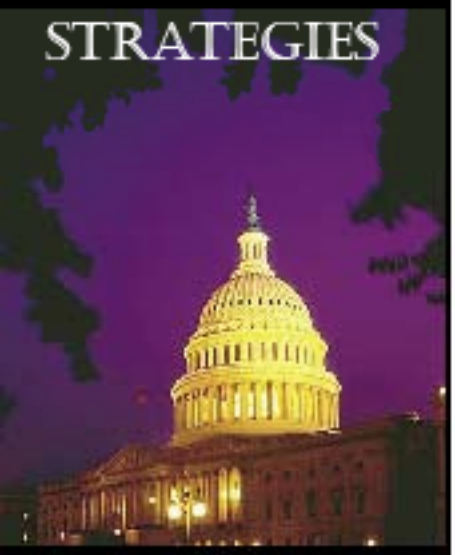
HART HEALTH STRATEGIES



Health Policy Briefing

February 20, 2012

Congress Passes Doc-Fix/Payroll-Tax-Cut Extenders; President's FY 2013 Budget DOA

Congress Passes Doc Fix/Payroll Tax Cut Extender Legislation

In a rush of self congratulation, the conferees on H.R. 3630, the Middle Class Tax Relief and Job Creation Act of 2012, finally reached agreement late last week on the provisions extending the payroll tax cut, unemployment benefits and so-called Doc-Fix. The House first cleared the bill on a vote of 293-132 and the Senate followed suit on a vote of 60-36, despite 30 Republican "no" votes. The President said he would promptly sign the bill into law.

While the payroll tax extension was not paid for, the extension to 12/31/2012 of the current rate of payment under the Medicare physician payment system was paid for with several health related ten-year offsets of about $18 billion. The extension avoids the 27% cut in MD payment rates scheduled to begin March 1st.

Several other Medicare/ Medicaid provisions would increase costs, including (see Appendix for more details):

(1) the extension of the adjustment to the work portion of MD payments in certain geographic areas where such payments would fall below a given floor;

(2) the extension through March of Medicare Inpatient Prospective Payment System (IPPS) payments for Section 508 hospitals;

(3) the extension through year-end of outpatient hold harmless payments for certain eligible rural hospitals and sole community hospitals (SCHs) with fewer than 100 beds;

(4) the extension through year-end of certain therapy cap exceptions;

(5) the extension through year-end of a provision allowing certain independent laboratories to bill Medicare directly;

(6) the extension through year-end of certain ambulance add-on payments;

(7) the extension through year-end of the Medicare QI program; and

(8) the extension through year-end of transitional medical assistance for certain low-income families.

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The ten year offsets for the $21.2 billion cost of these health related extensions include:

- a phase-down of bad debt payments to hospitals, SNFs, FQHCs and dialysis centers ($6.9 billion);

- a 2% reduction in clinical laboratory payment rates ($2.7 billion); a rebasing of DSH allotments ($4.1 billion);

- the elimination of the PPACA Louisiana hurricane related health subsidy ($2.5 billion); and

- a reduction in the funding of the PPACA Prevention and Public Health Fund ($5 billion).

The extension of the Doc-Fix limited to the end of this year almost guarantees that a lame-duck session of Congress will again have to hash out another fix shortly after the November elections. Some members decried the lost opportunity to use so-called "war savings" to provide the estimated ten-year $300 billion funding needed to permanently fix the SGR problem under the Medicare physician payment system. Another potential lame-duck fight could arise over the need to increase the federal debt limit. **Treasury Secretary Timothy Geithner** told the Senate Budget Committee that the $16.4 trillion limit could be breached before year end or extended, possibly, into early next year if the economy continues to generate higher tax receipts.

OMB Releases President's FY 2013 $ Trillion Budget

Last Monday the OMB released **President Obama's** FY 2013 budget recommendations which include $76.4 billion in discretionary spending for HHS, an increase of $260 million from this fiscal year. The Senate is not expected to bring the President's budget to a vote, nor any alternative, according to **Senate Majority Leader Harry Reid.**

Key elements of the budget include the following discretionary spending proposals for HHS agencies: CMS: $4.8 billion, up $864 million; FDA: $4.5 billion, up $864 million (with about 45% from user fees); NIH: $30.7 billion, level; CDC: $5.1 billion, down $664 million; SAMHSA: $3.2 billion, down $228 million; HRSA: $6.1 billion, down $140 million; Indian Health Service: $4.4 billion, up $115 million.

