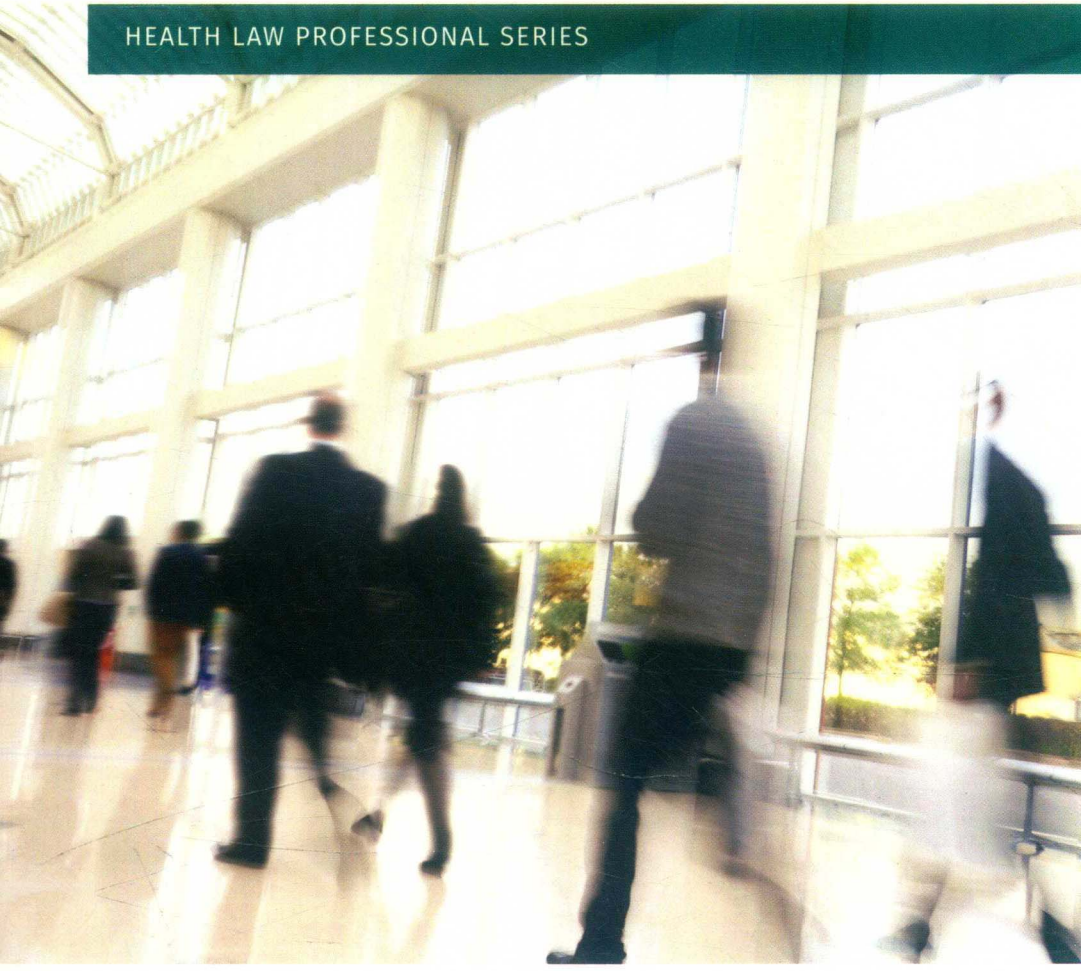
2017

Medicare Explained

HEALTH LAW PROFESSIONAL SERIES



Wolters Kluwer

2017 Medicare Explained

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Foreword

This book has been prepared for Medicare beneficiaries and others who need a relatively thorough explanation of the Medicare program with particular emphasis on services covered in institutional settings and services provided by physicians and suppliers.

Published annually, this book includes changes made by law and regulation amendments and by updates to program manuals issued by the Centers for Medicare and Medicaid Services (CMS). This edition includes changes issued during 2016 that affect Medicare beneficiaries and providers in 2017.

The 2017 highlights are as follows:

Medicare Part A (hospital insurance). For 2017, the inpatient hospital deductible will be $1,316 per each beneficiary "spell of illness," an increase from the $1,288 inpatient deductible in 2016. Patients are responsible for a coinsurance amount for each day after the 60th and through the 90th day per spell of illness, and in 2017 daily coinsurance amounts will be $329 for the 61st through 90th day of hospitalization. When Medicare patients use their lifetime reserve days in 2017, their coinsurance will be $658 per day. When Medicare patients are patients in skilled nursing facilities in 2017, their coinsurance will be $164.50 for the 21st through 100th day of skilled nursing facility care (see ¶ 220, ¶ 242).

Medicare Part B (supplementary medical insurance). Most people with Medicare Part B will be "held harmless" from any increase in premiums in 2017 and will pay about $109. The Part B premium for beneficiaries not subject to the "hold harmless" provision, i.e., those not collecting Social Security benefits, those who will enroll in Part B for the first time in 2017, dual-eligible beneficiaries who have their premiums paid by Medicaid, and beneficiaries who pay an additional income-related premium, will be $134.

