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Health Policy Briefing

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Fiscal Cliff Averted and Doc Fix Enacted in Final Minutes of the 112th Congress

Congress Passes Fiscal Deal and President Obama Signs Bill into Law

After the Senate acted first and the House passed H.R. 8, the American Taxpayer Relief Act of 2012, **President Obama** signed the fiscal cliff deal into law on January 2, 2013. The last minute negotiations conducted principally between Senate **Minority Leader Mitch McConnell** and **Vice President Joseph Biden** were instrumental in garnering an 89-8 vote in the Senate (with 5 Republicans and 3 Democrats objecting). The House abandoned the so-called "Hastert Rule" under which a majority of the majority Republicans would be needed to take up legislation and passed the bill by a vote of 257-167 with about 90% of all House Democrats voting for the bill and only about a third of the House Republicans.

In general, the tax provisions of the law: extends Bush-era tax cuts for individual with incomes under $400,000 ($450,000 for families); makes a permanent fix to the AMT; extends through 2013 various individual, business and energy tax exemptions and credits; provides for a 40% estate tax with a $5 million exemption. The bill would also repeal the congressional pay raise, extend jobless benefits for the long-term unemployed for another year and temporarily extend dairy price supports, among other things.

In addition, as described below and in the Appendix, the law provides for a one-year "doc fix" with the cost offset by other federal health program changes. Of note, the law delays until March 1, 2013 the BCA mandated spending cuts, including a 2% cut to Medicare. The law also exempts the budgetary effects of its various provisions from the PAYGO requirements of the Statutory Pay-As-You-Go Act of 2010.

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H.R. 8 Provides One-Year Doc Fix

In general, the fiscal cliff budget deal would rescind the 26.5% reduction in 2013 Medicare physician payments at a 10-year cost of about $25.2 billion. The law offsets this cost through a number of changes, including: a $10.5 billion reduction in Medicare payments by making documentation and coding adjustments under the inpatient prospective payment system for hospitals; a $4.2 billion cut to Medicaid disproportionate share payments to hospitals; savings of $600 million through a competitive bidding system for over-the-counter diabetic test strips; savings of $1.7 billion by repealing the Medicare Improvement Fund; savings of $2.5 billion by adjusting the coding intensity between Medicare Advantage and Medicare fee-for-service; savings of $4.9 billion from payment adjustments for end-stage renal disease; savings of $800 million through Medicare cuts for advanced imaging services; a $300 million cut to hospital reimbursements for radiation therapy among other savings as described in the Appendix. The law also extends the existing 1.0 floor on the Medicare payment "physician work" index through December 31, 2013.

H.R. 8 Changes to PPACA

The law prohibits HHS from distributing the bulk of about $1.9 billion in loans available to consumer oriented and operated plans (CO-OPs), but does maintain 10% of the remaining funds to help cover the administrative costs of CO-OP plans that have already have approved. The law also repeals the PPACA's long-term care Community Living Assistance Services and Support Program (CLASS Act), but includes provisions promoted by Senator Rockefeller which establish a Commission on Long-Term Care, a 15-member temporary body modeled on other independent health care panels, such as the Medicare Payment Advisory Commission. Within 30 days, three members will be named by the President and the minority and majority leaders in the House and Senate. The panel's recommendations could come as early as this fall; however Congress is not obligated to vote on the recommendations.

H.R. 8 Medicare Extenders

The law includes a number of so-called Medicare extender payment provisions that had expired or were scheduled to expire at the end of 2012 as described in the Appendix. Among the extensions for 2013 are: provisions for the outpatient therapy cap exceptions process; provisions related to Medicare Advantage plans for special needs beneficiaries; provisions extending the statute of limitations on Medicare overpayment recoveries from three years to five years; Qualifying Individual (QI) program provisions allowing Medicaid to pay the Medicare Part B premiums for Medicare beneficiaries with incomes between 120-135% of poverty; Transitional Medical Assistance (TMA) provisions allowing low-income families to maintain their Medicaid coverage as they transition into employment and increase their earnings; and Special Diabetes Program (SDP) provisions funding research for type I diabetes and supporting diabetes treatment and prevention initiatives for American Indians and Alaska Natives.

