National Conference of State Legislatures - Office of State-Federal Relations
444 North Capitol Street, N.W. Suite 515 Washington, D.C. 20001
(202) 624-8689 (202) 737-1069 fax

PROTECTING ACCESS TO MEDICARE ACT
(Public Law 113-93)

Prepared by: Joy Johnson Wilson, Health & Human Services Policy Director
April 8, 2014

TABLE OF CONTENTS

THE PROTECTING ACCESS TO MEDICARE ACT: IN BRIEF

The Protecting Access to Medicare Act (H.R. 4302; P.L. 113-93) is an "extender" bill, a bill that extends expiring program authorizations and/or appropriations and provides for the necessary "offsets" to pay for the extensions. Extension bills also may amend existing programs, authorize new programs and provide direction to federal agencies regarding existing programs. Often the extension bill extends program extensions from the previous year(s). This is the case with the current Act. The previous extension bills were: The American Taxpayers Relief Act of 2012, signed into law on January 2, 2013 as P.L. 112-240 and the Continuing Appropriations Resolution, 2014 was signed into law as P.L. 113-67 and included the Bipartisan Budget Agreement and the Pathway to SGR Reform Act of 2013. The Protecting Access to Medicare Act was signed into law on April 1, 2014, just in time to prevent a scheduled 24% reduction in Medicare physician reimbursement rates.

The Protecting Access to Medicare Act extends the authorization for physician reimbursement under Medicare under current law (Sustainable Growth Rate or SGR) through March 31, 2015, postponing the efforts to reform and improve Medicare physician reimbursement methodology or the "Doc Fix" yet again. It also extends a number of Medicare program authorizations, including a number of provisions of particular interest to rural health providers. The Act extends the following Medicaid programs: Qualified Individuals (QI), Temporary Medical Assistance (TMA), the Medicaid and CHIP Express Lane Eligibility Programs. It also proposes savings from the Medicaid Disproportionate Share Hospital (DSH) Program, amending similar provisions in the previous extension bills. **The Act also delays the implementation of previously adopted Medicaid third party liability changes from October 1, 2014 to October 1, 2016**. Among the other program extensions of note are the extensions of the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program and two teen pregnancy prevention programs. Finally the Act authorizes two new mental health programs: (1) a demonstration program to improve community mental health services; and (2) a grant program that would provide assisted outpatient treatment for individuals with serious mental illness. Many of the provisions in this Act will expire prior to the end of FY 2015, which would then require another extension bill early next year if no other action is taken to address the expiring program authorizations or appropriations.

SUMMARY: PROTECTING ACCESS TO MEDICARE ACT

ISSUE	SECTION NUMBER	DESCRIPTION	5-YEAR/10-YEAR SAVINGS/COSTS
MEDICARE EXTENSIONS			
Medicare Sustainable Growth Rate (SGR) Formula Extension ("Doc Fix")	**101**	The Act extends the current Medicare physician reimbursement rates until April 1, 2015, preventing the 23.7% cut that was scheduled to occur April 1, 2014. The $15.8 billion cost of the one-year doc fix and the cost of other extensions is fully offset by $22.1 billion in health-related spending reductions, resulting in $1.2 billion in deficit reduction over 10 years.	$25.2 billion

ISSUE	SECTION NUMBER	DESCRIPTION	5-YEAR/10-YEAR SAVINGS/COSTS
Extension of the Medicare Work Geographic Adjustment	**102**	The Act extends the adjustment through 2013 the Medicare Work Geographic Adjustment[1] through April 1, 2015.	$300 million
Extension of the Exemptions for Outpatient Therapy Payments	**103**	The Act extends the payment cap exemptions for outpatient therapy payments through March 31, 2015. Medicare sets annual per beneficiary payment caps for non-hospital outpatient therapy services, but permits providers to seek an exemption if the therapy is deemed medically necessary.	$800 million
Extension of Ambulance Add-on Payments	**104**	Extension of the Ground Ambulance and Super Rural Ambulance Add-On Payment –The Act extends the add-on payments through April 1, 2015. Extension of the Air Ambulance Add-On Payment - The Act extends the add-on payments through April 1, 2015.	$100 million
Extension of the Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals	**105**	The Act extends the Low Volume Hospital Program[2] through March 31, 2015.	$300 million
Extension of the Medicare-Dependent Hospital Program	**101**	The Act extends the Medicare Dependent Hospital (MDH) Program[3] through March 31, 2015.	$100 million
Extension of the Special-Needs Medicare Advantage Plans	**107**	The Act extends until January 1, 2017 the availability of Medicare Advantage Plans available to individuals with special needs.[4]	$200 million

