Summary of Medicare and Medicaid Provisions included in the
Bipartisan Budget Act of 2013
and the Pathway for SGR Reform Act of 2013,
as passed by the House (12/12/13) and the Senate (12/18/13)

On December 12, 2013 the House passed legislation (House Joint Resolution 59) that among other provisions, establishes appropriations funding limits for fiscal years 2014 and 2015, provides a three-month “patch” that delays the reduction in Medicare physician payments that would otherwise occur in January 2014, eliminates cuts in the federal limits on Medicaid disproportionate share hospital (DSH) payments for FYs 2014 and 2015 while increasing the cuts in later years, extends sequestration for an additional two years, extends a number of expiring provisions of Medicare law, and makes other changes that affect the Medicare and Medicaid programs.

Bipartisan Budget Act of 2013

Two-Year Extension of Sequester. The Budget Control Act of 2011, as later amended by the American Taxpayer Relief Act of 2013, imposes sequestration over a nine-year period. In general, the sequestration reduces spending for federal fiscal years 2013 through 2021. However, for Medicare, the sequester will reduce by 2 percent payments for items and services furnished during the nine-year period beginning April 1, 2013 through March 31, 2022.1 (Medicaid and most other mandatory spending programs are exempt entirely from sequestration.)

The Bipartisan Budget Act extends sequestration on non-exempt mandatory spending programs for two additional years, which means sequestration for Medicare will be in place through March 31, 2024. As discussed further below, the Pathway to SGR Reform Act modifies the Medicare sequester levels during the last 12-month period. Specifically, instead of a 2 percent reduction, the sequester level for the first 6 months of that period (April 1 through September 30 of 2023) will be 2.9 percent, and the level will be reduced to 1.1 percent for the final six months of the last year the sequester for Medicare (October 1, 2023 through March 31, 2024).

Sequestration will continue for all programs currently subject to it, including payments to qualified health plans in the Exchanges for cost sharing subsidies and any small business tax credit payments made in excess of tax liability under the Affordable Care Act. Advanced payments of health insurance premium tax credits for eligible individuals enrolled in Exchange coverage continue to be exempt from sequestration.

CBO estimates that across all affected programs, extending sequestration on non-exempt mandatory programs for two years will save $28 billion. The Medicare portion of this total is not broken out in the CBO score, but Medicare is expected to be the bulk of the savings because most other mandatory programs are exempt from sequestration. In its May 2013 Medicare

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1 The law exempts certain Medicare program expenditures from sequester. These include the Part D low-income subsidies, the Part D catastrophic subsidy, and premium subsidies provided to beneficiaries under the Qualified Individual program.
baseline, CBO estimates about $10 billion in savings from Medicare in what was then the final full year of sequestration, ending in March 2022.

**Increase in appropriations caps.** The caps that limit available appropriations funding for all discretionary spending programs are increased for FYs 2014 and 2015. For non-security discretionary programs, which include the National Institutes of Health, the Food and Drug Administration and other health-related agencies as well as other non-security programs, the FY 2014 appropriations cap is increased by $22.4 billion, to $491.8 billion. In 2015, the increase is $9.2 billion, with a cap of $492.4 billion. Actual program appropriations levels will be determined in separate legislation. Under the continuing resolution enacted in October (PL 113-46), discretionary programs are funded through January 15, 2014.

**Medicaid Third-Party Liability.** Two changes are made regarding Medicaid third-party liability, effective October 1, 2014. First, with respect to prenatal and preventive pediatric claims (including early periodic screening and diagnosis services), states may elect to make payment only if a liable third party has not paid within 90 days, if the state determines that doing so is cost-effective and will not adversely affect access to care. States may similarly delay payment when health insurance is available from a non-custodial parent. Second, changes are made to broaden the ability of states to recover costs from beneficiary liability settlements.

### Pathway to SGR Reform Act of 2013

**Physician Fee Schedule.** A 0.5 percent update is provided for the Medicare physician fee schedule conversion factor for January through March 2014 (thereby blocking the Sustainable Growth Rate cut slated to take effect on January 1, 2014). In addition, the 1.0 floor for the work geographic practice cost index (GPCI) under the Medicare physician fee schedule is extended through March 2014. CBO scores the update as costing $7.3 billion over ten years (FY 2014-FY 2023); the GPCI provision cost is $0.1 billion.

**Therapy caps.** Extends the therapy cap exceptions process through March 2014.

**Ambulance add-ons.** Extends the following Medicare ambulance payment policies through March 31, 2014:

- A 3 percent payment increase for covered ground ambulance transports that originate in a rural area or rural census tract of a metropolitan statistical area
- A 2 percent payment increase for covered ground ambulance transports that do not originate in rural areas or rural census tracts
- A 22.6 percent Super Rural Bonus for ground ambulance services originating in “super rural” areas.

**Low-volume hospitals.** Delays until April 1, 2014 the application of mileage and discharge criteria that would narrow eligibility for the Medicare inpatient hospital payment adjustment for low-volume hospitals in FY 2014.
Medicare-Dependent Hospitals. Extends the Medicare-Dependent, Small Rural Hospital Program, which expired on September 30, 2013, through March 31, 2014.

Special Needs Plans. Extends authorization for special needs plans under the Medicare Advantage program through December 31, 2015.