113th Congress Convenes

With Republican criticism still resonating on the fiscal cliff deal, the House and Senate reconvened on January 3 to begin the 113th Congress. The House reelected Rep. John Boehner as House Speaker (with 12 Republican objections) and adopted new House Rules, H.Res. 5, which would limit the ability of the House to consider recommendations from the PPACA's Independent Payment Advisory Board and eliminate a requirement that any IPAB replacement be offset by other Medicare cuts. The rules also exempt any repeal of the PPACA from the "Pay-as-you-go Rule" thus allowing for repeal without accounting for the impact on the deficit. The Rules Package also provides for the Chairman of the Budget Committee to set budget aggregates and allocations at the Ryan FY 2013 Budget levels until a new FY 2014 Budget is adopted. The Rules Package also enforces "spending reduction accounts" in appropriations bills so that if spending cuts are adopted during the appropriations amendment process and purported to count towards spending reduction, the money cannot be spent elsewhere during consideration of the bill. In the Senate, Senator Harry Reid remains the Majority Leader and Senator Mitch McConnell, the facilitator of the fiscal cliff deal along with Vice President Biden, remains the Minority Leader.

Appropriations Issues

With the remainder of FY 2013 appropriations and the Budget Control Act sequestration matters yet to be resolved, the House Appropriations Committee announced new subcommittee chairs, including a new assignment for Rep. Jack Kingston who will chair the Labor-HHS-Education Subcommittee. This subcommittee may consider funding reductions for PPACA programs in addition to the retrenchments included under the American Taxpayer Relief Act of 2012.

The BCA across-the-board spending cuts are pushed off until March 1st and the current continuing resolution for FY 2013 appropriations expires on March 27th. It is also likely that March 1st will turn out to be the deadline for Congress to extend the federal debt ceiling to avoid a possible default and downgrade of the federal credit rating. These critical dates set up another congressionally induced fiscal crisis demanding another compromise among congressional leaders and President Obama.

As to an extension of the debt ceiling, the President has put down the gauntlet saying that he will not negotiate over separate legislation needed for an extension of the current $16+ trillion debt limit while Republicans see this as a means to leverage tax reform and additional entitlement cuts from the President. As negotiations heat up this month and next, it is expected that Senator McConnell and other Republicans will again seek to change the basis for increasing Social Security benefits from the CPI to a so-called "chained-CPI" which would cut entitlement spending by about $112 billion over 10 years and increase revenues by about $72 billion, if the inflation adjuster is applied to federal income tax brackets. The President may be open to this change in some kind of "grand bargain" as well as to Medicare savings in the neighborhood of $400 billion over ten years (as offered during the fiscal cliff discussions). The contours of the debate over the debt limit, sequestration and FY 2013-14 appropriation levels have yet to be settled among the negotiating parties. The release of the President's FY 2014 budget in February will give some indication of the direction in which Democrats are willing to move to reduce federal deficits in the coming years.

Democrats Demand Final Regulations on Mental Health Parity

Reps. Ted Deutch, Tim Ryan and 30 other House Democrats sent a letter to the Secretaries of Labor, Treasury and HHS demanding that their departments issue final regulations under Public Law 110-343. They said "Insurance companies are finding new and creative ways to avoid the spirit of the landmark reforms signed into law through MHPAEA, and patients and their advocates continue to plea for real enforcement…."

PPACA Health Reform Update

HHS Approves Seven State Health Insurance Exchanges

Last week HHS granted conditional approval to the applications by California, Hawaii, Idaho, Nevada, New Mexico, Utah and Vermont to operate their own health insurance exchanges under the PPACA. Arkansas was given conditional approval to operate a federal/state partnership exchange. HHS also issued additional guidelines under which states can operate partnership exchanges. This brings to 19 the total number of states and DC which will operate their own exchanges.