[1] The Medicare physician fee schedule is adjusted to reflect the differences in the cost of providing services in different geographic areas. The adjustment is based on three factors: (1) physician work; (2) practice expense and; (3) the cost of medical malpractice insurance.

[2] This program provides additional Medicare funding to hospitals in rural communities that are more than 15 road miles from another comparable hospital and have fewer than 1,600 Medicare discharges per year.

[3] The program currently provides funding for 200 rural hospitals through special Medicare rates resulting from high populations of Medicare patients. A hospital qualifies for the MDH Program if it is located in a rural area, has 100 beds or fewer, is not a "sole community hospital" and has at least 60 percent of inpatient days or discharges covered by Medicare.

[4] Medicare Special Needs Plans (SNPs) are a type of Medicare Advantage Plan (like an HMO or PPO). Medicare SNPs limit membership to people with specific diseases or characteristics, and tailor their benefits, provider choices, and drug formularies (list of covered drugs) to best meet the specific needs of the groups they serve.

ISSUE	SECTION NUMBER	DESCRIPTION	5-YEAR/10-YEAR SAVINGS/COSTS
Extension of Medicare Reasonable Cost Contracts	**108**	The Act extends Medicare Reasonable Cost Contracts[5] through January 1, 2016.	$100 million
Extension of Funding for Quality Measure Endorsement, Input and Selection	**109**	Makes available $12.5 million for the first six months of 2015 for a contract with a consensus-based entity to make recommendations on an integrated national strategy and priorities for health care performance measurements and quality measure endorsements. The funds would remain available until expended.	Less than $50 million
Extension of Funding Outreach and Assistance for Low-Income Programs	**110**	The Act extends through March 31, 2015 and provides additional funding by direct appropriation to the programs below. **State Health Insurance Programs[6] –** Appropriates $7.5 million for FY 2014; and $3.75 million for FY 2015, before April 1, 2015. **Additional Funding for Area Agencies on Aging –** Appropriates $7.5 million for FY 2014; and $3.75 million for FY 2015 before April 1, 2015. **Additional Funding for Aging and Disability Resource Centers –** Appropriates $7.5 million for FY 2014; and $3.75 million for FY 2015, before April 1, 2015. **Additional Funding for Contract with the National Center for Benefits and Outreach Enrollment[7] –** Appropriates $5 million for FY 2014; and $2.5 million for FY 2015 before April 1, 2015.	Less than $50 million
Extension of Two-Midnight Rule	**111**	The Act allows HHS to continue medical review activities described in the	Less than $50 million

[5] Reasonable cost plans are Medicare Advantage (MA) plans that are reimbursed by Medicare for the actual cost of providing services to enrollees. The Balanced Budget Act of 1997 included a provision to phase-out the reasonable cost contracts, however, the phase-out has been delayed over the years through congressional action. These plans are allowed to operate indefinitely, unless two other plans of the same type (i.e., either 2 local or 2 regional plans) offered by different organizations operate for the entire year in the cost contract's service area. Under prior law, after January 1, 2010, the Secretary could not extend or renew a reasonable cost contract for a service area if: (1) during the entire previous year there were either two or more MA regional plans or two or more MA local plans in the service area offered by different MA organizations; and (2) these regional or local plans meet minimum enrollment requirements. The ACA extended the cost contract provision for three years—from January 1, 2010, to January 1, 2013.