HHS Secretary Kathleen Sebelius said that proposed reforms under Medicare and Medicaid would reduce the federal deficit by $366 billion over 10 years. The budget also recommends an additional $1 billion increase to implement the PPACA, including about $860 million for health exchanges. The Medicare and Medicaid "reform" proposals are similar to the Administration's FY 2012 recommendations, including: cutting payments for hospital bad debts; reducing Medicare GME payments; reducing drug costs for dual-eligibles (e.g. banning "pay for delay" agreements, etc.); introducing higher income beneficiary cost sharing; increasing the Medicare Part B deductible; instituting new copayments for home health services; increasing Medigap premiums; providing a single blended rate for Medicaid and SCHIP funding; limiting state provider taxes which fund the state share of Medicaid; adjusting the payment rates for DME; and eliminating funding for Area Health Education Centers.

Of note, the budget also proposes to reduce and reallocate funding under the PPACA Prevention and Public Health Fund, a recommendation which helped ease the $5 billion reduction in the fund used as a cost offset for the temporary Doc-Fix described above.

In general, the budget does not include a proposed long-term fix for the SGR problem under the Medicare physician payment system. Instead, the Administration said that "to promote more honest and transparent budgeting, the budget includes an adjustment totaling $429 billion over 10 years … to reflect the Administration's best estimate of the cost of future congressional action based on what Congress has done in recent years for physician payments." Republicans were critical of the President's recommendations or lack thereof. For example, **House Ways and Means Committee Chairman Dave Camp** said that again "the President has refused to address the looming bankruptcy in our entitlement programs…." Given the stalemate between the House and Senate as to FY 2013 budget matters, the provisions of the President's budget are instructive of possible changes that a successor Congress may take after the November elections.

Hearings on PPACA Contraceptive Mandate

The House Government Oversight and Reform Committee held contentious hearings on the HHS/PPACA rule requiring health insurers and self-insured sponsors of health plans covering religious based organizations, such as universities and non-profits, to provide women's contraceptive coverage at no cost to plan participants. Various religious organizations testified that the rule violates first amendment rights guaranteeing religious freedom while women's groups argued that the rule appropriately advances women's health measures. **Senate Majority Leader Harry Reid** announced that he will allow a vote this week on an amendment to be offered by **Senator Roy Blunt** (to an unrelated transportation bill, S. 1813) which would negate the PPACA-based mandate for such religious organizations.

Additional Briefs Filed in PPACA Constitutional Case

The Department of Justice filed its latest brief with the Supreme Court arguing that the expanded Medicaid eligibility required under the PPACA is properly exercised under Article I of the constitution. The brief filed earlier by 26 states argued that the expansion would overtax state budgets and that the provision amounted to a coercive action by the federal government to force states to comply or forfeit all federal Medicaid matching funds. The DOJ said the coercion argument "is nothing more than an argument that the citizens of their States would hold them politically responsible for either the reduction in benefits that would result from opting out of Medicaid or for the increased taxation needed to fund those benefits entirely at the state level" and that "Congress has broad authority to attach conditions to federal spending in order to further federal policy objectives…." Also, several private organizations, such as the Cato Institute and the Landmark Legal Foundation, filed briefs arguing that the individual mandate to purchase health insurance is unconstitutional in that the "outermost bounds" of the commerce clause "stops Congress from reaching intrastate non-economic activity regardless of its effect on the economy" and that the individual mandate is an "unprecedented and unconstitutional police power" supported by neither the commerce clause nor the necessary and proper clause.

Data Consolidation Under the PPACA

The Health Resources and Services Administration has proposed transferring all of the data in the Healthcare Integrity and Protection Data Bank to the National Practitioner Data Bank and eliminating the operations of the HIPDA. Under the proposed rule, all data would be reported only to the NPDB.

ICD-10 Coding Delayed

CMS announced that the agency is likely to delay the PPACA's required implementation by FY 2014 of the International Classification of Diseases, 10th Revision (ICD-10), coding system for classifying health care diagnoses and procedures. CMS said the agency will later announce its rulemaking agenda regarding the requirement.