Medicare/Medicaid/PHSA Corner

CMS Delays HIPAA HIT Rules

CMS announced that the agency is delaying until March 31 the enforcement of the operating rules for health plan and health claim status electronic transactions which otherwise became effective on January 1st.

Summary of H.R. 8, the "American Taxpayer Relief Act of 2012"

Background
In the early morning hours of January 1, 2013, the Senate passed, by a vote of 89-8, HR 8, the "American Taxpayer Relief Act of 2012." During the late evening of January 1, 2012, the House also passed, without amendment, HR 8, by a vote of 257 – 167. Provided below is a summary of the health-related provisions of that bill, with information from the Congressional Budget Office related to the total package and specific health-related provisions.

Title III – Business Tax Extenders

Section 301. Extension and modification of research credit.
Extends the R&D tax credit for tax years 2012 and 2013. Also includes changes to the credit, as outlined in section 201 of Senate-passed S. 3521. Specifically, under the provision, the special rules for taxpayers under common control and the special rules for computing the credit when a major portion of a trade or business (or unit thereof) changes hands are modified. Qualified research expenses paid or incurred by the disposing taxpayer in a taxable year that includes or ends with a change in ownership are treated as current year qualified research expenses of the disposing taxpayer. Further, such expenses are not treated as current year qualified research expenses of the acquiring taxpayer. In addition, the credit allowable to each member of a controlled group of corporations or each member of a group of businesses under common control is determined on a proportionate basis to its share of the aggregate qualified research expenses.

Note: The medical device tax was not delayed. Therefore, it will go into effect on January 1, 2013, as originally outlined in sec. 1405 of the Health Care and Education Reconciliation Act of 2010 (HCERA).

Title VI—Medicare and Other Health Extensions

Subtitle A -- Medicare Extensions

Section 601. Medicare Physician Payment Update.
This provision provides a one year patch to the Sustainable Growth Rate (SGR) through the end of 2013. The Medicare physician payment conversion factor would have been reduced by 26.5% on January 1, 2013. This provision would avoid that reduction, replacing it with a 0 percent update through December 31, 2013. According to CMS, the new 2013 Medicare physician fee schedule conversion factor will be $34.0230.

In addition, this section included a provision to allow eligible professionals, beginning in 2014, to report to a qualified clinical data registry that meets certain minimum standards as a substitute for satisfying more traditional Physician Quality Reporting System (PQRS) reporting requirements. Also requires a Government Accountability Office (GAO) study.

Section 602. Work Geographic Adjustment.
Under current law, the Medicare fee schedule is adjusted geographically for three factors to reflect differences in the cost of resources needed to produce physician services: physician work, practice expense, and medical malpractice insurance. This provision extends the existing 1.0 floor on the "physician work" index through December 31, 2013.

Section 603. Payment for Outpatient Therapy Services.
Current law places annual per beneficiary payment limits of $1,880 for all outpatient therapy services provided by non-hospital providers, but includes an exceptions process for cases in which the provision of additional therapy services is determined to be medically necessary. This provision extends the exception process through December 31, 2013. The

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provision also extends the cap to services received in hospital outpatient departments only through December 31, 2013.

Section 604. Ambulance Add-On Payments.
Under current law, ground ambulance transports receive add-on to their base rate payments of 2% for urban providers, 3% for rural providers, and 22.6% for super-rural providers. The air ambulance temporary payment policy maintains rural designation for application of rural air ambulance add-on for areas reclassified as urban by OMB in 2006. This provision extends the add-on payment for ground including in super rural areas, through December 31, 2013, and the air ambulance add-on until June 30, 2013. Also requires additional studies on ambulance costs.

