H.R. 4302, "Protecting Access to Medicare Act of 2014"
AMA Summary
March 28, 2014

TITLE I—MEDICARE EXTENDERS

Section 101: Physician Payment Update. Extends the current 0.5 percent update through the end of 2014, and provides a 0.0 percent update (freeze) from January to March 2015.

Section 102: Extension of Work GPCI Floor. The work GPCI (geographic practice cost index) "floor" of 1.0 is extended until April 1, 2015.

Section 103: Extension of Therapy Cap Exceptions Process. Extends the Medicare therapy cap exceptions process until March 31, 2015.

Section 104: Extension of Ambulance Add-ons. Extends Medicare add-on payments for ground ambulance services, with higher add-ons for ambulances from very rural areas, until April 1, 2015.

Section 105: Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-Volume Hospitals. In addition to Part A payments under the Inpatient Prospective Payment System, Medicare provides add-on payments to low-volume hospitals with less than 800 (inpatient, acute care) discharges per fiscal year, located more than 15 miles from another low-volume hospital. These discharge and distance standards were scheduled to be replaced on April 1, 2014 with higher presumptive standards of 1,600 discharges and 25 miles. However, section 105 extends the lower standards to September 30, 2015. It also extends to March 31, 2015 the current sliding scale methodology for the add-on payments—ranging from zero percent for hospitals with over 1,600 discharges, to 25 percent for those with up to 200 discharges. The bill also postpones until April 1, 2015 the effective date of a new requirement that add-on payments must reflect additional incremental costs, again limited to a maximum add-on of 25 percent.

Section 106: Extension of Medicare-Dependent Hospital (MDH) Program. Extends the MDH program, which supports small, rural hospitals with a high percentage of Medicare patients, until April 1, 2015.

Section 107: Extension of Specialized Medicare Advantage Plans for Special Needs Individuals. Extends Medicare Advantage Special Needs Plans for one year through 2016. Special Needs Plans are limited to only those seniors who have specific diseases or characteristics and provide benefits, provider choices, and drug formularies tailored to best meet the specific needs of the groups they serve.

Section 108: Extension of Medicare Reasonable Cost Contracts. Allows Medicare cost plans to continue to operate through December 31, 2015 in an area where at least two Medicare Advantage coordinated care plans operate. Cost plans are private plans that operate in much the same ways as a Medicare Advantage plan, but provide Medicare services on a reasonable per person amount based on the actual costs of services.

Section 109: Extension of Funding for Quality Measure Endorsement, Input, and Selection. Provides funding for the National Quality Forum of $5 million for FY 2014 and $15 million for the first half of FY 2015 for quality measure endorsement, input, and selection. Funds will remain available until expended.

Section 110: Extension of Funding Outreach and Assistance for Low-Income Programs. Extends funding for insurance outreach and assistance programs that help low-income Medicare beneficiaries and their families. Funding is extended through March 31, 2015 for State Health Insurance Counseling Programs ($11,250,000); Area Agencies on Aging ($11,250,000); Aging and Disability Resource Centers ($7,500,000); and The National Center for Benefits Outreach and Enrollment ($7,500,000).

Section 111: Extension of Two-Midnight Rule. Gives the Secretary of HHS discretion to extend the probe and educate hospital audits under the Two-Midnight policy (that differentiates between inpatient hospital admissions and observation status) through the first six months of 2015, and suspends RAC post-payment audits under the policy through March 2015.

Section 112: Technical Changes to Medicare LTCH Amendments. Contains several technical amendments to statutory provisions for the Medicare Long-Term Care Hospital (LTCH) Prospective Payment System. Also grandfathers long-term care hospitals that had already begun qualifying, construction, or certification as an LTCH when the Medicare, Medicaid, and SCHIP Extension Act of 2007 imposed a moratorium on new LTCH's.

TITLE II – OTHER HEALTH PROVISIONS

Section 201: Extension of the Qualifying Individual (QI) Program. Extends the QI program through March 31, 2015, allocating $285 million for the second half of FY 2014 (April through September); $300 million for October through December 2014; and $250 million for January through March 2015. The QI program allows Medicaid to pay Medicare part B premiums for low-income beneficiaries who have incomes between 120 and 135 percent of the federal poverty level.

Section 202: Temporary Extension of Transitional Medical Assistance (TMA). Extends the TMA program for 12 months. TMA allows low-income families to keep their Medicaid coverage while they transition to employment and increased income. The program was scheduled to expire on April 1, 2014.