Senate and House FDA Hearings

At a Senate Finance Committee hearing, **Senator Ron Wyden** and other members asked **HHS Secretary Kathleen Sebelius** to take proactive steps to prevent the shortage of prescription drugs, particularly pediatric cancer drugs, which have become more prevalent over time. The Secretary responded that advance notification might prevent "market glitches" and allow for alternative sources to be found and said HHS would work with senators who have introduced legislation, S. 1813, which would require mandatory notification to the FDA and the public of impending drug shortages. Also, at a House Energy and Commerce Health Subcommittee hearing on medical device safety, the Director of the FDA Center for Devices and Radiological Health said that the FDA's regulations are not hurting innovation and that more can be done to meet the agency's goals. **Chairman Joe Pitts** had this to say about the FDA agreement with manufacturers over user fees: "What is best for patients, and what is best for jobs, is to have a device review process that is clear, transparent, predictable, and accountable. I hope that is what the proposed agreement accomplishes." However, consumer advocates said that they think the user fee agreement fails to make any patient safety improvements and falls short of providing the resources needed to meet increasing demands on the FDA.

Medicare Overpayment Recovery Rule

CMS announced a proposed rule which would require Medicare providers to return overpayments (e.g. for non-covered services, duplicate payments, errors, etc.) within 60 days of such a determination. Comments are due by April 16th.

Coburn/Burr Medicare Reform Proposal

Senators Tom Coburn and Richard Burr announced their plans to introduce a Medicare reform proposal which they said would save between $200-500 billion over ten years. In general, the plan would restructure Medicare along the Medicare Part D model, increase the age of eligibility to 67 over time, raise premiums for higher-income beneficiaries, limit eligibility to Medigap insurance coverage, and combine the deductibles for Part A and Part B, among other things.

S. 2103 (CHILDREN'S HEALTH), to amend Title 18, United States Code, to protect pain-capable unborn children in the District of Columbia, and for other purposes; LEE; to the Committee on Homeland Security and Governmental Affairs, Feb. 13.

S. 2106 (DEFIBRILLATORS), to establish a grant program for automated external defibrillators in elementary schools and secondary schools; BROWN of Ohio; to the Committee on Health, Education, Labor, and Pensions, Feb. 14.

H.R. 4023 (VETERANS' HEALTH), to amend Title 38, U.S. Code, to improve the use of teleconsultation, teleretinal imaging, telemedicine, and telehealth coordination services for the provision of health care to veterans, and for other purposes; HOCHUL; to the Committee on Veterans' Affairs, Feb. 14.

H.R. 4031 (NATIVE AMERICAN HEALTH), to provide that claims presented to an Indian Health Service contracting officer pursuant to the Indian Self-Determination and Education Assistance Act on or before Oct. 31, 2005, involving claims that accrued after Oct. 1, 1995 and on or before Sept. 30, 1999, shall be deemed timely presented; YOUNG of Alaska; to the Committee on Natural Resources, Feb. 14.

H.J. Res. 102 (FEDERAL BUDGET), resolution proposing a balanced budget amendment to the U.S. Constitution; CHABOT; to the Committee on the Judiciary, Feb. 14.

S. 2113 (FDA), to empower the Food and Drug Administration to ensure a clear and effective pathway that will encourage innovative products to benefit patients and improve public health; HAGAN; to the Committee on Health, Education, Labor, and Pensions, Feb. 15.

H.R. 4042 (VETERANS' HEALTH), to amend the Public Health Service Act to designate certain medical facilities of the Department of Veterans Affairs as health professional shortage areas, and for other purposes; BRALEY of Iowa; to the Committee on Energy and Commerce, Feb. 15.

S. 2118 (INDEPENDENT PAYMENT ADVISORY BOARD), to remove unelected, unaccountable bureaucrats from seniors' personal health decisions by repealing the Independent Payment Advisory Board; CORNYN; read the first time, Feb. 16.

S. 2119 (CHILDHOOD OBESITY), to establish a pilot program to address overweight/obesity among children from birth to age 5 in child care settings and to encourage parental engagement; UDALL of Colorado; to the Committee on Health, Education, Labor, and Pensions, Feb. 16.

H.R. 4053 (FRAUD, WASTE AND ABUSE), to intensify efforts to identify, prevent, and recover payment error, waste, fraud, and abuse within federal spending; TOWNS; to the Committee on Oversight and Government Reform, Feb. 16.