Section 605. Extension of Medicare inpatient hospital payment adjustment for low-volume hospitals.
Qualifying low-volume hospitals receive add-on payments based on the number of Medicare discharges. To qualify, the hospital must have less than 1,600 Medicare discharges and be 15 miles or greater from the nearest like hospital. This provision extends the payment adjustment until December 31, 2013.

Section 606. Extension of the Medicare-Dependent Hospital (MDH) program.
The Medicare Dependent Hospital (MDH) program provides enhanced reimbursement to support rural health infrastructure and to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This greater dependence on Medicare may make these hospitals more financially vulnerable to prospective payment, and the MDH designation is designed to reduce this risk. This provision extends the MDH program until October 1, 2013.

Section 607. Extension for specialized Medicare Advantage plans for special needs individuals.
Extends the authority of specialized plans to target enrollment to certain populations through 2015.

Section 608. Extension of Medicare Reasonable Cost Contracts.
This provision allows Medicare cost plans to continue to operate through 2014 in an area where at least two Medicare Advantage coordinated care plans operate.

Section 609. Performance Improvement.
Under the Medicare Improvement for Patients and Providers Act of 2008, HHS entered into a five year contract with the National Quality Forum (NQF) for certain activities relating to health care performance. This provision continues this funding through 2013. This provision also requires HHS to develop a strategy for providing data on performance improvement in a timely manner. Also requires a GAO study on information sharing activities.

Section 610. Extension of funding outreach and assistance for low-income programs.
This provision extends the funding for one year for State Health Insurance Counseling Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and The National Center for Benefits Outreach and Enrollment.

Subtitle B -- Other Health Extensions

Section 621. Extension of the Qualifying Individual Program.
The Qualifying Individual (QI) program allows Medicaid to pay the Medicare Part B premiums for low-income Medicare beneficiaries with incomes between 120% and 135% of poverty. Under current law, the QI program expires December 31, 2012. This provision extends the QI program until December 31, 2013.

Section 622. Extension of Transitional Medical Assistance.
Transitional Medical Assistance (TMA) allows low-income families to maintain their Medicaid coverage as they transition into employment and increase their earnings. Under current law, TMA expires December 31, 2012. This provision extends TMA until December 31, 2013.

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Section 623. Extension of Medicaid and CHIP Express Lane option.
The CHIP Reauthorization Act of 2009 created a new option that allows state Medicaid and CHIP offices to rely on data from other state offices, like SNAP and school lunch programs, in making income eligibility determinations for children, called Express Lane Eligibility (ELE). The authority to use ELE expires on September 30, 2013. This provision would extend ELE authority through September 30, 2014.

Section 624. Extension of Family-to-Family Health Information Centers.
This provision continues the Family to Family Health Information Centers (F2F HIC) through 2013 to assist families of children/youth with special health care needs in making informed choices about health care in order to promote good treatment decisions, cost-effectiveness and improved health outcomes. This provision will help families navigate the health care system so that their children can get the care and benefits they need through Medicaid, SCHIP, SSI, early intervention services, private insurance and other programs. In addition, F2F HICs provide leadership and training for health care providers and policymakers to promote a family-centered "medical home" for every child. There is one F2F HIC in every state and the District of Columbia. The total cost of this provision is $5 million per year.

Section 625. Extension of Special Diabetes Program for Type 1 diabetes and for Indians.
Funds research for type I diabetes and supports diabetes treatment and prevention initiatives for American Indians and Alaska Natives. The Special Diabetes Program (SDP) expires at the end of 2013, but early reauthorization is critical to the continuation of the existing research initiatives. This provision would extend the SDP for one year.

Subtitle C -- Other Health Provisions (Budget Offsets)

Section 631. Inpatient Prospective Payment System (IPPS) Documentation and Coding Adjustment for Implementation of MS-DRGs.
This provision will phase in the recoupment of past overpayments to hospitals made as a result of the transition to Medicare Severity Diagnosis Related Groups (MS-DRGs). Savings: $10.5 billion.

