and tribes with grants to support evidence-based in-home visiting programs for at-risk families.

Sec. 219. Tennessee disproportionate share hospital (DSH) allotment for fiscal years 2015 through 2025. The Medicaid statute requires that states make DSH payments to hospitals treating large numbers of low-income patients. States receive an annual DSH allotment, which is the maximum amount of federal matching funds a state is permitted to claim for Medicaid DSH payments. Hawaii and Tennessee have had different DSH arrangements provided through multiple previous laws due to unique past circumstances. This legislation provides parity by treating Tennessee like other states, thus providing an annual DSH allotment for fiscal years 2015 through 2025.

Sec. 220. Delay in effective date for Medicaid amendments relating to beneficiary liability settlements. In December 2013, the Bipartisan Budget Act of 2013 overturned a circuit court case dealing with Medicaid estate recovery, allowing a state to recover medical expense claims from any portion of a Medicaid beneficiary settlement, potentially allowing a state to commandeer money set aside for a beneficiary's future care or living expenses. The Protecting Access to Medicare Act of 2014 package delayed this provision until October 1, 2016. The legislation provides an additional delay, until October 1, 2017.

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

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

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

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

CHIP covers more than 8 million children and pregnant women in families that earn income above Medicaid eligibility levels. While the CHIP program is authorized through 2019, no new funding is available after fiscal year 2015. This provision preserves and extends CHIP, funding the program fiscal year 2017.

TITLE IV—OFFSETS

Subtitle A—Medicare Reforms

Sec. 401. Medigap. Some Medigap plans on the market today provide first-dollar coverage for beneficiaries – which means the plan pays the deductibles and co-payments so that the beneficiary has no out-of-pocket costs. Beginning in 2020 – for new enrollees only – this provision would limit coverage to costs above the amount of the Part B deductible (currently $147 a month).

Sec. 402. Income-related premium adjustment for Parts B and D. The portion of the Medicare Part B and Part D premium that a beneficiary pays is based on the beneficiary's income. This policy would increase the percentage that Medicare beneficiaries with modified adjusted gross income (MAGI) between $133,501 and $160,000 ($267,001-$320,000 for a couple) from 50 percent to 65 percent. Beneficiaries that have incomes at $160,001 and above ($320,001 and above for a couple) would pay 80 percent. Additionally, current law freezes the

income thresholds through 2019, at which point the income thresholds would be indexed to inflation as if they had not been frozen.

This provision would also apply to Part D premiums, meaning that beneficiaries who have income above the set thresholds are assessed an income-related monthly adjustment amount in addition the base Part D monthly premium.

Subtitle B—Other Offsets

Sec. 411. Market basket reductions. Medicare reimbursements for post-acute care providers will increase by no more than 1.0 percent in fiscal year 2018.

Sec. 412. Medicaid DSH. Medicaid DSH payments provide additional payments to hospitals that serve a disproportionate number of low-income patients. Currently, reductions in state DSH allotments are scheduled to begin in fiscal year 2017. This policy would delay Medicaid DSH cuts until fiscal year 2018 and add another year of DSH cuts in 2025.

Sec. 413. Levy on Medicare providers for nonpayment of taxes. Under current law, the Department of the Treasury may impose a levy of up to 30 percent against Medicare service providers with tax delinquencies. This provision will permit the Treasury to impose a levy of up to 100 percent on tax delinquent Medicare service providers.

Sec. 414. Adjustments to inpatient hospital payment rates. The American Taxpayer Relief Act (ATRA) of 2012 required CMS to retrospectively recoup $11 billion in Medicare overpayments to hospitals. Hospitals are scheduled to receive a one-time 3.2 percentage points payment increase in Fiscal Year (FY) 2018. This section provides for the anticipated hospital payment increase of 3.2 percentage points to be phased in at 0.5 percentage points per year over 6 years beginning in fiscal year 2018.

TITLE V—MISCELLANEOUS

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

Subtitle B—Other provisions

Sec. 521. Delay of two-midnights. Per CMS regulation, the two-midnight policy requires a patient stay of two-midnights in a hospital to qualify for inpatient status in most instances; stays less than that will be paid as an outpatient visit. This provision allows CMS to continue use of the Medicare Administrative Contractor (MAC) "probe and educate" program to assess provider

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

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

Sec. 523. Payment for global surgical packages. This provision reverses the CMS decision to eliminate the bundled payment for surgical services that span a 10 and 90-day period. It requires CMS to periodically collect information on the services that surgeons furnish during these global periods beginning not later than 2017 and use that information to ensure that the bundled payment amounts for surgical services are accurate. The Secretary has the authority to delay a portion of payment for services with a 10 and 90-day global period to incentivize reporting of information. The Secretary can cease the collection of information from surgeons once the needed information can be obtained through other mechanisms, such as clinical data requires and electronic medical records.

Sec. 524. Secure Rural Schools. Provides a two-year extension of Secure Rural Schools and Community Self-Determination Act of 2000. This program allows for payments to mitigate impacts on counties containing national forested public lands with declining timber revenues. It enables flexibility for county elections to spend payments over two years or the normal timeframe at a five percent reduction from fiscal year 2013 funding levels per current law.

Sec. 525. Exclusion from PAYGO scorecards.