Section 203: Extension of Medicaid and CHIP Express Lane Option. Extends the Express Lane Option under the Children's Health Insurance Program Reauthorization Act (CHIPRA) for 12 months, through September 30, 2015. This option permits states to rely on findings from an Express Lane agency to conduct simplified eligibility determinations and facilitate enrollment in Medicaid and CHIP.

Section 204: Extension of Special Diabetes Program for Type I Diabetes and For Indians. Extends the Special Diabetes Program through fiscal year 2015. This program was created by Congress in 1997 to provide additional resources to advance Type 1 diabetes research and to address the disproportionate burden Type 2 diabetes has on American Indian and Alaska Native populations.

Section 205: Extension of Abstinence Education. Extends the authorization and funding for the Title V, Section 510 Abstinence Education programs, which provide grants to states for abstinence education,

for an additional year through fiscal year 2015. Funding of $50 million is authorized (out of any money in the Treasury not otherwise appropriated).

Section 206: Extension of Personal Responsibility Education Program (PREP). Extends the Personal Responsibility Education Program (PREP), enacted as part of the ACA, through fiscal year 2015, and authorizes an appropriation of $75 million (out of any money in the Treasury not otherwise appropriated). PREP provides grants to states for programs designed to educate teens on both abstinence and contraception for the prevention of pregnancy and sexually-transmitted infections.

Section 207: Extension of Funding for Family-to-Family Health Information Centers. Continues the Family-to-Family Health Information Centers through fiscal year 2015, and authorizes an additional $5 million (out of funds not otherwise appropriated). The Family-to-Family Health Information Centers program provides federal grants to fund centers that assist families of children with disabilities or special health care needs to make informed choices about health care in order to promote good treatment decisions, cost-effectiveness, and improved health outcomes for such children.

Section 208: Extension of Health Workforce Demonstration Project for Low-Income Individuals. Extends the Health Workforce Demonstration for Low-Income Individuals for 12 months, authorizing an additional $85 million for fiscal year 2015 (out of funds not otherwise appropriated). This demonstration project, enacted as part of the ACA, provides grants to eligible entities to conduct demonstration projects that are designed to provide eligible individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to either experience labor shortages or be in high demand.

Section 209: Extension of Maternal, Infant, and Early Childhood Home Visiting Programs. Extends the funding for this program through March 31, 2015, authorizing an additional $400 million (out of funds not otherwise appropriated). This program was created under the ACA, and allows collaboration and partnership at the federal, state, tribal, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.

Section 210: Pediatric Quality Measures. Continues funding for the development, validation, and testing of measures for the pediatric quality measure program. No less than $15 million of the funds allocated for quality measures ($60 million per fiscal year from FY 2010 to 2014) would be for pediatric measures. Additionally, funding for pediatric measures under the Medicaid Quality Measurement Program would no longer be limited to the amount of funding for adult measures.

Section 211: Delay of Effective Date for Medicaid Amendments Relating to Beneficiary Liability Settlements. Delays by two years the authority that allows states to recoup a larger portion of Medicaid beneficiary liability settlements. Previously, Medicaid was limited to recouping costs set aside for medical expenses, but enactment of the Bipartisan Budget Act would allow Medicaid to also recover from costs for lost wages, pain, and suffering starting October 1, 2014.

Section 212: Delay in Transition from ICD–9 to ICD–10 Code Sets. Provides at least a one-year delay for implementing ICD-10, moving the implementation date from October 1, 2014 to not before October 1, 2015.

Section 213: Elimination of Limitation on Deductibles for Employer-Sponsored Health Plans. Repeals Section 1302(c)(2) of the ACA, thereby eliminating deductible limitations on small group health plans. This would allow deductibles in high-deductible health plans used in conjunction with health savings accounts to be higher, thereby creating incentives for such plans to be offered.

Section 214: GAO Report on the Children's Hospital Graduate Medical Education Program. Instructs the Government Accountability Office (GAO) to provide a report on Children's GME funding, outlining the number of hospitals receiving such payments, amounts awarded, and how the hospital used such payments.

Section 215: Skilled Nursing Facility Value-Based Purchasing. Adds an extensive new value-based purchasing program for skilled nursing facilities, with new quality reporting and value-based incentives.

Section 216: Improving Medicare Policies for Clinical Diagnostic Laboratory Tests. Limits the cuts to diagnostic tests on the laboratory fee schedule by tying pricing and payment to market-based private sector payments in order to constrain CMS discretion. Also requires the consolidation of Medicare Administrative Contractors (MACs) to establish coverage policies and process claims for clinical laboratory tests. Calls for a Federal Advisory Committee Act (FACA) committee to advise the Secretary of HHS on pricing and coverage. Codifies the requirements of contractors to follow the local coverage determination process. Directs the Secretary of HHS to utilize unique Healthcare Common Procedure Coding System (HCPCS) codes for advanced diagnostic laboratory tests.