Section 632. Revisions to the Medicare ESRD Bundled Payment System to Reflect Findings in the GAO Report.
This provision incorporates recommendations from the General Accountability Office by re-pricing the end stage renal dialysis (ESRD) bundled payment to take into account changes in behavior and utilization of drugs for dialysis. Savings: $4.9 billion.

Section 633. Treatment of Multiple Service Payment Policies for Therapy Services.
This provision further reduces payment for subsequent therapies when therapies are provided on the same day. Savings: $1.8 billion.

Section 634. Payment for Certain Radiology Services Furnished under the Medicare Hospital Outpatient Department Prospective Payment System.
This provision would equalize payments for stereotactic radiosurgery services provided under Medicare hospital outpatient payment system. Savings: $0.4 billion.

Section 635. Adjustment of Equipment Utilization Rate for Advance Imaging Services.
This policy would increase the utilization factor used in the setting of payment for advanced imaging services (i.e., CT, MRI) in Medicare from 75% to 90% for 2014 and thereafter. Savings: $0.8 billion. (Note: The Affordable Care Act or ACA increased the utilization factor from 50% to 75%.)

Section 636. Medicare Payment of Competitive Prices for Diabetic Supplies and Elimination of Overpayment for Diabetic Supplies.
This proposal would apply competitive bidding to diabetic test strips purchased at retail pharmacies. Savings: $0.6 billion.

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Section 637. Medicare Payment Adjustment for Non-Emergency Ambulance Transports For ESRD Beneficiaries.
This provision reduces the payment rates for ambulance services by 10%, beginning October 1, 2013, for individuals with ESRD obtaining non-emergency basic life support services involving transport, based on a recent GAO report. Savings: $0.4 billion

Section 638. Removing Obstacles to Collection of Overpayments.
This provision increases the statute of limitations to recover overpayments from three to five years, based on recommendations from the Office of Inspector General at the Department of Health and Human Services. Savings: $0.5 billion.

Section 639. Medicare Advantage Coding Intensity Adjustment.
Under current law, Medicare Advantage plans receive risk-adjustment payments that are further adjustment to reflect differences in coding practices between Medicare fee-for-service and Medicare Advantage. This provision increases this coding intensity adjustment (from 1.3 percentage points to 1.5 percentage points and from 5.7% to 5.98%). Savings: $2.5 billion.

Section 640. Elimination of all Funding for the Medicare Improvement Fund.
This provision eliminates funding for the Medicare Improvement Fund. Savings: $1.7 billion.

Section 641. Rebasing of State DSH Allotments.
This proposal rebases disproportionate share hospital (DSH) allotments to maintain the level of changes achieved in the ACA, and determines future allotments off of the rebased level using current law methodology. Savings: $4.2 billion.

Section 642. Repeal of CLASS Program.
The provision repeals the Community Living Assistance Services and Supports (CLASS) program established by the ACA. This provision has no scoring implications.

Section 643. Commission on Long Term Care.
The provision establishes the Commission on Long Term Care to develop a plan for the establishment, implementation, and financing of a high quality system that ensures the availability of long-term services and supports for individuals. This provision has no scoring implications.

Section 644. Consumer Operated and Oriented Plan (CO-OP) Program Contingency Fund.
This provision will rescind all unobligated CO-OP funds under section 1332(g) of the ACA. This provision also creates a contingency fund of 10% of the current unobligated funds to be used to further assist currently approved co-ops that have already been created. The provision does not take away any obligated CO-OP funds. Savings: $2.3 billion

Title IX – Budget Provisions

Subtitle A – Modifications of Sequestration

Section 901. Treatment of Sequester.
Delays the sequestration until for two months (until March 1, 2013). The White House said in a fact sheet that "the agreement saves $24 billion, half in revenue and half from spending cuts which are divided equally between defense and nondefense, in order to delay the sequester for two months. This will give Congress time to work on a balanced plan to end the sequester permanently through a combination of additional revenue and spending cuts in a balanced manner."