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Increasing Choice, Access, and Quality in Health Care for Americans Act (Division C of P.L. 114-255)

Namrata K. Uberoi, Coordinator
Analyst in Health Care Financing

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Summary

This report summarizes the Increasing Choice, Access, and Quality in Health Care for Americans Act, enacted December 13, 2016, as Division C of the 21st Century Cures Act (P.L. 114-255). Division C comprises Title XV through Title XVII, which include provisions primarily relating to Medicare and Title XVIII, which includes a provision relating to the small-group health insurance market.

Title XV Medicare Part A provisions:

- extend the Rural Community Hospital demonstration five years;
- require the Secretary of the Department of Health and Human Services (HHS) to account for socioeconomic factors in administering the Hospital Readmission Reduction Program;
- reduce a specific inpatient hospital payment update for FY2018;
- require the HHS Secretary to create a crosswalk between codes used for reimbursing procedures performed in inpatient and outpatient settings; and
- make adjustments to long-term care hospital (LTCH) reimbursement including creating or reinstating temporary clinical criteria for payment under the LTCH prospective payment system (PPS) rather than site neutral payment; modifying the average length of stay formula that determines whether a hospital qualifies as an LTCH; reinstating an exemption from a temporary moratorium on additional LTCH beds; delaying implementation of a rule that lowers reimbursement for certain LTCHs that rely disproportionately on referrals from a single acute-care hospital; and creating a new, non-LTCH hospital category in statute for a specific type of long-stay hospital.

Title XVI Medicare Part B provisions:

- make modifications for PPS-exempt cancer hospital and certain new provider-based hospital outpatient departments to be paid under the outpatient PPS;
- exclude certain ambulatory surgical center-based eligible professionals from the electronic health records meaningful use payment adjustment;
- allow physical therapists who furnish outpatient physical therapy in certain areas to use locum tenens arrangements for payment purposes;
- extend the delay in enforcement of direct physician supervision requirements for outpatient therapeutic services in critical access hospitals and small rural hospitals; and
- make changes to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) payment including delaying when competitive bidding information can be used to adjust fee schedule rates for Group 3 complex rehabilitative power wheelchairs accessories; extending the transition to the adjusted fee schedule for DMEPOS; and requiring the HHS Secretary to consider stakeholder input when adjusting fee schedule rates outside of competitive bidding areas.

Title XVII's other Medicare provisions:

- express Congress's intent to continue to study the effects of socioeconomic status and dual-eligible populations on the Medicare Advantage (MA) five-star rating system before reforming the system with stakeholder input;

- instruct that the HHS Secretary may not terminate MA or Prescription Drug Plan (PDP) contracts solely because of failure to achieve a minimum quality rating;
- create a three-month period at the beginning of the year during which an MA enrollee may switch to a different MA plan or return to Medicare Parts A and B (with or without a PDP);
- allow beneficiaries with end-stage renal disease (ESRD) to enroll in MA beginning January 1, 2021;
- modify the requirements for assigning beneficiaries to Medicare Shared Savings Program (MSSP) accountable care organizations;
- require the HHS Secretary to submit Medicare enrollment data to Congress annually;
- require the HHS Secretary to update the new beneficiary Welcome to Medicare package; and
- authorize the HHS Secretary to prohibit payment for services or items furnished by Medicare, Medicaid, or State Children’s Health Insurance Program providers and suppliers who are subject to temporary new provider or supplier enrollment moratoria.

Title XVIII:

- creates qualified small employer health reimbursement arrangements, which are arrangements offered by eligible employers that pay or reimburse employees for substantiated medical expenses. Under certain conditions, employers may make contributions up to a specified limit and employees do not owe income tax on the payments and reimbursements.

Contents

Introduction	1
Summary of Provisions	2
Title XV—Provisions Relating to Medicare Part A	2
Section 15001. Development of Medicare HCPCS Version of MS-DRG Codes for Similar Hospital Services.....	2
Section 15002. Establishing Beneficiary Equity in the Medicare Hospital Readmission Program.....	3
Section 15003. Five-Year Extension of the Rural Community Hospital Demonstration Program.....	3
Section 15004. Regulatory Relief for LTCHs.....	4
Section 15005. Savings from IPPS MACRA Pay-For Through Not Applying Documentation and Coding Adjustments	5
Section 15006. Extension of Certain LTCH Medicare Payment Rules	5
Section 15007. Application of Rules on the Calculation of Hospital Length of Stay to All LTCHs.....	5
Section 15008. Change in Medicare Classification for Certain Hospitals.....	6
Sections 15009 and 15010. Temporary Exceptions to the Application of the Medicare LTCH Site Neutral Provisions for Certain Spinal Cord Specialty Hospitals and for Certain Discharges with Severe Wounds.....	7
Title XVI—Provisions Relating to Medicare Part B.....	8
Section 16001. Continuing Medicare Payment Under HOPD Prospective Payment System for Services Furnished by Mid-build Off-Campus Outpatient Departments of Providers	8
Section 16002. Treatment of Cancer Hospitals in Off-Campus Outpatient Department of a Provider Policy	9
Section 16003. Treatment of Eligible Professionals in Ambulatory Surgical Centers for Meaningful Use and MIPS.....	10
Section 16004. Continuing Access to Hospitals Act of 2016.....	11
Section 16005. Delay of Implementation of Medicare Fee Schedule Adjustments for Wheelchair Accessories and Seating Systems When Used in Conjunction with Complex Rehabilitation Technology (CRT) Wheelchairs	12
Section 16006. Allowing Physical Therapists to Utilize Locum Tenens Arrangements Under Medicare.....	12
Section 16007. Extension of the Transition to New Payment Rates for Durable Medical Equipment Under the Medicare Program	13
Section 16008. Requirements in Determining Adjustments Using Information from Competitive Bidding Programs.....	14
Title XVII—Other Medicare Provisions	15
Section 17001. Delay in Authority to Terminate Contracts for Medicare Advantage Plans Failing to Achieve Minimum Quality Ratings.....	15
Section 17002. Requirement for Enrollment Data Reporting for Medicare	16
Section 17003. Updating the Welcome to Medicare Package	16
Section 17004. No Payment for Items and Services Furnished by Newly Enrolled Providers or Suppliers Within a Temporary Moratorium Area.....	16
Section 17005. Preservation of Medicare Beneficiary Choice Under Medicare Advantage.....	18

Section 17006. Allowing End-Stage Renal Disease Beneficiaries to Choose a Medicare Advantage Plan 18

Section 17007. Improvements to the Assignment of Beneficiaries Under the Medicare Shared Savings Program..... 20

Title XVIII—Other Provisions..... 20

Section 18001. Exception from Group Health Plan Requirements for Qualified Small Employer Health Reimbursement Arrangements 20

Appendixes

Appendix. List of Abbreviations 24

Contacts

Author Contact Information 26

Introduction

The 21st Century Cures Act (P.L. 114-255) was signed into law on December 13, 2016, by President Barack Obama. On November 30, 2016, the House passed an amendment to the Senate amendment to H.R. 34, the 21st Century Cures Act, on a vote of 392 to 26. The bill was then sent to the Senate, where it was considered and passed, with only minor technical modification, on December 7, 2016, on a vote of 94 to 5.¹

The law consists of three divisions:

- Division A—21st Century Cures;
- Division B—Helping Families in Mental Health Crisis; and
- Division C—Increasing Choice, Access, and Quality in Health Care for Americans.

CRS has published a series of reports on this law, one on each division. This report provides information on Division C of the law.²

The Increasing Choice, Access, and Quality in Health Care for Americans Act (Division C of P.L. 114-255) primarily focuses on Medicare. A single provision of the act focuses on the small-group market within the private health insurance market.³

Division C comprises Title XV through Title XVIII. The first three titles in Division C include provisions primarily relating to Medicare.⁴ Title XV focuses on provisions relating to Medicare Part A (Hospital Insurance, or HI), which provides coverage for inpatient hospital services, posthospital skilled nursing facility services, hospice care, and some home health services, subject to certain conditions and limitations. Title XVI focuses on provisions relating to Medicare Part B (Supplementary Medical Insurance, or SMI), which covers physicians' services, outpatient hospital services, durable medical equipment, and other medical services. Title XVII focuses on provisions relating to other aspects of Medicare, such as Medicare Part C (Medicare Advantage, or MA, the private plan option for beneficiaries that covers all Parts A and B services, except hospice); Medicare Part D (Prescription Drug Plan, or PDP, which covers outpatient prescription drug benefits); MA quality ratings; enrollment data; the Welcome to Medicare package; the Medicare Shared Savings Program (MSSP); and payments to Medicare, Medicaid, or Children's Health Insurance Program (CHIP) providers and suppliers. The fourth title in Division C includes a single provision relating to the small-group health insurance market.⁵

This report briefly summarizes each provision of the Increasing Choice, Access, and Quality in Health Care for Americans Act by title and section. For each section, the report provides relevant

¹ The Congressional Budget Office's (CBO's) score of P.L. 114-255 (Rules Committee Print 114-67, as amended by Amendment Number 5) is available at <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr34amendment5.pdf>.

² For information on Division A, see CRS Report R44720, *The 21st Century Cures Act (Division A of P.L. 114-255)*. For information on Division B, see CRS Report R44718, *The Helping Families in Mental Health Crisis Reform Act of 2016 (Division B of P.L. 114-255)*.