[6] State Health Insurance Assistance Programs (SHIPs) provide counseling and assistance to Medicare beneficiaries, their families and caregivers regarding health insurance coverage and other supportive services. SHIPs are in the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam.

[7] Housed within the National Council on Aging (NCOA), the National Center for Benefits and Outreach Enrollment helps organizations enroll seniors and younger adults with disabilities with limited means into the benefits programs for which they are eligible. The National Council on Aging is a nonprofit service and advocacy organization headquartered in Washington, D.C. and serves as a national voice for older Americans and the community organizations that serve them.

ISSUE	SECTION NUMBER	DESCRIPTION	5-YEAR/10-YEAR SAVINGS/COSTS
		notice "Selecting Hospital Claims for Patient Status Reviews: Admissions On or After October 1, 2013," through the first six months of FY 2015. It bars HHS from conducting patient status reviews, however, on a post-payment basis through recovery audit contractors unless there is evidence of systematic gaming, fraud, abuse or delays in the provision of care. [8]	
Technical Change to Medicare Long Term Care Hospital Amendments	**112**	The Act makes technical and other changes to the treatment of Medicare Long Term Care Hospitals (LTCHs).[9] The technical amendments become effective on the date of enactment.	$100 million
MEDICAID AND CHILDRENS HEALTH INSURANCE PROGRAM (CHIP) EXTENSIONS			
Qualified Individual (QI) Program Extension	**201**	The Act extends the Qualified Individual (QI) program[10] and funds it through March 2015. The Act allocates the funding as follows: $485 million for the period ending Sept. 30; $300 million for the period October1 – December 31; and $250 million for January 1- March, 31 in 2015.	$800 million
Transitional Medical Assistance (TMA) Program Extension	**202**	The Act extends the Transitional Medical Assistance (TMA) program[11] through March 31, 2015.	Less than $50 million
Extension of the Medicaid and Childrens Health Insurance Program (CHIP) Express Lane Eligibility Program	**203**	The Act extends the CHIP Express Lane program option[12] through September 30, 2015.	Less than $50 million

[8] Under the two-midnight rule, surgical procedures, diagnostic tests and certain other treatments are generally appropriate for inpatient hospital admission and payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses at least two midnights and admits the beneficiary to the hospital based upon that expectation. Last fall, the Centers for Medicare and Medicaid Services (CMS) issued guidance to Medicare administrative contractors about how to select hospital claims for review under this rule for admissions that occurred from Oct. 1, 2013 through March 31, 2014.

[9] The December 2013 budget agreement (P.L. 113-67, The Bipartisan Budget Agreement and the Pathway to SGR Reform Act of 2013) extended a moratorium on the establishment of and increase in beds for certain long-term care hospitals and facilities through FY 2017. The bill creates exceptions from this moratorium for long-term care hospitals that began their qualifying periods for payment as a long-term care hospital before the date of enactment; have a binding written agreement with an outside party for the construction or demolition for a long-term care hospital and have expended at least 10% of the cost of the project; or have obtained an approved certificate of need in a state where one is required.

[10] The Qualified Individual (QI) program allows Medicaid to pay the Medicare Part B premium for qualifying low-income individuals.

[11] The Transitional Medical Assistance (TMA) Program provides continued medical coverage for certain families who become ineligible for Medicaid because of increased earnings.

[12] The CHIP Express Lane Eligibility (ELE) Program enables state Medicaid and CHIP agencies to identify, enroll, and recertify children by relying on eligibility findings from other federal assistance programs, such as Head Start or Food Stamps, in lieu of conducting a separate eligibility process under Medicaid or CHIP.