Reasonable cost contracts. Delays until January 1, 2015 provisions that would have prohibited the extension or renewal of Medicare reasonable cost reimbursement contracts in certain service areas (those with 2 or more Medicare Advantage regional plans or 2 or more Medicare Advantage local plans, provided that such plans are not offered by the same Medicare Advantage organization).

National Quality Forum. Extends funding for the contract with a consensus-based entity regarding performance measurement (currently the National Quality Forum) by allowing amounts previously transferred from the Medicare Trust Funds for fiscal years 2009 through 2013 to remain available until expended.

Outreach and assistance programs. Extends funding for the following outreach and assistance programs for low income Medicare beneficiaries (via transfers from the Medicare Trust Funds) for the portion of FY 2014 before April 1, 2014:

- $3.75 million for State health insurance programs;
- $3.75 million for Area Agencies on Aging;
- $2.5 million for Aging and Disability Resource Centers; and
- $2.5 million for the National Center for Benefits and Outreach Enrollment.

Additional programs extended through March 31, 2014.

- Qualifying Individual (QI) Program. $200 million for the period from January 1, 2014 through March 31, 2014.
- Transitional Medical Assistance (TMA) Program.
- Family-to-Family Health Information Centers. $2.5 million for the portion of FY 2014 prior to March 31, 2014.

Delay of Medicaid DSH reductions. Reductions required under the Affordable Care Act (ACA) in the limits on federal spending (called state allotments) for state disproportionate share hospital payments are modified. Eliminated are reductions in DSH allotments totaling $500 million each for FYs 2014 and 2015. For FY 2016, the aggregate reduction in DSH allotments is increased from $600 million to $1.2 billion. In addition, the reductions are extended into FY 2023. CBO scores the total ten-year federal savings from these changes as $3.9 billion.

Realignment of Sequester. Taking into account the two-year extension of sequestration, the last year of the Medicare sequester begins April 1, 2023 and ends March 31, 2024. For the first six months of that period (April 1, 2023 through September 30, 2023), the Medicare sequester level will be 2.9 percent instead of 2 percent. For the second six months (October 1, 2023 through March 31, 2024) the sequester level will be 1.1 percent. This provision appears to be capturing a
portion of Medicare savings resulting from the two-year sequester extension that would otherwise fall outside the current ten year budget scoring window, which ends September 30, 2023. CBO scores this provision as saving $2.1 billion in FY 2023. However, because it is shifting the timing of sequester payments, this score does not represent an increase in the total amount of savings from final year of the Medicare sequester. Some difference could occur, however, depending on the distribution of items services furnished during the two six-month periods.

**Payment for Long Term Care Hospitals (LTCHs).** Beginning in FY 2016, payments to LTCHs will be based on a ‘site neutral payment rate’ that is the lower of either the comparable inpatient prospective payment system (IPPS) per diem rate, including outlier payments, or service costs. The site neutral payment will be phased in so that for FYs 2016 and 2017 it is weighted as 50 percent of the payment, with the other 50 percent the payment rate that would otherwise be in effect. For FY 2018 and later, payment will be based fully on the site neutral payment rate. Exceptions are provided for discharges that do not have a principal diagnosis relating to rehabilitation or a psychiatric diagnosis, were immediately preceded by a stay in an acute care hospital and meet one of two criteria:

- the acute-care hospital stay included at least three days in an intensive care unit, or
- the individual was assigned to a LTCH diagnosis group based on the receipt of ventilator services of at least 96 hours.

CMS will inform LTCHs of the percentage of its discharges for which payment is not made at the site neutral rate, and beginning in FY 2020, if the percentage is less than 50 percent, the LTCH will be paid as if it were an IPPS hospital. CMS must also create a process for a hospital to “requalify” for payment under the LTCH PPS.

In calculating the length of stay requirement for LTCHs, CMS will exclude patients for whom payment was made on the site-neutral rate and Medicare Advantage patients. An exception is provided for certain acute care hospitals currently seeking to convert to LTCH status.

LTCH payment rules regarding hospitals-within-hospitals, the 25 percent patient threshold payment adjustment are extended to December 29, 2016. However, a permanent exemption from the 25 percent patient threshold is provided to those long-term care hospitals grandfathered under BBA section 4417(a). The moratorium on the establishment or classification of some new long-term care hospitals or increases in bed capacity enacted in 2007 expired on December 29, 2012; this legislation imposes a new moratorium on the establishment or classification of all new long-term care hospitals as well as a moratorium on all increases in bed capacity from January, 1, 2015 through September 30, 2017.

The Secretary is required to establish a functional status quality measure for change in mobility for inpatients requiring ventilator support. Also, the Secretary must evaluate payment rates for those long-term care hospitals with significant numbers of discharges with a principal diagnosis reflecting a finding of neoplastic disease currently not paid under the IPPS or the LTCH IPPS, and may adjust payment rates to those hospitals as well as make changes to other regulations governing those hospitals.
The Medicare Payment Assessment Commission will conduct a study and report by June 30, 2019 on the effect of the new payment policy on quality of care in LTCHs, use of hospice and post-acute care, different types of LTCHs, and growth in Medicare spending for LTCHs. The report will include recommendations regarding the payment policy and the continued application of the 25 percent rule.

CBO scores this package of LTCH changes as saving $3 billion over FYs 2015-2023.