³ Some provisions in Division A and Division B of the 21st Century Cures Act also focus on Medicare, Medicaid, and the private health insurance market.

⁴ For more information on Medicare, see CRS Report R40425, *Medicare Primer*.

⁵ For more information on the small-group health insurance market, see CRS Report RL32237, *Health Insurance: A Primer*.

background information and a discussion of the act’s provision. See below for a list of which CRS analyst authored which provision of this report. The **Appendix** provides a list of abbreviations used throughout this report.

Author List

Author	Section(s)
Cliff Binder	Section 17004
Patricia A. Davis	Sections 17002 and 17003
Susannah V. Gopalan	Sections 15008, 15009, 15010, and 17001
Jim Hahn	Sections 16001, 16002, 16003, 16004, 16006, and 17007
Annie L. Mach	Section 18001
Paulette C. Morgan	Sections 16005, 16007, 16008, 17005, and 17006
Marco A. Villagrana	Sections 15001, 15002, 15003, 15004, 15005, 15006, and 15007

Summary of Provisions

Division C begins before Title XV with the short title (Section 15000), “Increasing Choice, Access, and Quality in Health Care for Americans Act.”

Title XV—Provisions Relating to Medicare Part A

Section 15001. Development of Medicare HCPCS Version of MS-DRG Codes for Similar Hospital Services

Currently, billing and reimbursement for hospital inpatient services under Medicare differ from billing and reimbursement for hospital outpatient services. For hospital inpatient billing, Medicare uses International Classification of Diseases (ICD) diagnosis and procedure codes to assign a case to a Medicare Severity Diagnosis Related Group (MS-DRG) to determine the reimbursement amount for that case. Hospital outpatient and other outpatient settings use Healthcare Common Procedure Code System (HCPCS) codes as the basis for determining Medicare reimbursement. According to analysis published in the Medicare Payment Advisory Commission’s (MedPAC’s) June 2015 *Report to the Congress: Medicare and the Health Care Delivery System* that crosswalked hospital inpatient and outpatient billing codes, Medicare generally reimbursed more for clinically similar short-stay patients served in a hospital inpatient setting compared to an outpatient setting.⁶

Provision

Section 15001 amends Social Security Act Section 1886 to require the Secretary of the Department of Health and Human Services (HHS) to develop a crosswalk that links outpatient HCPCS codes to inpatient MS-DRGs for a minimum of 10 surgical procedures that are commonly performed in both an inpatient and outpatient setting by no later than January 1, 2018.

⁶ Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare and the Health Care Delivery System*, June 2015, at <http://www.medpac.gov/docs/default-source/reports/june-2015-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0>.

In developing the crosswalk, the HHS Secretary is required to consult with MedPAC and consider the analysis contained in Chapter 7 of MedPAC's June 2015 *Report to the Congress: Medicare and the Health Care Delivery System*. Section 15001 also requires the HHS Secretary to make the crosswalk, including a definitions manual and software, available in the public domain without charge.

Section 15002. Establishing Beneficiary Equity in the Medicare Hospital Readmission Program

The Hospital Readmission Reduction Program (HRRP) reduces Medicare's inpatient prospective payment system (IPPS) reimbursement to hospitals with Medicare risk-adjusted readmission rates for certain conditions that exceed the national average. Under the HRRP, a hospital's readmission penalty is based on a complex formula that determines a hospital's excess readmissions (defined generally as actual readmissions divided by expected readmissions) across all HRRP conditions.

Currently, the HRRP formula does not adjust for the effect of socioeconomic status on readmissions. MedPAC has found that hospitals with a higher share of low-income patients have higher readmission rates and thus higher penalties under the HRRP. MedPAC has suggested that one option to address this issue is to refine the HRRP to allow hospitals to be evaluated against their peers relative to the share of low-income patients served. However, the Centers for Medicare & Medicaid Services (CMS) has argued that adjusting for low-income patients would hold hospitals that serve low-income communities to a lower standard of quality and mask disparities in care.

Provision

Section 15002 amends Social Security Act Section 1886(q)(3) to require the HHS Secretary to implement a transitional methodology, effective for discharges beginning in fiscal year (FY) 2019, that accounts for the proportion of low-income Medicare beneficiaries—specifically, those who are full-benefit dually eligible for Medicare and Medicaid—that a hospital serves in determining the HRRP penalty. The transitional methodology must be budget neutral, and in implementing such methodology, the HHS Secretary must not impose additional reporting burden on hospitals. Section 15002 also permits the HHS Secretary to (1) refine the HRRP methodology based on information learned from implementation of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act; P.L. 113-185); (2) consider certain diagnosis codes for exclusion from HRRP; and (3) remove certain conditions related to transplants, end-stage renal disease (ESRD), burns, trauma, psychosis, or substance abuse from HRRP. In addition, Section 15002 requires MedPAC to conduct a study of the effect of outpatient and emergency services on readmissions and submit a report to Congress by June 2018.

Section 15003. Five-Year Extension of the Rural Community Hospital Demonstration Program

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173), Section 410A, as amended by the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), Sections 3123(a) and 10313(a), established and extended the Rural Community Hospital (RCH) demonstration, which tests the feasibility and advisability of establishing RCHs in 20 states with low population densities for Medicare hospital inpatient payment purposes. An RCH must (1) be in a rural area; (2) have fewer than 51 acute-care inpatient beds; (3) have 24-hour emergency care services; and (4) not currently be (or not be eligible to be) designated as a critical access hospital (CAH). Under the demonstration,

participating hospitals are paid the reasonable costs of providing Medicare-covered inpatient services (excluding psychiatric or rehabilitation care) and extended care services, rather than reimbursement under Medicare's IPPS. According to CMS, the second five-year period of the RCH demonstration program was to expire after December 2016.

Provision

Section 15003 extends the RCH demonstration program for an additional five years and expands the program to rural areas nationwide. It also requires the HHS Secretary to issue a solicitation for application within 120 days of enactment to select RCHs to participate in the demonstration during this period, up to the maximum of 30 hospitals permitted under the demonstration. Priority for selecting additional participant hospitals is to be given to hospitals located in the 20 states with the lowest population densities.

Section 15004. Regulatory Relief for LTCHs

Long-term care hospitals (LTCHs) generally treat patients who have been discharged from acute-care hospitals but require prolonged inpatient hospital care due to the patients' medical conditions. Medicare reimburses LTCHs under the LTCH Prospective Payment System (LTCH PPS), which provides a per-discharge reimbursement based on the average costs and patient mix of LTCHs. The LTCH PPS typically provides higher Medicare reimbursement rates for inpatient hospital care than the IPPS.

With some exceptions, LTCHs have faced a moratorium on (1) new LTCH facilities and (2) new LTCH beds since the enactment of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA; P.L. 110-173). MMSEA provided a temporary exception to the moratorium on new LTCH facilities for LTCHs that (1) had a binding written agreement before the enactment of MMSEA for the actual construction, renovation, lease, or demolition of an LTCH and had expended at least 10% of the estimated cost of the project (or \$2.5 million, if less) and (2) had obtained an approved certificate of need in a state where one is required on or before the date of enactment of MMSEA. MMSEA also provided an exception for new LTCH beds for LTCHs (1) located in a state where there is only one other LTCH and (2) that requested an increase in beds following the closure or decrease in the number of beds of another LTCH in the state. The moratorium lapsed at the end of 2012 but was reinstated without the exceptions by the Pathway for SGR Reform Act of 2013 (Pathway for SGR Reform; P.L. 113-67) for the period January 1, 2015, through September 30, 2017. The Protecting Access to Medicare Act of 2014 (PAMA; P.L. 113-93) reinstated the exception for new LTCH facilities but not for new LTCH beds.

Provision

Section 15004 amends MMSEA Section 114(d)(7), as amended by ACA Sections 3106(b) and 10312(b), the Pathway for SGR Reform Section 1206(b)(2), and PAMA Section 112, to reinstate the exception to the moratorium on the expansion of LTCH beds, effective as if it had been enacted by PAMA, April 1, 2014, to coincide with the previously reinstated exception for new LTCH facilities.

Section 15004 includes an offset that reduces LTCH PPS outlier payments in perpetuity beginning October 1, 2017. The reduction does not apply to site neutral case outlier payments. (For an explanation of the LTCH site neutral policy, refer to "Sections 15009 and 15010. Temporary Exceptions to the Application of the Medicare LTCH Site Neutral Provisions for Certain Spinal Cord Specialty Hospitals and for Certain Discharges with Severe Wounds".)

Section 15005. Savings from IPPS MACRA Pay-For Through Not Applying Documentation and Coding Adjustments

The TMA, Abstinence Education, and QI Programs Extension Act of 2007 (P.L. 110-90), as amended by the American Taxpayer Relief Act of 2012 (ATRA; P.L. 112-240) and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10), adjusted hospital IPPS rates for discharges occurring during FY2018 through FY2023. Specifically, MACRA replaced the ATRA one-time 2018 payment increase of 3.2% with a phased-in payment rate increase of 0.5% per year for FY2018 through FY2023.

Provision

Section 15005 amends the TMA, Abstinence Education, and QI Programs Extension Act of 2007, as amended by ATRA and MACRA, to reduce the MACRA annual update from 0.5% to 0.4588% for FY2018.