ISSUE	SECTION NUMBER	DESCRIPTION	5-YEAR/10-YEAR SAVINGS/COSTS
OTHER HEALTH EXTENSIONS			
Extension of the Special Diabetes Program for Type I Diabetes and for Indians	**204**	The Act reauthorizes the Special Diabetes Program for Type 1 Diabetes[13] and the Special Diabetes Program for Indians (SPDI)[14] through September 30, 2015.	$300 million
Extension of the State Abstinence Education Grant Program	**205**	The Act extends the authorization for the State Abstinence Education Grant program (AEGP)[15] through FY 2015 and continues the mandatory authorization of $50 million annually for the program.	Less than $50 million
Personal Responsibility Education Program Extension	**206**	The Act extends the authorization for the Personal Responsibility Education Program (PREP)[16] through FY 2015.	$100 million
Extension of Family-to-Family	**207**	The Act extends the Family-to-Family Information Center program[17] through	Less than $50

[13] The Special Statutory Funding Program for Type 1 Diabetes Research, or Special Diabetes Program, is a special appropriation that the National Institutes of Health's (NIH) National Institutes of Diabetes and Digestive and Kidney Disease (NIDDK) administers on behalf of the HHS Secretary, in collaboration with multiple NIH Institutes and Centers and the Centers for Disease (CDC), for research on the prevention and cure of type 1 diabetes.

[14] Congress established the initial Special Diabetes Program for Indians (SDPI) through the Balanced Budget Act of 1997 and augmented support for the Program through the Consolidated Appropriations Act of 2001 and House Resolution 5738 in 2004. SDPI funding was reauthorized in 2007 and again in 2008 extending it through fiscal year 2011. In December 2010, Congress extended the SDPI for two additional years through fiscal year 2013, at the funding level of $150 million a year. The SDPI provides grants for diabetes treatment and prevention services to 404 Indian Health Service (HIS), Tribal, and Urban Indian health programs.

[15] The State Abstinence Education Grant Program (AEGP) provides funding to states and territories for abstinence education, and where appropriate, mentoring, counseling and adult supervision to promote abstinence from sexual activity. Projects focus on those groups most likely to bear children out of wedlock. , including youth, ages 10 to 19, who are homeless, in foster care, live in rural areas or geographic areas with high teen birth rates, or come from racial or ethnic minority groups. The Affordable Care Act (ACA) authorized and appropriated funding for AEGP for FYs 2010-2014. AEGP funds are distributed based on the proportion of low-income children in each state or territory. States must fund at least 43 percent of the project's total cost with non-federal resources. For further information about AEGP, contact the National Clearinghouse on Families & Youth, 5515 Security Lane, Suite 800, North Bethesda, MD 20852; (301) 608-8098; e-mail: ncfy@acf.hhs.gov.

[16] Under the Personal Responsibility Education Program (PREP) Act, authorized as part of the Affordable Care Act, the Family and Youth Services Bureau (FYSB) within the U.S. Department of Health and Human Services, awards grants to state agencies to educate young people on both abstinence and contraception to prevent pregnancy and on the prevention of sexually transmitted infections, including HIV/AIDS. The program targets at-risk youth ages 10-19 and also supports pregnant youth and mothers under the age of 21. PREP projects replicate effective, evidence-based program models or substantially incorporate elements of projects that have been proven to delay sexual activity, increase condom or contraceptive use for sexually active youth, or reduce pregnancy among youth. Through a systematic review, the Department of Health and Human Services (HHS) selected 28 models that states could use, depending on the needs and age of the target population in each state. FYSB provides PREP funding as formula grants to states. All States and U.S. Territories are eligible to apply for a minimum of $250,000 per year for FY 2015. Allotments are calculated based on the number of young people in each state or territory. States can administer the project directly or through sub-awards to public or private entities. For further information about PREP, contact the National Clearinghouse on Families & Youth, 5515 Security Lane, Suite 800, N. Bethesda, MD 20852; (301) 608-8098; e-mail: ncfy@acf.hhs.gov.

[17] The Family-to-Family Information Center program provides grants to nonprofit service providers that provide care to special-needs children and their families.