H.R. 4056 (DRUGS/MEDICAL DEVICES), to amend the Federal Food, Drug, and Cosmetic Act to prevent a state or political subdivision thereof from conducting or requiring duplicative inspections of establishments in which a drug or device is manufactured, processed, packed, or held by a manufacturer or wholesale distributor of the drug or device; BILBRAY; to the Committee on Energy and Commerce, Feb. 16.

H.R. 4065 (MEDICARE), bill to amend Title XVIII of the Social Security Act to provide parity to Puerto Rico hospitals with respect to inpatient hospital payments under Medicare; PIERLUISI; to the Committee on Ways and Means, Feb. 16.

H.R. 4066 (MEDICARE/MEDICAID), to amend titles XVIII and XIX of the Social Security Act to exclude pathologists from incentive payments and penalties under Medicare and Medicaid relating to the meaningful use of electronic health records; PRICE of Georgia; jointly, to the committees on Energy and Commerce and Ways and Means, Feb. 16.

Summary of Health-Related Provisions in the "Middle Class Tax Relief and Job Creation Act of 2012"

MEDICARE EXTENDERS

Section 3001 - Section 508 Hospital Payments – Under Medicare's Inpatient Prospective Payment System (IPPS), payments are adjusted by a wage index that is intended to reflect the cost of labor in the area where the services are furnished compared to a national average. This provision extends higher wage payments to certain eligible hospitals, known as "Section 508 hospitals," through March 31, 2012, after which time the program will terminate. These special payments were created in 2003 and were intended to last for just three years. However, subsequent legislation allowed these hospitals to continue receiving the higher funding, without ever having to reapply for the higher wage rate despite the fact that the 1,200+ hospitals that go through the standard wage reclassification process have to reapply every three years. CBO estimates this provision would increase spending by $100 million from 2012 through 2022.

Section 3002 - Hospital Outpatient Hold Harmless Payments –
This provision eliminates an expansion that was created in the PPACA and extends the outpatient hold harmless payments for eligible rural hospitals and sole community hospitals (SCHs) with fewer than 100 beds through December 31, 2012. The hold harmless payment provides a payment equal to 85 percent of the difference between an eligible hospital's outpatient prospective payment system (OPPS) and the hospital's costs. The provision also requires a study by the Department of Health and Human Services (HHS) on which types of hospitals truly need these payments in order to maintain beneficiary access to outpatient services. CBO estimates this provision would increase spending by $100 million from 2012 through 2022.

Section 3003 - Physician Payment Rates – This provision prevents a 27.4 percent cut in Medicare physician payment rates slated to begin on March 1, 2012, and instead freezes payment rates at their current level though December 31, 2012. This provision also requires the Government Accountability Office (GAO) and HHS to submit reports to assist Congress in the development of a long-term replacement to the current Medicare physician payment system. CBO estimates this provision would increase spending by $18 billion from 2012 through 2022.

Section 3004 - Physician Work Geographic Adjustment – This provision extends the floor on the adjustment to the work portion of payments for physician services that accounts for the geographic area where a physician practices. This provision increases payments to physicians in the 54 of the 89 Medicare geographic areas that would otherwise have an adjustment value below the floor. Additionally, the provision requires the Medicare Payment Advisory Commission (MedPAC) to examine whether any work geographic adjustment is needed, if so, at what level it should be applied, and the impact of the floor on beneficiary access to care. CBO estimates this provision would increase spending by $400 million from 2012 though 2022.

Section 3005 - Outpatient Therapy Caps – This provision extends the therapy caps exceptions process through December 31, 2012, with modifications that will require that the physician reviewing the therapy plan of care be detailed on the claim, reject all claims above the spending cap that do not include the proper billing modifier, and provide for a manual review of all claims for high cost beneficiaries to ensure that only medically necessary services are being provided. Furthermore, the spending caps ($1,880 in 2012), which have been in effect since 2006, would be extended to the hospital outpatient department setting to prevent a shift in the site of service to higher cost settings once enforcement of the current exceptions process begins. Exempting these services in the HOPD setting made sense when the hard therapy cap was in place, but it no longer makes sense with the exceptions process. Additionally, HHS is required to collect data to assist in reforming the payment system for therapy services. MedPAC is required to recommend improvements to the outpatient therapy benefit to reflect the individual needs of patients. CBO estimates this provision would increase spending by $700 million from 2012 through 2022.