Section 15006. Extension of Certain LTCH Medicare Payment Rules

LTCHs can be (1) freestanding—a hospital that in general is not integrated with any other hospital; (2) colocated with another hospital, either in the same building or in a separate building on that hospital’s campus; or (3) a satellite facility of an LTCH—a facility that operates as part of the LTCH but in a separate location (which may be colocated with another hospital).

Beginning in FY2005, CMS implemented a new payment regulation for colocated LTCHs and LTCH satellites to limit inappropriate patient shifting driven by financial rather than clinical considerations. Under this policy, if such an LTCH received more than 25% of its Medicare patients from any single referring hospital, the LTCH would be reimbursed the lower of the LTCH PPS or the IPPS reimbursement for discharges that exceeded the threshold. Beginning in FY2008, CMS, by regulation, expanded the 25% patient threshold adjustment policy to include all LTCHs.

Congress enacted a number of delays of CMS’s implementation of the 25% patient threshold adjustment for LTCHs. The most recent delay expired after June 30, 2016 (or after September 30, 2016, for certain LTCHs colocated with another hospital).

Provision

Section 15006 amends MMSEA Section 114(c), as amended by the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5), the ACA, and the Pathway for SGR Reform, to reinstate the delay of CMS’s implementation of the 25% threshold adjustment for discharges from freestanding LTCHs and certain colocated LTCHs occurring October 1, 2016, through September 30, 2017.

Section 15007. Application of Rules on the Calculation of Hospital Length of Stay to All LTCHs

To receive Medicare reimbursement under the LTCH PPS, with some exceptions, LTCHs are required to maintain a Medicare inpatient average length of stay (ALOS) of greater than 25 days. The PAMA amended the Pathway for SGR Reform to allow only LTCHs classified as such as of December 10, 2013, to exclude cases that are reimbursed under MA and those subject to the LTCH site neutral policy from the calculation of ALOS. (For an explanation of the LTCH site neutral policy, refer to Section 15009.)

Provision

Section 15007 amends the Pathway for SGR Reform, Section 1206(a)(3), as amended by the PAMA, Section 112(c)(2), to permit all LTCHs, regardless of the date on which they were classified as such, to exclude cases reimbursed under MA and those subject to the LTCH site neutral policy from the LTCH ALOS calculation. This provision is effective as if enacted by the Pathway for SGR Reform, December 26, 2013.

Section 15008. Change in Medicare Classification for Certain Hospitals

As noted above in the discussion of Section 15007, the vast majority of LTCHs qualify as such because they have an ALOS, as determined by the HHS Secretary, of greater than 25 days. However, the Balanced Budget Act of 1997 (BBA 1997; P.L. 105-33), Section 4417(b), recognized a second LTCH category comprised of hospitals that (1) first received payment under Part A in 1986; (2) had an ALOS, as determined by the HHS Secretary, of greater than 20 days; and (3) had 80% or more of their annual Medicare inpatient discharges with a principle diagnosis of neoplastic disease (including cancer) in FY1997. This category is referred to as a *subclause (II) LTCH* because it was so designated under Social Security Act Section 1886(d)(1)(B)(iv)(II). According to CMS, there is only one subclause (II) hospital in the country, which since 1986 has focused on the provision of palliative care to patients with end-stage cancer.⁷

In the Pathway for SGR Reform, Section 1206(d), Congress required the HHS Secretary to evaluate the payment levels for subclause (II) LTCHs. The law authorized the HHS Secretary to adjust payment rates to subclause (II) LTCHs and to amend the payment regulations accordingly. CMS concluded that payments were inadequate, so CMS promulgated a regulation, effective for cost-reporting periods beginning on or after October 1, 2014, that created a unique payment methodology for subclause (II) LTCHs. The regulation (42 C.F.R. §412.526) applied an “adjustment” to the LTCH PPS such that the subclause (II) LTCH effectively would be paid on a reasonable-cost basis with a hospital-specific ceiling.

Provision

Section 15008 removes the LTCH designation for the former subclause (II) hospital category by redesignating Social Security Act Section 1886(d)(1)(B)(iv)(II) as Section 1886(d)(1)(B)(vi) (clause (vi)). Section 15008 provides that a clause (vi) hospital is not an LTCH and is not subject to the LTCH PPS.

Section 15008 does not substantively change the way this hospital type is paid; the new clause (vi) hospital type will be paid under the same methodology that has governed subclause (II) LTCH reimbursement since FY2014. Instead, the provision merely changes the statutory treatment of this hospital type so that it is no longer nominally subject to the LTCH PPS methodology. For beneficiaries discharged from a clause (vi) hospital on or after January 1, 2017, the associated claims will be treated simply as claims reimbursed on a reasonable-cost basis rather than as claims paid under the LTCH PPS with a reasonable-cost “adjustment.”

⁷ Centers for Medicare & Medicaid Services (CMS), “Final Rule: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long-Term Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2015 Rates;” 79 *Federal Register* 49854, 50193, August 22, 2014.

Sections 15009 and 15010. Temporary Exceptions to the Application of the Medicare LTCH Site Neutral Provisions for Certain Spinal Cord Specialty Hospitals and for Certain Discharges with Severe Wounds

The Pathway for SGR Reform, Section 1206(a), amended the law so that LTCH PPS payment was no longer available for all LTCH discharges but instead was available only for those that meet specific clinical criteria. Effective for cost-reporting periods beginning in FY2016, LTCHs are eligible to receive full payment under the LTCH PPS for a discharge if the beneficiary (1) had a prior three-day intensive-care-unit stay at a hospital paid under the IPPS immediately preceding the LTCH stay or (2) was assigned to an LTCH PPS case-mix group based on the receipt of ventilator services for at least 96 hours and had a prior hospital stay at a hospital paid under the IPPS immediately preceding the LTCH stay. LTCH discharges involving beneficiaries with a principal diagnosis relating to a psychiatric issue or rehabilitation do not qualify for the LTCH PPS rate even if they otherwise meet one of the two criteria.

For LTCH discharges that do not qualify for the LTCH PPS under either clinical criterion above, the Pathway for SGR Reform provided for the phasing in of a “site neutral payment rate” similar to hospital reimbursement. The site neutral rate is defined as the lower of an “IPPS-comparable” per diem amount, as defined in regulations, or the estimated cost of the services involved. For discharges in cost-reporting periods beginning in FY2016 and FY2017, LTCHs receive a blended payment amount based on 50% of what the LTCH would have been reimbursed under the LTCH PPS rate and 50% of the site neutral payment rate. For cost-reporting periods beginning in FY2018 and subsequent years, the LTCH will receive the site neutral payment rate.

The Consolidated Appropriations Act of 2016 (CAA 2016; P.L. 114-113), Section 231, amended the law to provide for a temporary third set of clinical criteria for an LTCH to receive payment under the LTCH PPS rather than the site neutral payment rate. For discharges occurring before January 1, 2017, an LTCH is entitled to the full LTCH PPS if all of the following apply: (1) the LTCH participated in Medicare as an LTCH and was colocated with another hospital as of September 30, 1995, and meets the current regulatory requirements for “grandfathered” hospital-within-hospital status; (2) the LTCH is located in a rural area or is treated as being so located; and (3) the individual discharged has a “severe wound,” as defined in the statute.

Provisions

Sections 15009 and 15010 create or reinstate two sets of temporary clinical criteria for an LTCH to receive payment under the LTCH PPS rather than the site neutral payment.

Section 15009 creates a temporary fourth set of clinical criteria for payment under the LTCH PPS. For discharges occurring in cost-reporting periods beginning during FY2018 and FY2019, an LTCH will be paid under the LTCH PPS if all of the following apply: (1) the LTCH was a not-for-profit LTCH on June 1, 2014; (2) of the LTCH’s discharges in calendar year (CY) 2013 for which payment was made under the LTCH PPS, at least 50% were classified under LTCH diagnosis related groups (DRGs) associated with catastrophic spinal cord injuries, acquired brain injury, or other paralyzing neuromuscular conditions; and (3) the LTCH during FY2014 discharged patients (including Medicare beneficiaries and others) who had been admitted from at least 20 of the 50 states, as determined by the patient’s state of residency. Section 15009 gives the HHS Secretary the authority to implement the state-of-residency requirement by program instruction.

Section 15009 requires the U.S. Comptroller General to conduct a study of the LTCHs that meet these criteria and report to Congress on the study by October 1, 2018. The study must include an

analysis of the Medicare payment rates for the hospitals; the number and health care needs of Medicare beneficiaries with spinal cord, acquired brain injuries, or other paralyzing neuromuscular conditions who are receiving services from the hospitals; and how the hospitals are impacted by state facility licensure rules.

Section 15010 temporarily reinstates, with some modifications, the set of clinical criteria under CAA 2016 for payment of the LTCH PPS for discharges of patients with severe wounds. The CAA 2016 provision expired after December 31, 2016. Under Section 15010, for discharges occurring in cost-reporting periods that begin in FY2018, an LTCH will be eligible to receive the LTCH PPS where all of the following apply: (1) the hospital was designated as an LTCH on or before September 30, 1995, and is colocated with another hospital; (2) the discharge is associated with a DRG relating to cellulitis or osteomyelitis; and (3) the individual was treated in the LTCH for a severe wound, as defined in the statute.