ISSUE	SECTION NUMBER	DESCRIPTION	5-YEAR/10-YEAR SAVINGS/COSTS
Information Centers		March 31, 2015 and provides $2.5 million for the period April 1, 2015 through the end of 2014 and $2.5 million in 2015 through March 31, 2015.	million
Extension of Health Workforce Demonstration Project for Low-Income Individuals	**208**	The Act extends the Health Workforce Demonstration Program through FY 2015. The program provides grants to conduct demonstration projects designed to provide low-income individuals with an opportunity to receive an education and training for occupations in the health care field. Eligible entities include states, Indian tribes or tribal organizations, institutions of higher education, a local workforce investment board, or a sponsor of an apprenticeship program.	$100 million
Maternal, Infant, and Early Childhood Home Visiting Program Extension	**209**	The Act extends through March 31, 2015, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.[18]	$400 million
Pediatric Quality Measures	**210**	The Act directs the HHS Secretary to use up to $15 million of existing funding appropriated for adult quality measure development for children's quality measure development.	0
OTHER HEALTH PROVISIONS			

[18] The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program facilitates collaboration and partnership at the federal, state, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs. Authorized in the Affordable Care Act (ACA), the statutory purposes of the program are to (1) strengthen and improve the programs and activities carried out under Title V of the Social Security Act; (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. MIECHV includes grants to states and six jurisdictions; and grants to Indian Tribes, Tribal Organizations, and Urban Indian Organizations. The legislation requires that grantees demonstrate improvement among eligible families participating in the program in six benchmark areas: (1) Improved maternal and newborn health; (2) Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; (3) Improvement in school readiness and achievement; (4) Reduction in crime or domestic violence; (5) Improvements in family economic self-sufficiency; and (6) Improvements in the coordination and referrals for other community resources and supports. MIECHV is an evidence-based policy initiative and the authorizing legislation requires that the majority of grant funds be spent on programs to implement evidence-based home visiting models. Currently, 14 home visiting models meet the HHS criteria for evidence-based home visiting. Additionally, up to 25 percent may be spent on promising approaches that must be rigorously evaluated. For additional information on the MIECHV, click here http://mchb.hrsa.gov/programs/homevisiting.

ISSUE	SECTION NUMBER	DESCRIPTION	5-YEAR/10-YEAR SAVINGS/COSTS
Delay of Effective Date for Medicaid Provisions Relating to Beneficiary Liability Settlements	**211**	The Act delays the implementation of Medicaid third party liability changes[19] enacted in the Bipartisan Budget Act (P.L. 113-67) from October 1, 2014 to October 1, 2016.	$200 million
One-Year Delay in Transition from ICD-9 to ICD-10 Code Sets	**212**	The Act bars HHS from adopting ICD-10 code sets[20] as the standard in reporting patient diagnoses and hospital inpatient procedures, replacing the less complex ICD-9 system, prior to October 1, 2015. The code sets were scheduled to become effective October 1, 2014 and apply to all HIPAA-covered entities, including state Medicaid programs.	Less than $50 million
Repeals the Limitation on Deductibles for Small Group Employer-Sponsored Health Plans	**213**	The Act eliminates the annual limitation on deductibles in small group health insurance plans, as provided for in the Affordable Care Act (ACA).[21]	0
GAO Report on the Children's Graduate Medical Education Program	**214**	The Act directs the U.S. Government Accountability Office (GAO), to submit a report to Congress on the Children's Hospital Graduate Medical Education Program (CHGME) by November 2017 and to assess the number of hospitals applying and receiving payments under the program, how much each hospital receives, how hospitals use the payments, and the impact of the payments.	0
MENTAL HEALTH DEMONSTRATION/GRANT PROVISIONS			
Demonstration Programs to Improve Community Mental Health Services	**223**	Under the community mental health services program, no more than eight states would be selected for two-year demonstration programs. HHS would pay participating states a federal matching percentage for amounts spent by the state to provide medical assistance for mental health services under the	$600 million $1.1 billion