Section 217: Revisions Under the Medicare ESRD Prospective Payment System. Preserves until January 1, 2024 separate payments for oral-only medications for end-stage renal disease (ESRD), rather than treating those as included in the bundled payment for dialysis. Spreads out payment reductions due to the reduced use of intravenous or injectable drugs as part of dialysis; requires a new regulatory process to reimburse injectable and intravenous products in the bundled payments; and supports new quality measures specific to conditions treated by oral-only drugs, including those endorsed by organizations with expertise in kidney disease. Calls for audits of Medicare cost reports from a representative sample of ESRD and dialysis providers, funded with $18 million for FY 2014/until expended.

Section 218: Quality Incentives for Computed Tomography Diagnostic Imaging and Promoting Evidence-Based Care. Reduces Medicare payment for CT scans from equipment that does not comply with national dosage standards. The reduction is five percent in 2016, 15 percent in 2017 and beyond, and these are not budget-neutral. It also establishes a new program requiring consultation of "appropriate use" (AU) criteria before ordering certain services. Starting in January 2017, ordering professionals must consult AU criteria for advanced imaging services selected by the Secretary (e.g., CTs, MRIs, PET scans) when performed in physician offices and outpatient/ambulatory settings. (Exceptions apply for emergencies, inpatients, and hardships such as rural areas without internet access.) Selected services must have at least one clinical decision support mechanism available free of charge. The criteria must be endorsed by national medical specialty societies or other provider-led entities, and evidence-based when feasible. Prior authorization will be required, starting in 2020, for "outlier ordering professionals"—up to five percent of professionals—identified from at least two years of data. Within 18 months of enactment, the GAO must report on whether AU criteria should be used for other services, such as radiation therapy and clinical diagnostic lab services.

Section 219: Using Funding from Transitional Fund for Sustainable Growth Rate (SGR) Reform. The Bipartisan Budget Act of 2013 provided $2.3 billion for the Medicare Improvement Fund for SGR Reform to ensure the 2017 conversion factor for physicians' services is at least what it was in 2013. This section removes that $2.3 billion to help offset the cost of this legislation.

Section 220: Ensuring Accurate Valuation of Services Under the Physician Fee Schedule. Sets an annual target of 0.5 percent in savings from misvalued Medicare Physician Fee Schedule services for each of the years 2017 through 2020. If the target is met, the savings are redistributed to other services, and excess savings can carry forward to future years. Otherwise, across-the-board cuts apply, which are not budget-neutral. Also sets new screens to identify potentially misvalued codes; gives the Secretary of HHS wide discretion to collect information (including through physician surveys) to set the work and practice expense components of relative values; provides $2 million per fiscal year for this purpose; and allows "smoothing" of relative values within groups of services. Relative value reductions of 20 percent or more for existing codes will phase in over two years. The GAO is required to study and report on the RUC processes within one year of enactment. Finally, this section also redefines Metropolitan Statistical Areas in California for the Medicare GPCI adjustment.

Section 221: Medicaid DSH. Delays by one year reductions in payments under Medicaid to Disproportionate Share Hospitals (DSH) expected under current law, and makes additional reductions through 2024. Requires the Medicaid and CHIP Payment and Access Commission (MACPAC) to review and submit an annual report to Congress on disproportionate share hospital payments, beginning no later than February 1, 2016.

Section 222: Realignment of the Medicare Sequester for Fiscal Year 2024. For fiscal year 2024, the sequester cut would change from two percent for the entire year, to four percent for the first six months then zero percent for the second six months. This could increase the overall cut for the year, since most of the payments are made in the beginning of the year.

Section 223. Demonstration Programs to Improve Community Mental Health Services. Establishes an eight-state demonstration program over a two-year period to incentivize community mental health providers to offer a broad range of mental health services in certified community behavioral health clinics. The Secretary of HHS would be required to issue guidance on the development of a prospective payment system under Medicaid for mental health services furnished by such centers. Appropriates $27 million.

Section 224. Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness. Authorizes $15 million each for fiscal years 2015-2018 for demonstration grants for local jurisdictions to implement assisted outpatient treatment (AOT) programs for individuals with serious mental illness.

Section 225. Exclusion from PAYGO Scorecards. Excludes the budgetary effects of this bill from the PAYGO scorecard under the Statutory Pay-As-You-Go Act of 2010, as well as any Senate scorecard under section 201 of S. Con. Res. 21 (110th Congress).