The severe wound criteria for LTCH PPS payment under Section 15010 do not align precisely with those under CAA 2016. Both provisions designate a narrow set of hospitals by requiring that the LTCH at issue be a grandfathered hospital-within-hospital. However, Section 15010 is broader than the prior severe-wound exception in that it does not require that the LTCH be located in a rural area. Conversely, Section 15010 is narrower in that it requires the patient to have a diagnosis associated with cellulitis or osteomyelitis and in that the statutory definition of *severe wound* in Section 15010 is narrower than the one used in CAA 2016.

Section 15010 requires the Comptroller General to conduct a study on the treatment needs of Medicare beneficiaries who require specialized wound care and the costs of wound care in rural and urban areas and to report to Congress on the study by October 1, 2020. The study is required to address beneficiaries' access to care; how the Medicare LTCH site neutral payment provisions will affect the access, quality, and cost of specialized wound care; and how to pay for such care appropriately under Medicare.

Title XVI—Provisions Relating to Medicare Part B

Section 16001. Continuing Medicare Payment Under HOPD Prospective Payment System for Services Furnished by Mid-build Off-Campus Outpatient Departments of Providers

Some Medicare-covered items and services can be provided in multiple settings, for instance, in a physician's office, in a hospital outpatient department, or in freestanding or hospital-operated ambulatory surgical centers (ASCs). The applicable payment is determined by the site of service: the Medicare physician fee schedule (MPFS), the Medicare hospital outpatient prospective payment system (OPPS) fee schedule, or the Medicare ASC payment system, respectively, in the prior examples. MedPAC has recommended that Medicare implement site neutral policies, for instance, those that would equalize outpatient payment rates at hospitals to rates at freestanding physician offices.⁸

⁸ MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2013, at <http://www.medpac.gov/docs/default-source/reports/june-2015-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0> http://www.medpac.gov/docs/default-source/reports/mar13_entirereport.pdf?sfvrsn=0. MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2013, at http://www.medpac.gov/docs/default-source/reports/jun13_entirereport.pdf?sfvrsn=0.

The Bipartisan Budget Act of 2015 (BBA 2015; P.L. 114-74), Section 603, among other things, codified the CMS definition of provider-based (PBD) off-campus hospital outpatient departments (HOPDs) as “a department of a provider ... that is not located on the campus ... or within [250 yards from] a remote location of a hospital facility,” and defined a “new” PBD HOPD as an entity that was not billing as a hospital department prior to November 2, 2015 (the date of enactment of BBA 2015). Although existing PBD HOPDs are grandfathered to continue to receive payments according to the OPSS, new PBD HOPDs are paid under the ASC payment system or the MPFS rather than the OPSS, effective January 1, 2017.

Provision

Section 16001 makes modifications for certain new PBD HOPDs to be paid under the OPSS in 2017 and beyond. For purposes of applying the criteria described above, PBD HOPDs are deemed to be billing prior to November 2, 2015, if the HHS Secretary received an attestation from the provider prior to December 2, 2015, that the off-campus HOPD was and is part of a hospital. These PBD HOPDs are to be paid under the OPSS beginning January 1, 2017.

For 2018 and in subsequent years, “mid-build” PBD HOPDs, defined as those PBD HOPDs for which the provider had a binding written agreement with an outside, unrelated party for the actual construction of such a department prior to November 2, 2015, also will be exempted from the BBA 2015 modification and will receive payments according to the OPSS. The HHS Secretary must receive such attestations by December 31, 2016, or, if later, by 60 days after enactment. The HHS Secretary must audit the accuracy of the statements no later than December 31, 2018.

To implement this modification, \$10 million will be made available from the Federal SMI Trust Fund, to remain available until December 31, 2018. The modifications in this section will be effective as if included in the enactment of BBA 2015 Section 603.

Section 16002. Treatment of Cancer Hospitals in Off-Campus Outpatient Department of a Provider Policy

Eleven cancer hospitals meet certain statutory criteria that exempt them from the Medicare inpatient PPS. These PPS-exempt cancer hospitals (PCHs) receive Medicare payments for inpatient services based on their reported costs, subject to an upper limit, as well as potential add-on payments. After the implementation of the OPSS in 1989, BBA 1997 established that PCH HOPDs would be paid no less than what they would have been paid prior to the implementation of the OPSS, applying an upward payment adjustment based on reported costs and a payment-to-cost ratio (PCR).

BBA 2015 Section 603 did not make any exceptions for cancer hospitals. (See background to Section 16001.)

Provision

Section 16002 excludes PCH OPDs from the modifications made in BBA 2015 for applicable items and services furnished in 2017 and in subsequent years. PCHs are required to notify the HHS Secretary that their outpatient departments meet the requirements for being an HOPD, and such attestations are subject to audit by the HHS Secretary.

Section 16002 also makes modifications to the PCR that result in offsetting savings. Beginning on January 1, 2018, for the payment adjustment for outpatient services provided at a PCH, the HHS Secretary is to use a target PCR that is 1.0 percentage point less than the target PCR that otherwise would apply. The HHS Secretary also may consider “an additional percentage point

reduction” to the PCR, taking into account payments for applicable items and services furnished by off-campus outpatient departments made under Medicare payment systems other than the OPPS.

To implement the modification made by Section 16002, \$2 million will be made available from the Federal SMI Trust Fund, to remain available until expended. The changes made by this section will be effective as if included in the enactment of BBA 2015 Section 603.

Section 16003. Treatment of Eligible Professionals in Ambulatory Surgical Centers for Meaningful Use and MIPS

The Health Information Technology for Economic and Clinical Health (HITECH) Act, which was incorporated in ARRA, authorized Medicare and Medicaid incentive payments to promote the adoption and use of certified electronic health record technology (CEHRT). Eligible hospitals and nonhospital-based physicians qualify for incentive payments under the HITECH Act if they become meaningful users of CEHRT. *Meaningful use* is defined as using CEHRT to capture and exchange clinical information to improve the coordination and quality of care, and using such technology to report clinical quality measures.

Under the HITECH Act, Medicare electronic health record (EHR) incentive payments for eligible physicians demonstrating meaningful use of CEHRT ended in 2016. Beginning in 2015, physicians who do not successfully demonstrate meaningful use are subject to a penalty in the form of a payment adjustment that reduces their Part B reimbursement for covered services.

ASCs were not mentioned in the law; however, physicians who operate in ASCs are still eligible professionals and are subject to the meaningful use requirements. For eligible physicians who see patients in multiple practices or multiple locations, such as surgeons who use ASCs and physicians who treat patients in nursing homes, at least 50% of their patient encounters must occur at practices or locations equipped with CEHRT for them to be considered meaningful EHR users. Physicians who practice at multiple locations, including ASCs, have expressed concern that they lack control over the availability of CEHRT and may be unable to meet the 50% patient threshold. Currently, those physicians who cannot meet this threshold because they lack control over the availability of CEHRT can apply annually through 2018 for a hardship exception to avoid the annual payment adjustment.

MACRA sunset the Medicare EHR payment adjustment for physicians at the end of 2018 and, among other things, established a new merit-based incentive payment system (MIPS). MIPS will incorporate many EHR-related meaningful use measures in a new measurement category (advancing care information, or ACI), which will be used to adjust payments to physicians and other practitioners beginning in 2019. Data on ACI measures will be collected beginning in 2017, and physicians’ performance scores in the ACI category (as well as in the other MIPS categories) and how these scores would affect payments will be reported back to physicians beginning in 2018. However, MIPS adjustments to actual Medicare payments based on MIPS will not apply until 2019.

In the November 4, 2016, final rule implementing MIPS, CMS noted that some commenters “urged the addition of an exclusion for MIPS eligible clinicians practicing in multiple locations because they may encounter specific hardships due to CEHRT availability.”⁹ CMS responded that

⁹ CMS, “Final Rule: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models” 81 *Federal Register* 7700-77831, November 4, 2016.

it is “finalizing fewer required measures for the base score of the advancing care information performance category than [it] had proposed. As there are now fewer required measures, [CMS does] not believe that it is necessary to create additional exclusions for measures which are now optional for reporting.”¹⁰

Provision

Section 16003 excludes physicians from the Medicare meaningful use payment adjustment in 2017 and 2018 in cases where “substantially all of the covered professional services” by the professional are furnished in an ASC. The determination of whether an ASC-based professional is to be excluded will be made on the basis of the site of service, as defined by the HHS Secretary, or an attestation submitted by the professional. The exclusion will sunset three years after the HHS Secretary, through notice and comment rulemaking, determines that certified EHR technology applicable to the ASC setting is available.

Section 16004. Continuing Access to Hospitals Act of 2016

In the 2009 OPPTS final rule, CMS established that outpatient therapeutic services furnished in hospital outpatient departments are required to have direct physician supervision, defined as having a physician “present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure.”¹¹

On March 15, 2010, CMS instructed its Medicare contractors not to enforce these supervision requirements with respect to CAHs in CY2010. As CMS continued to refine its direct supervision policy, the agency extended the moratorium on enforcement through CY2011 and expanded the scope of the moratorium to include both CAHs and small rural hospitals (which CMS defined as having 100 or fewer beds, being geographically located in a rural area, or being paid under the OPPTS using a rural wage index). On November 1, 2012, CMS issued a notice that extended the moratorium through the end of CY2013. Two subsequent acts of Congress (P.L. 113-198, Section 1, and P.L. 114-112, Section 1) further extended the moratorium through the end of CY2015.