[19] The Act delays the effective date of Medicaid amendments relating to beneficiary liability settlements adopted in the Bipartisan Budget Act (P.L.113-67), from October 1, 2014 to October 1, 2016. The Bipartisan Budget Act made three changes to Medicaid third-party liability law to affirm Medicaid's position as payer of last resort. All three changes were to become effective October 1, 2014. These changes modified mandatory exceptions to the requirement that state Medicaid agencies reject medical claims when another entity is legally liable to pay the claim. The law would: (1) allow a state to delay payment for prenatal and preventive pediatric care for 90 days after the date the provider initially submitted a claim to the third party payer, if the state determines doing so is cost-effective and will not adversely affect access to care; and (2) allow a state to delay payment for 90 days for services where child support enforcement is being carried out; however, the state could continue to make payment within 30 days, if it found that to be cost-effective and necessary to ensure access to care; and (3) give states the ability to recover costs from the full amount of a beneficiary's liability settlement, instead of only the portion of the settlement designated for medical expenses and established an option for states to place liens against Medicaid beneficiaries' liability settlements.

[20] For additional information on the conversion from ICD-9 to ICD 10, go to the Centers for Medicare and Medicaid Services (CMS) website and view the ICD-10 FAQs at http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10FAQs2013.pdf.

[21] Under the ACA, deductibles cannot exceed $2,000 for plans covering single individuals or $4,000 for any other plan. The limits are indexed to a premium adjustment percentage for calendar years after 2014.

ISSUE	SECTION NUMBER	DESCRIPTION	5-YEAR/10-YEAR SAVINGS/COSTS
		demonstration programs — but no federal payments would be made for inpatient care, residential treatment, room and board expenses, or other non-ambulatory services. The HHS Secretary is directed to publish, no later than September 1, 2015, criteria for a clinic to be certified by a state as a "certified behavioral health clinic" for purposes of participating in this demonstration program. The criteria must address staffing, availability and accessibility of services; care coordination, scope of services, quality and other reporting, and organizational authority. The Secretary, through the Administrator of the Centers for Medicare and Medicaid Services (CMS), is also directed to provide guidance for the establishment of a prospective payment system for this demonstration program, no later than September 1, 2015. The Act directs the Secretary to award planning grants to states for the development of demonstration proposals by January 1, 2016 and to select states to participate in the demonstration program by September 1, 2017. The Act appropriates a total of $27 million for the demonstration programs, including $25 million for planning grants.	
Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness	**224**	The Act establishes a four-year pilot program to award up to 50 grants each year to eligible entities for assisted outpatient treatment programs for individuals with serious mental illness (SMI). Grants under this program would be no more than $1 million for each of FY 2015– FY 2018 and authorizes the appropriation of a total of $60 million for FY 2015-FY 2018. Funding for this program is subject to the annual appropriation process.	0
OFFSET PROVISIONS			
Skilled Nursing Facility Value-Based Purchasing Program	**215**	The Act establishes a value-based Medicare program for making payments to skilled nursing facilities, which would take into account hospital readmission rates and requires HHS to establish an all-cause, all-condition hospital readmission performance measurement for skilled nursing facilities no later than October 1, 2015, and a similar performance measure to reflect a risk-adjusted potentially preventable hospital readmission rate for skilled nursing facilities no later than October 1, 2016. The Act requires HHS, beginning in FY 2017 and every subsequent quarter, to provide feedback reports to skilled nursing facilities on their performance with regard to the new measures and would make the performance information	-$2 billion

ISSUE	SECTION NUMBER	DESCRIPTION	5-YEAR/10-YEAR SAVINGS/COSTS
		publicly available no later than FY 2018 and to create a skilled nursing facility value-based purchasing program (i.e., a payment program) under which incentives are provided each year to skilled nursing facilities using the readmission and resource use performance measures, beginning in FY 2019. The performance measures would include levels of achievement and improvement, and HHS would use the higher of either in calculating a facility's performance score. HHS would rank skilled nursing facility performance scores from low to high and increase federal per diem rates for higher-performing facilities. The Act directs the Medicare Payment Advisory Commission (MedPAC)[22] to report to Congress on the progress of the skilled nursing facility value-based purchasing program no later than June 30, 2021. Funding for the value-based incentive payments would come from an across-the-board 2% reduction in the adjusted federal per diem rate for all skilled nursing facilities, beginning in FY 2019. The Act provides for the one-time transfer of $12 million from the Federal Hospital Insurance Trust Fund for program management.	
Improving Medicare Policies for Clinical Diagnostic Laboratory Tests	**216**	The Act changes the way Medicare pays for clinical laboratory tests to more closely align the reimbursements with market rates. Beginning in 2016, it requires the reporting of private sector payment rates for advanced diagnostic laboratory tests in order to establish Medicare payment rates and allows HHS to apply a civil penalty of up to $10,000 per day to private laboratories that fail to report or that misrepresent their data. Payments for clinical diagnostic laboratory tests furnished under Medicare after January 1, 2017, would align with a weighted median payment for the test under the collected private laboratory data. It creates a phase-in period through 2022 so reductions in payments do not initially exceed a certain percentage. The Act establishes	-$1 billion -$2.5 billion