Section 3006 - Payment for Technical Component of Certain Physician Pathology Services – This provision allows independent laboratories that have an arrangement with eligible hospitals to bill Medicare directly, as opposed to billing the hospital, for the surgical pathology services through June 30, 2012. This four-month extension provides time for the labs and hospitals to establish payment arrangements. Expiration after a reasonable transition period addresses concerns that Medicare is paying twice for the same service, which causes beneficiaries to make an extra co-payment. Minimal CMS oversight of the policy has also made Medicare susceptible to making inappropriate payments. The GAO has recommended that this policy expire. CBO estimates this provision would increase spending by less than $50 million from 2012 through 2022.

Section 3007 - Ambulance Add-On Payments – This provision would extend through December 31, 2012, the following add-on payments: two percent for urban ground ambulance services, three percent for rural ground ambulance services, and an increase to the base rate for ambulance trips originating in qualified "super rural" areas as calculated by the Secretary (currently 22.6 percent). It also requires two reports – one from GAO on ambulance provider costs and another from MedPAC on whether or not the ambulance fee schedule should be reformed. These studies will help inform Congress as to whether these add-on payments should be continued in future years. This provision also extends a policy that allows air ambulance services originating in certain rural areas to continue to receive a 50 percent add-on payment to their base rate.
CBO estimates these provisions would increase spending by $100 million from 2012 through 2022.

OTHER HEALTH PROVISIONS

Section 3101 – Qualifying Individual (QI) Program – This provision would extend the Medicare QI program, which provides federal reimbursement for states to cover Part B premiums for seniors with incomes between 120 and 135 percent of poverty, through December 31, 2012. CBO estimates that this provision would increase spending by $600 million from 2012 through 2022.

Sec 3102 – Extension of Transitional Medical Assistance (TMA) - This provision would extend TMA, through December 31, 2012, for low-income families transitioning into employment. CBO estimates this provision would increase spending by $1.1 billion from 2012 through 2022.

OFFSETS

Section 3201 - Reducing Bad Debt Payments – Under current law, Medicare reimburses hospitals and skilled nursing facilities (SNFs) for 70 percent of the beneficiary cost-sharing they are unable, or unwilling, to collect ("bad debt"). Certain other providers, such as federally qualified health centers (FQHCs) and dialysis centers, are reimbursed 100 percent for the bad debt. SNFs are reimbursed 100 percent for the bad debt resulting from the treatment of "dual eligible" beneficiaries, those enrolled in both Medicare and Medicaid. Although CMS requires providers to take reasonable steps to collect bad debt, this generous reimbursement policy is believed to discourage providers from doing as much as they could. This provision would phase down the bad debt reimbursements to 65 percent beginning in FY2013 for providers who are currently being reimbursed at 70 percent, while phasing in the reduction to 65 percent over three years for those who are reimbursed at 100 percent of their bad debt. President Obama recommends that bad debt payments be reduced to 25 percent. CBO estimates this provision would reduce spending by $6.9 billion from 2012 through 2022.

Section 3202 - Resetting Clinical Laboratory Payment Rates – This provision reduces payment rates for clinical laboratory services by two percent in 2013. As the two percent reduction is applied after the update is calculated, the resulting 2013 update amount becomes the new reset base on which the 2014 update will be applied. The two percent reduction is less than the ten percent cut MedPAC suggested as part of its October 2011 package of potential policies to offset the cost of a comprehensive SGR fix. CBO estimates this provision would reduce spending by $2.7 billion from 2012 through 2022.

Section 3203 - Medicaid Disproportionate Share Hospital (DSH) Allotments - This provision would

rebase the DSH allotments for FY2021. CBO estimates this provision would reduce spending by $4.1 billion from 2012 through 2022.

Section 3204 – Correcting the Medicaid "Federal Disaster" Matching Rate - This provision eliminates funding for the "Louisiana Purchase" contained in the PPACA beginning in FY2014. CBO estimates this provision would reduce spending by $2.5 billion from 2012 through 2022.

Section 3205 - Reduction in the Prevention and Public Health Fund - This provision reduces funding in the so-called "Prevention and Public Health Fund" under the PPACA which provides the Secretary of HHS unlimited authority to spend above and beyond appropriated levels for any activity authorized by the Public Health Service Act. CBO estimates this provision would reduce spending by $5 billion from 2012 through 2022.