Provision

Section 16004 extends the moratorium on enforcement of the requirement of direct supervision of outpatient therapeutic services furnished in CAHs and small rural hospitals through the end of CY2016. The section also requires MedPAC to report to Congress no later than one year after enactment on an analysis of the effect of the extension of the moratorium “on the access to health care by Medicare beneficiaries, on the economic impact and the impact upon hospital staffing needs, and on the quality of health care furnished to such beneficiaries.”

¹⁰ Ibid.

¹¹ CMS, “Final Rule: Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates” 74 *Federal Register* 60316-60983, November 20, 2009.

Section 16005. Delay of Implementation of Medicare Fee Schedule Adjustments for Wheelchair Accessories and Seating Systems When Used in Conjunction with Complex Rehabilitation Technology (CRT) Wheelchairs

Medicare covers a variety of durable medical equipment (DME) when it is medically necessary and prescribed by a physician. The amount that Medicare will pay for the equipment is determined in one of two ways. First, in *competitive bidding* geographic areas, the Medicare payments are determined for selected items based on the bids (or estimates of the cost of providing the item) submitted by winning DME suppliers. Second, outside of competitive bidding areas, payments are determined through statutorily specified formulas (fee schedules) adjusted based on information from the competitive bidding process, when information is available. Not all items of DME are competitively bid. Therefore, not all items outside of competitive bidding areas have their fee schedule payments adjusted based on competitive bidding information. Competitive bidding tends to result in lower payment amounts for DME, so adjusting the fee schedules based on competitive bidding can result in lower payments.

Certain items of DME were statutorily excluded from the competitive bidding program, including Group 3 complex rehabilitative power wheelchairs and their accessories. Group 2 complex rehabilitative power wheelchairs and their accessories were not excluded and were competitively bid in the first round of the program. In general, the difference between Group 2 and Group 3 complex rehabilitative power wheelchairs is related to the number of different power accessories that can be plugged into the chair and to the power, durability, and performance of the chair. Certain accessories can be used with either Group 2 or Group 3 chairs and were part of the competitive bidding process. The HHS Secretary published final regulations on November 6, 2014, that would have adjusted the fee schedule payments for wheelchair accessories based on information from the competitive bidding program regardless of the type of wheelchair the accessory was used with, effective starting January 1, 2016, for areas outside of competitive bidding areas. However, the Patient Access and Medicare Protection Act (P.L. 114-115), prohibited the HHS Secretary from using information from the competitive bidding program to adjust the fee schedule payments for accessories furnished in conjunction with Group 3 complex rehabilitative power wheelchairs prior to January 1, 2017.

Provision

Section 16005 delays the date when the HHS Secretary can begin using information from competitive bidding to adjust the fee schedule rates for accessories used with Group 3 complex rehabilitative power wheelchairs by six months (to July 1, 2017).

Section 16006. Allowing Physical Therapists to Utilize Locum Tenens Arrangements Under Medicare

Physicians who are absent from their practices (for reasons such as illness, pregnancy, vacation, or continuing medical education) may retain substitute physicians to take over their practices temporarily. The regular physician may bill and receive payment for the substitute physician's services as though he or she performed them; the regular physician generally pays the substitute physician a fixed amount per diem or on a similar fee-for-time basis, with the substitute physician having the status of an independent contractor rather than of an employee. These substitute physicians are generally called locum tenens physicians.

The Social Security Act Amendments of 1994, Section 125(b), authorized regular physicians to bill Medicare for the services of locum tenens physicians beginning January 1, 1995. Medicare

statute (Section 1861(r)) defines a physician as a doctor of medicine or osteopathy, licensed in the state where he or she practices. In addition, for certain purposes and within limitations, a doctor of dental surgery or of dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor is also considered a physician. Prior to passage of P.L. 114-255, health care professionals not included in that list were nonphysicians under the Medicare program and therefore were unable to serve locum tenens.

Provision

Section 16006 allows physical therapists who furnish outpatient physical therapy services in a health professional shortage area (as defined in Public Health Service Act (PHSA) Section 332(a)(1)(A)), a medically underserved area (as designated pursuant to PHSA Section 330(b)(3)(A)), or a rural area (as defined in Social Security Act Section 1886(d)(2)(D)), to use locum tenens arrangements for payment purposes for these services in the same manner as such arrangements are used for physicians. This modification is to be effective no later than six months after enactment.

Section 16007. Extension of the Transition to New Payment Rates for Durable Medical Equipment Under the Medicare Program

Medicare pays for most durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) on the basis of fee schedules. However, in competitive bidding areas, the prices paid by Medicare for selected items of DMEPOS are based on the bids of winning suppliers rather than on fee schedules. Starting in 2016, the ACA required the HHS Secretary to either expand competitive bidding to more areas or use information from competitive bidding to adjust the fee schedule amounts that apply *outside* of competitive bidding areas. The final rule establishing the methodology was published November 6, 2014, and phased in the methodology as follows: (1) for items and services furnished January 1, 2016, through June 30, 2016, 50% of the payment was based on the new adjusted fee schedule methodology and 50% was based on the unadjusted fee schedule amount and (2) for items and services furnished starting July 1, 2016, the Medicare payment was based entirely on the adjusted fee schedule amount.¹²

Provision

Section 16007 requires the HHS Secretary to extend the transition to the adjusted fee schedule amounts by six months so that (1) for items and services furnished January 1, 2016, through December 31, 2016, 50% of the payment is based on the new adjusted fee schedule methodology and 50% is based on the unadjusted fee schedule amount and (2) for items and services furnished starting January 1, 2017, the Medicare payment is based entirely on the adjusted fee schedule amount.

Section 16007 also requires the HHS Secretary to examine the impact of the payment adjustments on the number of suppliers that ceased to conduct business as suppliers during CY2016 and the availability of equipment to beneficiaries during the same period. The HHS Secretary is to submit a report on the findings to Congress by January 12, 2017.

¹² CMS, “Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetic, Orthotics, and Supplies,” 79 *Federal Register* 66223-66233, November 6, 2014.

Section 16008. Requirements in Determining Adjustments Using Information from Competitive Bidding Programs

As described in “Section 16007. Extension of the Transition to New Payment Rates for Durable Medical Equipment Under the Medicare Program,” the ACA required the HHS Secretary to either expand competitive bidding to more geographic areas or use information from competitive bidding to adjust fee schedule amounts that apply outside of competitive bidding areas. In doing so, the HHS Secretary was required to specify the methodology for adjusting fee schedule amounts through regulation and to consider the costs of items and services in areas in which the methodology would be applied relative to costs in competitive bidding areas.

On February 26, 2014, the HHS Secretary published an advance notice of proposed rulemaking (ANPR) and requested comments on factors to consider when developing the methodology; the HHS Secretary specifically asked for comments about whether costs of providing items and services varied by geography, size of the market, or delivery distance. The HHS Secretary also asked what alternative information could be relied upon to determine relative costs. The HHS Secretary published a proposed rule on July 11, 2014, which summarized the comments received in the ANPR. Commenters generally agreed that costs vary by geography and among rural and non-rural areas but offered few suggestions about how to measure the differences. For example, “one commenter representing many suppliers said that there exists no reliable cost data.”¹³

The final rule, published November 6, 2014, indicated “Although we do not have direct evidence that cost[s] in rural areas are higher than costs in urban areas or vice versa or that the SPAs [Competitive Bidding Single Payment Amounts] do not cover costs in rural areas, we believe it is prudent for the sake of ensuring access to items and services in these areas to proceed cautiously in adjusting fee schedule amounts in these areas.”¹⁴ In general, the regulation set the adjustments to the fee schedule amounts based on regional averages with a ceiling and floor based on a national average of the regional averages. Rural areas are prohibited from having their payment adjusted below 110% of the national average for an item.

Provision

Section 16008 requires the HHS Secretary to solicit and take into account stakeholder input when adjusting fee schedule rates outside of competitive bidding areas for items and services furnished on or after January 1, 2019. It also requires the HHS Secretary to take into account the highest bid amount by a winning supplier in a competitive bidding area and a comparison of each of the following with respect to competitive bidding areas and non-competitive bidding areas: (1) the average travel distance and cost associated with furnishing items and services in the area, (2) the average volume of items and services furnished by suppliers in the area, and (3) the number of suppliers in the area.

¹³ Department of Health and Human Services (HHS), “Medicare Program: End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, Proposed Rule,” 79 *Federal Register* 40281, July 11, 2014.

¹⁴ HHS, “Medicare Program: End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, Final Rule,” 79 *Federal Register* 66228, November 6, 2014.