[22] The Medicare Payment Advisory Commission (MedPAC) is an independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. The Commission's statutory mandate is quite broad: In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare. The Commission's 17 members bring diverse expertise in the financing and delivery of health care services. Commissioners are appointed to three-year terms (subject to renewal) by the Comptroller General and serve part time. Appointments are staggered; the terms of five or six Commissioners expire each year. Two reports -- issued in March and June each year -- are the primary outlet for Commission recommendations. In addition to these reports and others on subjects requested by the Congress, MedPAC advises the Congress through other avenues, including comments on reports and proposed regulations issued by the Secretary of the Department of Health and Human Services, testimony, and briefings for congressional staff. For additional information on MedPAC, click here http://www.medpac.gov.

ISSUE	SECTION NUMBER	DESCRIPTION	5-YEAR/10-YEAR SAVINGS/COSTS
		special rules for payment for new tests. Specifically, it requires HHS to consult with an outside expert advisory panel of molecular pathologists, researchers, and experts on health economics to provide input on establishing payment rates. To help implement the new payment rates system, the measure provides for the transfer of $35 million for FY 2014 through FY 2023 from the Federal Supplementary Medicaid Insurance Trust Fund, to remain available until expended.	
Revisions under the Medicare End-Stage Renal Disease (ESRD) Prospective Payment System	**217**	The Act makes a number of revisions under the Medicare End-Stage Renal Disease (ESRD) Prospective Payment System, including those relating to payments for kidney drugs. The Act bars HHS from implementing a policy relating to oral-only ESRD-related drugs in the ESRD prospective payment system prior to January 1, 2024. The fiscal cliff law enacted at the beginning of 2013 included a two-year delay of the policy, to January 2016. The Act also extends for an additional year, to January 1, 2015, a policy in the fiscal cliff law related to payments for renal dialysis services that requires HHS to take into account certain data on average sales prices and the utilization of certain drugs. It outlines certain calculations for increase factors for 2016 through 2018.	-$100 million -$1.8 billion
Quality Incentives for Computed Tomography Diagnostic Imaging and Promoting Evidence-Based Care	**218**	The Act includes quality incentives for computed tomography (CT) diagnostic imaging, including a reduction in payments for services that use equipment inconsistent with the CT equipment standard. It directs HHS to establish a program promoting the utilization of appropriate use criteria for certain imaging services. Beginning in 2020, the Act requires health care professionals who are outliers in their ordering of advanced imaging tests, to apply for prior authorization for applicable imaging services. The measure provides for the transfer of $15 million for this purpose.	Less than $50 million -$200 million
Using Funding from Transitional Fund for Sustainable Growth Rate Reform	**219**	The Act uses funds from a military pension law (P.L. 113-82), enacted February 2014 that extended the Medicare sequestration for FY 2014 to help pay for the repeal of previously enacted reductions to cost-of-living-adjustments for certain military retirees and set aside $2.3 billion of the savings in a Transitional Fund for Sustainable Growth Rate (SGR) Reform to help pay for either a permanent overhaul of the SGR or another temporary patch. Those funds are being used to help offset the cost of extending the "doc fix" for another year.	-$2.3 billion
Ensuring Accurate Valuation of	**220**	The Act allows HHS to collect or obtain information on physicians' services in	-$600 million

