Discussion Draft

Medicare and Other Health and Human Services Extender Provisions

Section-By-Section Summary

TITLE I – MEDICARE AND OTHER HEALTH AND HUMAN SERVICES EXTENDERS

Subtitle A – Medicare Extenders

Sec. 101. Extension of work Geographic Practice Expense Index (GPCI) floor. Increases payments for the work component of physician fees in areas where labor cost is determined to be lower than the national average by extending the current 1.0 physician work GPCI floor for two years through December 31, 2019. In addition, the Government Accountability Office (GAO) would be required to assess the appropriateness of the current method for calculating the work GPCI adjustment and provide recommendations within 18 months.

Sec. 102. Permanent repeal of the therapy caps. Medicare beneficiaries face annual payment limits ("caps") for outpatient therapy services, including physical therapy, speech-language pathology services, and occupational therapy. In 2006, Congress established an exceptions process to allow providers and practitioners to request an exception to the therapy caps on behalf of a beneficiary when the additional services are reasonable and necessary. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended this exceptions process through December 31, 2017, and it also required the HHS Secretary to implement a targeted manual medical review process for outpatient therapy services. The discussion draft would permanently repeal the outpatient therapy caps beginning January 1, 2018. It would continue to require that an appropriate modifier be included on claims over the current exception threshold indicating that the services are medically necessary, and it would lower the threshold for the targeted manual medical review process from $3,700 to $3,000.

Sec. 103. Extension of the ambulance add-on payments. Extends the temporary increase in the ambulance fee schedule rates for all ground ambulance services (i.e., 2 percent urban add-on payment and 3 percent rural add-on payment) and the super-rural ambulance add-on payments for five years through December 31, 2022. The discussion draft would also require the Secretary of Health and Human Services (HHS), in consultation with stakeholders, to develop a data collection system for ambulance providers and suppliers to collect cost, revenue, utilization, and other information determined appropriate by the Secretary.

Sec. 104. Extension and improvement of inpatient hospital payment adjustment for certain low-volume hospitals. The low-volume adjustment is based on the concept that large hospitals benefit from certain economies of scale that are not available to small hospitals with limited discharges. To account for the higher incremental costs per discharge, certain low-volume hospitals receive a payment adjustment. Specifically, hospitals with 200 or fewer Medicare discharges receive a 25 percent payment increase, decreasing on a sliding scale to 0 percent for hospitals with more than 1,600 Medicare discharges. The Medicare Payment Advisory Commission (MedPAC) has reported that this adjustment is not well targeted because hospitals may have a small number of Medicare patients while

also treating a large number of non-Medicare patients. The discussion draft would extend Medicare low-volume hospital payments for five years through September 30, 2022. The payment adjustments would be based on total discharges rather than Medicare discharges beginning October 1, 2017. For fiscal year 2018 through fiscal year 2022, the low-volume adjustment standard would be set at 25 percent for hospitals with 500 or fewer total discharges, decreasing on a sliding scale to 0 percent for hospitals with more than 2,500 total discharges.

Sec. 105. Extension of the Medicare-dependent hospital (MDH) program. MDHs are rural hospitals with no more than 100 beds that serve a higher percentage of Medicare beneficiaries. These hospitals receive inpatient prospective payment system (IPPS) rates plus 75 percent of the difference between the IPPS payment and a hospital-specific cost per discharge amount that is calculated using base-year costs. The discussion draft would extend the MDH program for five years through September 30, 2022. No later than two years after the date of enactment, the GAO would be required to complete a study on the MDH program.

Sec. 106. Extension of funding for quality measure endorsement, input, and selection. Section 183 of the Medicare Improvements for Patients and Providers Act of 2008 required the Secretary of Health and Human Services (HHS) to contract with a consensus-based entity (e.g., National Quality Forum or NQF) to carry out specified duties related to quality measurement and performance improvement. According to the Centers for Medicare & Medicaid Services (CMS), carryover funding allocated under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) remains unobligated and available for expenditure in future years. To supplement those existing funds, the discussion draft would provide $7.5 million for each of fiscal years 2018 and 2019 to ensure CMS has the resources necessary to fulfill the agency's statutory obligations. The discussion draft would also institute enhanced transparency of the dollars spent under Section 1890 and 1890A of the Social Security Act (SSA) by requiring new and updated reports to Congress describing how the funds appropriated to the Secretary of HHS are used to help CMS meet Medicare and Medicaid program quality measurement goals now and in the future.

Sec. 107. Extension of funding outreach and assistance for low-income programs. The discussion draft extends for two years, at current law levels, funding for outreach and education activities for Medicare beneficiaries, specifically, for the State Health Insurance Programs (SHIPs), Area Agencies on Aging, Aging and Disability Resource Centers, and The National Center for Benefits and Outreach Enrollment.

Sec. 108. Extension of home health rural add-on. The discussion draft would extend the home health add-on and improve the targeting of future payments in order to protect the Medicare Trust Fund. In 2018 and 2019, the home health add-on would increase from 3 to 4 percent for counties with a population density of 6 or fewer individuals per square mile. This payment add-on would then phase down to 3 percent in 2020, 2 percent in 2021 and 1 percent in 2022. According to the Medicare Payment Advisory Commission (MedPAC), many rural counties have well above average utilization of home health services and face little barriers to access home health services. In these counties, the home health add-on would be reduced to 1.5 percent in 2018 and 0.5 percent in 2019. In all other rural counties not described above, the home health add-on would be extended at the current law rate in 2018 and then reduced to 2 percent in 2019 and 1 percent in 2020.

Subtitle B – Other Health and Human Services Extenders

Sec. 109. Extension of abstinence education. The discussion draft extends abstinence only programs and associated funding through fiscal year 2019. This program provides funds to states to provide abstinence education and mentoring, counseling, and adult supervision to promote abstinence from sexual activity.

Sec. 110. Extension of personal responsibility education program (PREP). The discussion draft extends PREP and associated funding through fiscal year 2019. 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. 111. Extension of funding for family-to-family health information centers. The discussion draft extends Family-to-Family Health Information Center funding through fiscal year 2019. 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. 112. Extension of health workforce demonstration project for low-income individuals. The discussion draft extends the Health Workforce Demonstration Project 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 2019.

Sec. 113. Extension of maternal, infant, and early childhood home visiting programs. The discussion draft extends the Maternal, Infant, and Early Childhood Home Visiting Program funding through fiscal year 2019. This program provides states, territories, and tribes with grants to support evidence-based home visiting programs for at-risk families.

Sec. 114. Delay in effective date for Bipartisan Budget Act of 2013 amendments related to Medicaid third-party liability. Under third-party liability (TPL) rules, Medicaid is the payer of last resort. The Bipartisan Budget Act of 2013 included a policy change to allow states to recover medical expense claims from any portion of a Medicaid beneficiary settlement, allowing a state to recover money set aside for a beneficiary's future care or living expenses, as well as a change related to Medicaid pay and chase requirements for certain select services and populations. The Protecting Access to Medicare Act of 2014 delayed these changes until October 1, 2016. The Medicare and CHIP Reauthorization Act (MACRA) further delayed these provisions until October 1, 2017. The discussion draft would further delay Section 202(c) of the Bipartisan Budget Act of 2013.