Title XVII—Other Medicare Provisions

Section 17001. Delay in Authority to Terminate Contracts for Medicare Advantage Plans Failing to Achieve Minimum Quality Ratings

Under MA, CMS pays private health plans a per-enrollee amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plans. Social Security Act Section 1853(o)(4) requires the HHS Secretary to use a five-star quality rating system to administer bonus payments to high-performing MA organizations. High star ratings also result in an increase in an MA organization's rebate if its contract bid is less than the maximum amount Medicare will pay. In addition, the five-star quality rating system is used to rate PDPs.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act; P.L. 113-185) required the HHS Secretary to conduct a study examining the effect of Medicare beneficiaries' socioeconomic status on quality measures and resource use. This provision reflected Congress's concern that Medicare providers and MA organizations that serve high-needs populations (and, in particular, Medicare-Medicaid dual-eligible beneficiaries) may be disadvantaged under quality rating systems that focus to some extent on health outcomes.

The Social Security Act authorizes the HHS Secretary to terminate a contract with an MA organization or a PDP if the HHS Secretary determines that the MA organization or PDP has failed substantially to carry out the contract, is carrying out the contract in a manner inconsistent with the efficient and effective administration of the Medicare program, or no longer meets the applicable Medicare program conditions.¹⁵ CMS amended its regulations in 2012 to include a ground for contract termination relating to an MA organization's or a PDP's rating under the five-star system. Specifically, under the regulation, CMS may terminate a contract with an MA organization or a PDP if the plan receives a "summary plan rating of less than 3 stars for 3 consecutive contract years."¹⁶ The regulation applies to plan ratings issued by CMS after September 1, 2012. In recent years, CMS has terminated some MA organizations' contracts on this basis.

Provision

Section 17001 expresses the intent of Congress, consistent with the IMPACT Act, to continue to study and request input on the effects of socioeconomic status and dual-eligible populations on the MA five-star rating system before reforming the system with the input of stakeholders. The provision also expresses Congress's intent to delay CMS's authority to terminate MA organizations' contracts solely on the basis of low quality ratings, pending the results of these studies.

Accordingly, Section 17001 provides that from the date of enactment of P.L. 114-255 until the end of plan year 2018, the HHS Secretary may not terminate an MA organization's contract solely because the MA plan has failed to achieve a minimum quality rating under the five-star rating system. Because the contract termination procedures for MA organizations statutorily apply to

¹⁵ Social Security Act §1857(c)(2) (contract termination authority under Medicare Advantage) and §1860D-12(b)(3)(B) (contract termination authority under Medicare Part D).

¹⁶ 42 C.F.R. §§422.510(a)(4)(xi), 423.509(a)(4)(x) CMS, "Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2013 and Other Changes" 77 *Federal Register* 22072-22175, April 12, 2012.

PDPs, as well, the provision also bars the Secretary from terminating a PDP's contract on the basis of failure to achieve a minimum quality rating.¹⁷

Section 17002. Requirement for Enrollment Data Reporting for Medicare

CMS provides data on Medicare beneficiary enrollment for fee-for-service (FFS) Medicare (Parts A and/or B), MA, and Part D on the "CMS Program Statistics" website. There is no statutory requirement for CMS to provide this data.

Provision

Section 17002 requires the HHS Secretary to submit Medicare enrollment data to the congressional committees of jurisdiction on an annual basis, beginning in 2016. These data are to include enrollment figures for FFS Medicare, MA (for both stand-alone plans and plans that include Part D), and Part D at the state and congressional district levels.

Section 17003. Updating the Welcome to Medicare Package

Individuals who are receiving Social Security benefits at least four months prior to the month in which they turn 65 years of age (or in the case of the disabled, for at least four months prior to their 25th month of disability benefit) are automatically enrolled in Medicare Parts A and B.¹⁸ These individuals are sent a "Welcome to Medicare" package three months prior to their month of eligibility. This package includes the following: (1) Welcome to Medicare cover letter; (2) Welcome to Medicare booklet; (3) Medicare card; and (4) Form CMS-1966 (Part B refusal card), together with a postage-paid envelope.

The booklet provides a basic overview of the various parts of Medicare and lists key decisions that new Medicare beneficiaries need to make. Such decisions include whether to keep Part B coverage, stay in original Medicare (Parts A and B) or select an MA plan, enroll in a PDP, and/or purchase private supplemental coverage (Medigap).

Provision

Section 17003 requires the HHS Secretary to update the Welcome to Medicare package, taking into consideration information and recommendations provided by stakeholders on how to improve the enrollment and coverage information provided in this package. The HHS Secretary is to request the information from stakeholders (including patient advocates, issuers, and employers) within 6 months of the date of enactment and to update the information in the Welcome to Medicare package not later than 12 months after the last day of the period for the request of this information. The HHS Secretary is to make subsequent updates to the information in this package as appropriate.

Section 17004. No Payment for Items and Services Furnished by Newly Enrolled Providers or Suppliers Within a Temporary Moratorium Area

The ACA Section 6401(a) authorizes the HHS Secretary to impose a temporary moratorium on enrollment of new Medicare, Medicaid, or CHIP FFS providers and suppliers if the HHS

¹⁷ Social Security Act §1860D-12(b)(3)(F) (applying the termination procedures in §1857(h) to PDP contracts).

¹⁸ Beneficiaries who reside in Puerto Rico are not automatically signed up for Part B.

Secretary determines a moratorium is necessary to address Medicare, Medicaid, or CHIP fraud, waste, or abuse.

Under this temporary enrollment moratorium authority, the HHS Secretary can impose numerical caps or otherwise limit provider or supplier enrollment. Subject to CMS approval, state Medicaid programs also are authorized to impose temporary moratoriums on new provider or supplier enrollment. Under the temporary moratorium authority, the HHS Secretary is required to specify the particular type of providers or suppliers that are temporarily prohibited from enrolling or the geographic area subject to the new provider enrollment moratorium.

Before initiating a temporary moratorium on new provider enrollment, the HHS Secretary is required to consult with state Medicaid programs affected by the moratorium. After consultation with states affected by the moratorium, the HHS Secretary is required to impose the moratorium unless an affected state determines that a moratorium on new provider or supplier enrollment would reduce Medicaid or CHIP beneficiaries' access to care. States that determine a temporary moratorium on new provider enrollment would reduce beneficiaries' access to care are required to notify the HHS Secretary in writing. All temporary provider or supplier enrollment moratoriums, state or federal, may be imposed for six months initially and extended in six-month increments.

ACA Sections 6401(b) and (c) require state Medicaid and CHIP programs to comply with any moratorium imposed by the HHS Secretary unless the state determines that a moratorium would reduce Medicaid beneficiaries' access to care.

Provision

Under Section 17004, beginning October 1, 2017, the HHS Secretary is authorized to prohibit payment for services or items furnished by Medicare, Medicaid, or CHIP providers and suppliers who are subject to temporary new provider or supplier enrollment moratoria. To be subject to the payment prohibition, providers and suppliers must be enrolled in Medicare, Medicaid, or CHIP as of the effective date of the new provider moratorium and must be in the same geographic area and provider or supplier category as those in the temporary new provider enrollment moratorium.

Section 17004 prohibits the HHS Secretary from making federal matching payments to states for items and services provided by Medicaid (and CHIP) providers or suppliers that are subject to a temporary new provider moratorium and a payment prohibition.

Providers and suppliers subject to a temporary new provider enrollment moratorium and a Section 17004 payment prohibition are prohibited from charging individuals eligible for Medicare Part A or enrolled in Part B, Medicaid, or CHIP for items or services subject to the payment prohibition. In addition, the HHS Secretary is authorized to exempt state Medicaid programs from a temporary new provider and supplier enrollment moratorium and to make federal matching payments for services and supplies provided by exempt providers if the state determines that the moratorium will restrict beneficiaries' access to Medicaid or CHIP services or supplies.

States are required under Section 17004 to amend their state plans to specify that providers and suppliers affected by a temporary new provider enrollment moratorium and payment prohibition are prohibited from charging Medicaid beneficiaries covered under a state plan or waiver for items and services provided by the provider or supplier during the moratorium period.

Section 17005. Preservation of Medicare Beneficiary Choice Under Medicare Advantage

Medicare beneficiaries may enroll in or change their enrollment in MA from October 15 through December 7 each year (the annual, coordinated election period). Changes go into effect on January 1 of the next year. Starting in 2011, at any time during the first 45 days of the year, MA enrollees may disenroll from their MA plans and return to Parts A and B and may elect to enroll in a stand-alone PDP (the annual 45-day period for disenrollment). In addition, MA enrollees may discontinue or change their MA enrollment during specified special election periods. One such special election period pertains to individuals who (1) first become eligible for Part A at the age of 65, (2) enroll in Part B, and (3) immediately enroll in an MA plan; such individuals may discontinue election of their MA plans and elect coverage in Parts A and B at any time during their first 12 months of enrollment.

Provision

Section 17005 discontinues the annual 45-day period of disenrollment at the end of the 2018 period. Starting in 2019, this provision creates a continuous open enrollment and disenrollment period during the first three months of each year, during which an MA enrollee may switch to a different MA plan or disenroll from MA to return to Parts A and B (with or without a PDP). Also starting in 2019, a comparable three-month window will be provided to individuals who enroll in an MA plan upon first becoming eligible for Medicare during the year. MA enrollees may make only one change during the continuous open enrollment and disenrollment period for a year. Section 17005 prohibits marketing materials from being sent to individuals during the continuous open enrollment and disenrollment period.