ISSUE	SECTION NUMBER	DESCRIPTION	5-YEAR/10-YEAR SAVINGS/COSTS
Services under the Physician Fee Schedule		determining relative values in providing medical services. Data could include time involved in furnishing services, prices for practice expense inputs and information on the overhead costs of physician practices. The Act provides for the transfer of $2 million for each fiscal year for the data collection.	-$4 billion
Medicaid Disproportionate Share Hospital (DSH) Program	**221**	The Act delays scheduled reductions in payments to Disproportionate Share Hospitals (DSH).[23] The Act postpones currently scheduled reductions by an additional year, to FY 2017, and extends the reductions by four years, to FY 2024.[24] The Act sets the reduction at $4.7 billion for FY 2018; $5 billion for FY 2022 and FY 2023, then reduces it to $4.4 billion for FY 2024.	$2.9 billion -$4.4 billion

[23] States receive an annual DSH allotment to cover the costs of DSH hospitals that provide care to low-income patients that are not paid by other public or private payers. The allotment is calculated through a statutory formula. The Affordable Care Act (ACA) modified DSH payments, reducing the rates as the availability of health insurance subsidies and state exchanges were to become available in 2014.

[24] **DSH Reductions FY 2014 – FY 2024 (ACA, Bipartisan Budget Act (P.L. 113-67) and Continuing Appropriations Resolution, 2014 (P.L. 113-93) -- (in millions of dollars)**

Fiscal Year	ACA	P.L. 113-67	P.L. 113-93
2014	-500	0	0
2015	-600	0	0
2016	-600	-1,200	0
2017	-1,800	-1,800	-1,800
2018	-5,000	-5,000	-4,700
2019	-5,600	-5,600	-4,700
2020	-4,000	-4,000	-4,700
2021	0	-4,000	-4,800
2022	0	-4,200	-5,000
2023	0	-4,300	-5,000
2024	0	0	-4,400
Total Savings - FY 2014-FY 2024	**-14,500**	**-30,100**	**-35,100**

Sources: Federal Funds Information for States (FFIS), *President Signs Bill to Extend Health Programs, Delay DSH Reductions*, Issue Brief 14-13, April 7, 2014. For additional information go to www.ffis.org; Congressional Budget Office, *Cost Estimate for the Protecting Access to Medicare Act of 2014,* http://www.reuters.com/investigates/adoption/#article/part1

ISSUE	SECTION NUMBER	DESCRIPTION	5-YEAR/10-YEAR SAVINGS/COSTS
		The Act also requires the Medicaid Payment and Access Commission (MACPAC)[25] to review and submit an annual report to Congress on disproportionate share hospitals, including data relating to changes in uninsured individuals and data on hospitals' uncompensated care costs. The first report is to be submitted to Congress no later than February 1, 2016, and would be submitted each fiscal year through 2024.	
Realignment of the Medicare Sequester for FY 2024	**222**	The Act amends the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings Act) to adjust the 2% maximum reduction for specified Medicare programs for FY 2024 under any presidential sequester order to make it 4% for the first six months of FY 2024 and 0% for the last 6 months.	**0** -$4.9 billion

[25] The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan, federal agency charged with providing policy and data analysis to the Congress on Medicaid and CHIP, and for making recommendations to the Congress and the Secretary of the U.S. Department of Health and Human Services, and the states on a wide range of issues affecting these programs. Appointed by the U.S. Comptroller General, the 17 commissioners have diverse backgrounds, offer broad perspectives on Medicaid and CHIP, and represent different regions across the United States. As required in its statutory charge, the Commission submits reports to the Congress by March 15 and June 15 of each year. The statute requires that each member of the Commission vote on recommendations contained in the reports. The Commission's reports are intended to provide the Congress with a better understanding of the Medicaid and CHIP programs, their roles in the U.S. health care system, and key policy and data issues. For additional information on MACPAC, click here www.macpac.gov.