Income-adjusted premiums for 2017 are as follows: Individuals with modified adjusted gross income (MAGI) greater than $85,000 but less than or equal to $107,000 and couples with MAGI greater than $170,000 but less than or equal to $214,000 will pay a monthly premium of $187.50. Individuals with MAGI greater than $107,000 but less than or equal to $160,000 and couples with MAGI greater than $214,000 and less than or equal to $320,000 will pay a monthly premium of $267.90. Individuals with MAGI greater than $160,000 but less than or equal to $214,000 and couples with MAGI greater than $320,000 and less than or equal to $428,000 will pay a monthly premium of $348.30. Individuals with MAGI greater than $214,000 and couples with MAGI greater than $428,000 will pay a monthly premium of $398.80. The rates are modified slightly for beneficiaries who are married and lived with their spouse at any time during the taxable year but file a separate tax return from their spouse (see ¶ 320).

For 2017, the Part B deductible will be $183 (see ¶ 335).

Beginning January 1, 2017, Part B covers renal dialysis services furnished by a renal dialysis facility or provider of services to an individual with acute kidney injury, defined as an individual who has acute loss of renal function and does not receive renal dialysis services for which payment is made under the end-stage renal disease (ESRD) prospective payment system (see ¶ 389).

The 21st Century Cures Act (P.L. 114-255) provides separate coverage of home infusion therapy effective January 1, 2021, which includes the following services furnished in a beneficiary's home: (1) professional services, including nursing services, furnished in accordance with the plan of care; and (2) training and education (not otherwise paid for as durable medical equipment), remote monitoring, and monitoring services for the provision of home

infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. Home infusion therapy will be specifically excluded from the definition of home health services (see ¶ 390).

Physician reimbursement. The physician fee schedule payment amount for a service is determined by a formula that takes into consideration the relative value unit for the service, the conversion factor for the year, and the geographic adjustment factor for the service. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) changed how the conversion factor is updated. Under MACRA, starting in 2019, the amounts paid to individual providers will be subject to adjustment through one of two mechanisms, depending on whether the physician chooses to participate in an Advanced Alternative Payment Model (APM) program or the Merit-Based Incentive Payment System (MIPS) program (see ¶ 855).

Medicare Part C (managed care plans). The 21st Century Cures Act also made several significant changes to the Part C program. Beginning in 2021, individuals with ESRD will be permitted to enroll in MA plans. Starting in 2019, there will be an open enrollment period during the first three months of the year for Medicare Advantage (MA)-eligible individuals, during which an individual who is enrolled in an MA plan will be permitted to change his or her election at any time (see ¶ 401). Beginning January 1, 2021, organ acquisitions for kidney transplants will no longer be covered under Part C and instead will be covered by Parts A and B (see ¶ 402).

Medicare Part D (prescription drug plans). The Comprehensive Addiction and Recovery Act of 2016 (P.L. 114-198) provides, effective for plan years beginning after January 1, 2019, for two programs intended to prevent drug abuse under Part D: (1) a drug management programs for at-risk beneficiaries; and (2) utilization management tools to prevent drug abuse (see ¶ 525).

For 2017, beneficiaries in standard prescription drug plans (PDPs) will be subject to a $400 deductible. In 2017, beneficiaries in the coverage gap will continue to receive a 50 percent discount on brand-name drugs. PDPs also must pay another 5 percent, providing Part D beneficiaries with total coverage of 55 percent in the donut hole (see ¶ 507).

For 2017, the national average monthly bid amount for a PDP will be $61.08, down from $64.66 in 2016. The 2017 base beneficiary premium is $35.63, up from $34.10 in 2016. High-income beneficiaries are subject to income-adjusted premiums for Part D, just as they are for Part B. For 2017, the income-related monthly adjustment amount for a PDP premium will be $13.30 for an individual with MAGI greater that $85,000, but not more than $107,000; $34.20 for an individual with MAGI greater than $107,000, but not more than $160,000; $55.20 for an individual with MAGI greater than $160,000, but not more than $214,000; and $76.20 for an individual with MAGI greater than $214,000. In the case of a joint tax return, the MAGI dollar amounts are doubled (see ¶ 505).

Quality of care. CMS will continue to implement a number of quality of care initiatives in 2017, many of which will affect provider and facility reimbursement.

MACRA consolidates and replaces the electronic health record meaningful use program, Physician Quality Reporting System, and the value-based payment modifier into the MIPS program. MACRA will sunset the three programs at the end of 2018 (see ¶ 855).

Inpatient hospitals that do not submit required quality data on specific quality indicators to the Medicare program each year will have their applicable hospital market basket percentage increase reduced by 2 percent. Similarly, Medicare payments to hospitals can be reduced under the Hospital Readmissions Reduction Program and the Hospital-Acquired

Condition Reduction Program, and hospitals can earn incentives under the Hospital Inpatient Value-Based Purchasing Program (see ¶ 810).

Outpatient hospitals that fail to report on quality measures in 2017 will have their payments reduced by 2.0 percent in calendar year 2019. To ensure that hospitals are accurately reporting quality of care measures for chart-abstracted data, CMS may validate one or more measures by reviewing documentation of patient encounters submitted by selected participating hospitals. CMS requires outpatient hospitals to achieve a minimum 75 percent validation score based on this validation process to receive the full update (see ¶ 820).

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