Section 17006. Allowing End-Stage Renal Disease Beneficiaries to Choose a Medicare Advantage Plan

An individual is eligible to enroll in an MA plan if he or she is eligible for Part A, enrolled in Part B, and does not have ESRD. An MA enrollee who develops ESRD is allowed to remain enrolled. MA plans are paid a capitated, monthly payment to provide all required benefits to enrollees (except hospice, which is covered for MA enrollees through a Part A payment). The maximum possible amount of that payment is called the *benchmark* and is determined through a statutory formula for each county. As of payment year 2017, the benchmarks are based on a percentage of per capita spending in Parts A and B, with certain costs excluded and certain other adjustments made. Benchmarks also are increased based on plan quality, as measured by a five-star rating system. Payments to MA plans are risk adjusted to take into account the demographics and health histories of the beneficiaries who actually enroll in the plan.

The risk-adjustment model used to adjust MA payments takes into account age, disability status, gender, institutional status, and other factors the HHS Secretary determines appropriate. One factor, in particular, is whether a beneficiary is enrolled in both the Medicare and Medicaid programs (dual-eligible beneficiaries). Programmatically, there are two categories of dual-eligible beneficiaries—full-benefit and partial dual-eligible beneficiaries. Full-benefit dual-eligible beneficiaries receive full benefits from Medicare and Medicaid. Partial dual-eligible beneficiaries receive full benefits from Medicare and financial assistance from Medicaid for Medicare premiums and/or cost sharing. Prior to payment year 2017, the risk-adjustment model did not distinguish between full-benefit and partial dual-eligible beneficiaries (i.e., both simply counted as dual eligibles) and research showed that the model overestimated the cost of partial dual-eligible beneficiaries and underestimated the cost of full-benefit dual-eligible beneficiaries. In

October 2015, the HHS Secretary proposed to update the risk-adjustment model for payment year 2017. One aspect of the update was to replace the model with six separate models that took into account full-benefit dual eligibility, partial dual eligibility, and non-dual eligibility for both aged and disabled beneficiaries. CMS analysis showed that creating separate models more accurately estimated costs for these groups but would result in lower payments for MA plans that enrolled a larger proportion of partial dual-eligible beneficiaries.

Provision

Section 17006 allows beneficiaries with ESRD to enroll in MA for plan years beginning on or after January 1, 2021. For the same year, the HHS Secretary is required to adjust benchmarks to exclude the HHS Secretary's estimate of the cost of organ acquisition for kidney transplants covered under Medicare, including the expenses covered for individuals donating a kidney for transplant. Similar to the way hospice is paid for MA enrollees, the costs associated with kidney acquisition for MA enrollees are to be payable under Parts A and B.

Section 17006 requires the HHS Secretary to evaluate whether the MA five-star quality rating system should include a quality measure specifically related to the care of MA enrollees with ESRD; the HHS Secretary is to publish the results on the CMS website no later than April 1, 2020. Section 17006 also requires the HHS Secretary to submit to Congress a report on the impact of these provisions on the following: (1) spending under Parts A and B and under MA and (2) the number of beneficiaries determined to have ESRD in Parts A and B and in MA. The report is required to include information on whether the amount of data under Parts A and B on ESRD beneficiaries is sufficient for determining payments for MA enrollees with ESRD. The report is required to be submitted not later than December 31, 2023.

Section 17006 requires the HHS Secretary to change certain aspects of risk adjustment starting in 2019. The HHS Secretary is required to take into account the total number of diseases or conditions of an MA enrollee and make additional adjustments as the number of diseases or conditions of an individual increases. The HHS Secretary is required to make separate risk adjustments for beneficiaries who are full-benefit dual-eligible beneficiaries and those who are *not* full-benefit dual-eligible beneficiaries. The HHS Secretary is required to evaluate the impact of additional diagnosis codes related to mental health and substance-use disorders in the risk-adjustment model. The HHS Secretary also is required to evaluate the impact of including the severity of chronic kidney disease in the model and to evaluate whether other ESRD factors should be taken into consideration. In addition, the HHS Secretary may use at least two years of diagnosis data for risk adjustment. Any changes to risk adjustment are required to be phased in over a three-year period, beginning in 2019 with such changes being fully implemented for 2022 and subsequent years. The HHS Secretary is required to provide an opportunity for review and comment for a period of not less than 60 days before implementing such changes.

Section 17006 requires MedPAC to evaluate the impact of provisions in this section on risk scores for enrollees in MA and payments to plans, including the impact on overall accuracy of risk scores. MedPAC is required to submit the report, along with recommendations, by no later than July 1, 2020.

Section 17006 requires the HHS Secretary to submit a report to Congress no later than December 31, 2018, and at least every three years thereafter, on the risk-adjustment model and the ESRD risk-adjustment model under MA. The report is to include any revisions to the model since the last report and how changes impact predictive ratios under MA, including for the very high and very low cost enrollees and for groups defined by chronic conditions.

Section 17006 requires the comptroller general to conduct a study on how to most accurately measure functional status of enrollees in MA plans and whether the use of such status would improve the accuracy of risk adjustment. This report, along with recommendations, is required to be submitted to Congress by no later than June 30, 2018.

Section 17007. Improvements to the Assignment of Beneficiaries Under the Medicare Shared Savings Program

The Medicare Shared Savings Program (MSSP) was established by the ACA as a type of accountable care organization (ACO) that “promotes accountability for a patient population and coordinates items and services under Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.” By statute, Medicare FFS beneficiaries would be assigned to MSSP ACOs “based on their utilization of [Medicare] primary care services provided ... by an ACO professional,” defined as a physician or practitioner under current law.

Provision

Section 17007 modifies the requirements for the assignment of Medicare beneficiaries to MSSP ACOs beginning January 1, 2019. In addition to considering the care furnished by a primary care physician or practitioner, primary care services furnished by a federally qualified health center or a rural health clinic to a Medicare FFS beneficiary also will be used in determining assignment to MSSP ACOs.

Title XVIII—Other Provisions

Section 18001. Exception from Group Health Plan Requirements for Qualified Small Employer Health Reimbursement Arrangements

Health reimbursement arrangements (HRAs) are employer-established arrangements that pay or reimburse employees for substantiated medical care expenses up to a maximum dollar amount.¹⁹ HRAs are funded solely by employers; employees cannot contribute to HRAs directly or through salary reduction agreements. Employers choose how much to contribute to employees’ HRAs. Payments and reimbursements for medical care expenses generally are excluded from the employee’s income (i.e., are not subject to taxes), provided the HRA meets specified requirements.

Current, former, and retired employees and their spouses and dependents are eligible to participate in HRAs. An HRA can only be used to pay or reimburse individuals for substantiated medical care expenses. *Medical care* is defined in the Internal Revenue Code (IRC) Section 213(d); medical care expenses include amounts paid for the “diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.”²⁰ They also include certain transportation and lodging expenditures, amounts paid for health insurance premiums and qualified long-term care costs, and long-term care insurance premiums that do not exceed certain amounts. If a distribution is, or can be, made from the HRA

¹⁹ Health reimbursement arrangements (HRAs) are not defined in the tax code but are described in Internal Revenue Service (IRS) guidance. See, for example, IRS Notice 2002-45.

²⁰ Internal Revenue Code (IRC) §213(d)(1)(A).

for payment or reimbursement of anything other than medical care expenses, all distributions from the HRA in that tax year are included in the employee's income (i.e., are subject to taxes).

In September 2013, the Department of the Treasury, HHS, and Department of Labor issued guidance in which the agencies determined that, in general, an HRA must be integrated with another group health plan (that is not an HRA) to comply with two requirements that apply to group health plans.²¹ The two requirements are described below.

- Prohibition on annual limits: Group health plans are prohibited from having dollar limits on the amount the plan will spend for covered health benefits during a plan year.
- Preventive services requirement: Group health plans must provide coverage for certain preventive health services without imposing cost sharing.

Employers that offer group health plans that do not comply with one or both of these requirements—including an HRA that is not integrated with a non-HRA group health plan—could be subject to an excise tax of \$100 per day per employee covered under the noncompliant arrangement.

A salient aspect of the guidance (and subsequent follow-up guidance) is that it specifically addresses HRAs that pay or reimburse employees for health insurance coverage purchased in the non-group, or individual, market.²² In general, the guidance provides that an HRA that can be used for such purposes may not be integrated with a non-HRA group health plan and therefore is not in compliance with the prohibition on annual limits and the preventive service requirement.²³

The guidance issued in September 2013 was effective for plan years beginning January 1, 2014,²⁴ however, transition relief was provided for small employers in guidance issued by the Internal Revenue Service (IRS) in April 2015.²⁵ Under the transition relief, a small employer is one with fewer than 50 full-time-equivalent employees.²⁶ Employers eligible for the transition relief did not have to comply with the requirements of the September 2013 guidance until after June 30, 2015.

²¹ IRS Notice 2013-54; Department of Labor Technical Release 2013-03. The agencies reasoned that the two requirements should apply because HRAs are generally considered group health plans under IRC §9832(a), Employee Retirement Income Security Act (ERISA) §733(a), and PHSa §2791(a). The guidance also applies to employer payment plans under which an employer provides reimbursement of premiums for an employee's non-group health insurance policy.

²² IRS Notice 2015-17; IRS Notice 2015-87.

²³ The IRS identifies circumstances in which the restriction on using HRA funds for coverage purchased in the non-group market does not apply. For example, the restriction does not apply to retiree-only HRAs, as defined as having fewer than two current employees on the first day of the plan year. Similarly, the restriction does not apply to HRAs that reimburse or directly pay the premiums for non-group policies that only offer excepted benefits. Excepted benefits are defined at IRC Section 9831(b) and include, among other things, accident-only coverage, disability income, and certain limited-scope dental and vision benefits. For more information, see IRS Notices 2013-54, 2015-17, and 2015-87.

²⁴ IRS Notice 2013-54; Department of Labor Technical Release 2013-03.

²⁵ IRS Notice 2015-17.

²⁶ The transition relief applies to all employers that are not considered applicable large employers (ALEs) for purposes of IRC §4980H (shared responsibility for employers regarding health coverage). In general, employers with fewer than 50 full-time equivalent employees are not considered ALEs, but see IRC §4980H and its implementing regulations for details about determining ALE status.

Provision

Section 18001(a)(1) creates qualified small employer health reimbursement arrangements (SEHRAs). A SEHRA is an arrangement offered by an eligible employer that pays or reimburses employees for substantiated medical expenses. A SEHRA can only be funded by an employer. Employees cannot contribute to a SEHRA directly or via salary reduction agreement. Payments and reimbursements from the SEHRA cannot exceed \$4,950 per year for self-only coverage or \$10,000 per year for coverage that includes family members. (These dollar amounts are prorated for part-year employees and are indexed for inflation in future years.) The maximum dollar amount of payments or reimbursements an employee can receive under a SEHRA in a year is referred to as the *permitted benefit*.

An employer must provide a SEHRA “on the same terms” to all “eligible employees.” A SEHRA does not fail the test of “on the same terms” simply because employees’ permitted benefits vary in accordance with permitted variations for age and family size in the price of insurance policies available in the non-group market. An eligible employee is any employee of the employer, except that the terms of the SEHRA may exclude certain types of employees as described in IRC Section 105(h)(3)(B).²⁷ An eligible employee’s family members’ expenses are eligible for reimbursement from the SEHRA. Eligible family members are determined “under the terms of the arrangement.”

SEHRAs generally are exempted from the definition of group health plan; therefore, they do not have to comply with requirements that apply to group health plans.²⁸ As a result, SEHRAs are not subject to the requirement, as interpreted by the agencies in the 2013 guidance, that applies to HRAs to be integrated with a (non-HRA) group health plan or the restriction on the use of payments or reimbursements for coverage purchased in the non-group market.

Employers eligible to offer SEHRAs are those with fewer than 50 full-time-equivalent employees that do not offer group health plans to any of their employees.²⁹ No later than 90 days prior to the beginning of a year in which an employer provides SEHRAs to its employees, the employer must provide written notification to its employees. The notification must include the following content:

- the amount of the permitted benefit the employee is eligible to receive under the SEHRA;
- a statement telling the employee that he or she should provide information about the permitted benefit when applying to a health insurance exchange for premium tax credits (as provided under IRC Section 36B); and
- a statement explaining that if the employee is not covered by minimum essential coverage for any month in which the individual is eligible to receive reimbursements from a SEHRA, the individual could be subject to the penalty for not complying with the requirement to maintain health insurance coverage (IRC Section 5000A) and reimbursements from the SEHRA could be included in gross income.

Section 18001(a)(5) imposes a fine on employers that fail to provide this notification as required. The fine is equal to \$50 per employee per failure, limited to a maximum fine of \$2,500 per calendar year for all such failures.

²⁷ This is applied to IRC §105(h)(3)(B) by substituting “90 days” for “three years” in 105(h)(3)(B)(i).

²⁸ An exception to this exemption—related to IRC §4980I—is discussed in a subsequent paragraph.

²⁹ Technically, employers that are not considered ALEs for purposes of IRC §4980H are allowed to offer small employer health reimbursement arrangements (SEHRAs).

Under Section 18001(a)(2), payments and reimbursements from a SEHRA are excludable from an employee's income as long as the payments and reimbursements are for medical care expenses (as defined in IRC Section 213(d)) and the medical care is received in a month when the individual is covered by minimum essential coverage (as defined in IRC Section 5000(f)).

Section 18001(a)(3) provides that if an employee's SEHRA constitutes affordable coverage (as discussed below), the employee is not eligible to receive a premium tax credit for non-group coverage purchased through an exchange. If an employee's SEHRA does not constitute affordable coverage, the employee may be eligible to receive a premium tax credit; however, the credit amount the employee is eligible to receive in a month would be reduced (but not below zero) by an amount equal to one-twelfth of the permitted benefit amount for the SEHRA. A SEHRA constitutes affordable coverage in a month if the monthly premium for self-only coverage for the second-lowest-cost silver plan available to the employee through an exchange that is over one-twelfth of the employee's permitted benefit amount does not exceed one-twelfth of 9.5% of the employee's household income. (The formula is prorated for part-year employees, and the 9.5% is indexed for inflation in future years.)

Section 18001(a)(4) provides that with respect to IRC Section 4980I (the excise tax on high-cost employer-sponsored health insurance), the definition of group health plan includes SEHRAs. As a result, when an employer calculates the cost of the health coverage it provides to each of its employees for purposes of determining whether the employer is subject to the excise tax, the employer must include the amounts contributed to employees' SEHRAs.

Section 18001(a)(6) provides that employers must report information about permitted benefits under a SEHRA on employees' W-2 forms.

Section 18001(a)(7) provides that, in general, all amendments made by Section 18001 are effective for years beginning after December 31, 2016. Additionally, the subsection extends the transition relief provided under IRS Notice 2015-17 for small employers through December 31, 2016.

Section 18001(b) and (c) amend the Employee Retirement Income Security Act (ERISA) and the PHSA, respectively, to generally exempt SEHRAs from the definition of group health plan. The amendments apply to plan years beginning after December 31, 2016.

Appendix. List of Abbreviations

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

ACI: Advancing Care Information

ACO: Accountable Care Organization

ALE: Applicable Large Employer

ALOS: Average Length of Stay

ANPR: Advance Notice of Proposed Rulemaking

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

ASC: Ambulatory Surgical Center

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

BBA 1997: Balance Budget Act of 1997 (P.L. 105-33)

BBA 2015: Bipartisan Budget Act of 2015 (P.L. 114-74)

CY: Calendar Year

CAA 2016: Consolidated Appropriations Act of 2016 (P.L. 114-113)

CAH: Critical Access Hospital

CBO: Congressional Budget Office

CEHRT: Certified Electronic Health Records Technology

CHIP: Children’s Health Insurance Program

CMS: Centers for Medicare & Medicaid Services

DRG: Diagnosis Related Group

DME: Durable Medical Equipment

DMEPOS: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

EHR: Electronic Health Record

ERISA: Employee Retirement Income Security Act

ESRD: End-Stage Renal Disease

FFS: Fee-For-Service

FY: Fiscal Year

HCPCS: Healthcare Common Procedure Code System

HHS: Department of Health and Human Services

HI: Hospital Insurance

HITECH: Health Information Technology for Economic and Clinical Health Act

HOPD: Hospital Outpatient Department

HRA: Health Reimbursement Arrangement

HRRP: Hospital Readmission Reduction Program
ICD: International Classification of Diseases
IMPACT: Improving Medicare Post-Acute Care Transformation Act of 2014 (P.L. 113-185)
IPPS: Inpatient Prospective Payment System
IRC: Internal Revenue Code
IRS: Internal Revenue Service
LTCH: Long-Term Care Hospital
MA: Medicare Advantage
MACRA: Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10)
MedPAC: Medicare Payment Advisory Commission
MIPS: Merit-Based Incentive Payment System
MMA: Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173)
MMSEA: Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173)
MPFS: Medicare Physician Fee Schedule
MS-DRG: Medicare Severity Diagnosis Related Group
MSSP: Medicare Shared Savings Program
OPD: Outpatient Department
OPPS: Outpatient Prospective Payment System
PAMA: Protecting Access to Medicare Act of 2014 (P.L. 113-93)
PBD: Provider-Based
PCH: Prospective Payment System-Exempt Cancer Hospitals
PCR: Payment-to-Cost Ratio
PDP: Prescription Drug Plan
PHSA: Public Health Service Act
PPS: Prospective Payment System
RCH: Rural Community Hospital
SEHRA: Small Employer Health Reimbursement Arrangement
SMI: Supplementary Medical Insurance
SPA: Competitive Bidding Single Payment Amount

Author Contact Information

Namrata K. Uberoi, Coordinator
Analyst in Health Care Financing
nuberoi@crs.loc.gov, 7-0688

Cliff Binder
Analyst in Health Care Financing
cbinder@crs.loc.gov, 7-7965

Patricia A. Davis
Specialist in Health Care Financing
pdavis@crs.loc.gov, 7-7362

Susannah V. Gopalan
Analyst in Health Care Financing
sgopalan@crs.loc.gov, 7-3351

Jim Hahn
Specialist in Health Care Financing
jhahn@crs.loc.gov, 7-4914

Annie L. Mach
Specialist in Health Care Financing
amach@crs.loc.gov, 7-7825

Paulette C. Morgan
Specialist in Health Care Financing
pcmorgan@crs.loc.gov, 7-7317

Marco A. Villagrana
Analyst in Health Care Financing
mvillagrana@crs.loc.gov, 7-3509