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Client Alert

Life Sciences Health Industry Group

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"Fiscal Cliff" Deal Includes Medicare Cuts and Other Health Policy Changes

On January 2, 2013, President Obama signed into law (via autopen) the "fiscal cliff" deal, H.R. 8, the American Taxpayer Relief Act of 2012 (ATRA). In addition to making well-publicized changes to the tax code, the new law includes numerous Medicare payment provisions. Most notably, the law includes a one-year Medicare physician fee schedule (MPFS) fix that is paid for by approximately $30 billion in other health care (mainly Medicare) spending reductions over 10 years. The health provisions of ATRA are summarized below. ATRA also delays until March 2013 the automatic, across-the-board "sequestration" cuts in federal spending imposed by the Budget Control Act of 2011 (BCA), which are expected to reduce Medicare provider payments by more than $11 billion in fiscal year (FY) 2013, and $123 billion over the period of FYs 2013 to 2021. The delay in sequestration, coupled with the government again reaching its debt ceiling, sets up another near-term battle on federal spending, during which Medicare, Medicaid, and other health care programs could be targeted for even more significant cuts.

The following are highlights of the health policy and payment provisions of ATRA:

- *Medicare Physician Payments* – ATRA once again kicks the can a year down the road and overrides a 26.5 percent across-the-board cut in MPFS payments that was scheduled to be imposed for calendar year 2013 under the statutory sustainable growth rate (SGR) formula. Instead, ATRA provides for a zero percent conversion factor update, which essentially extends 2012 rates through 2013 (note that rates for individual procedures still could vary in 2013 as a result of changes in relative value units (RVUs) and other policy and payment changes contained in the final calendar year 2013 MPFS rule). The Congressional Budget Office (CBO) estimates that the SGR fix will increase Medicare spending by $25.2 billion over 10 years.[1] The Centers for Medicare & Medicaid Services (CMS) announced January 3, 2013 that the 2013 conversion factor is $34.0230, and the agency directed Medicare contractors

to post revised payment rates on their websites by January 23, 2013. In light of the legislative action, CMS also is extending the 2013 annual participation enrollment period through February 15, 2013 (the effective date for any participation status changes during the extension remains at January 1, 2013). In addition to the SGR override, ATRA includes provisions to promote the use of clinical data registries for quality measure reporting beginning in 2014 (increasing spending by $0.1 billion over 10 years). ATRA also extends the current 1.0 floor used in the physician work geographic adjustment through December 31, 2013 (for an increase of $0.5 billion/ 10 years). Watch for our future blog posts on expected Congressional attempts to find a longer-term solution for the SGR formula.

- *Outpatient Therapy Services* – Similarly, ATRA extends the Medicare outpatient therapy cap exceptions process yet one more year through December 31, 2013 (for physical therapy and speech language pathology services combined, the 2013 cap is $1,900, and the separate cap for occupational therapy services is $1,900). In addition, ATRA extends through 2013 the requirement that Medicare perform manual medical review of therapy services when an exception is requested for cases in which the beneficiary has reached a specified dollar aggregate threshold. There are two separate thresholds: $3,700 for physical therapy services and speech-language pathology services, and $3,700 for occupational therapy services. ATRA also extends through December 31, 2013, the therapy caps and manual medical review thresholds to services furnished in hospital outpatient department settings, and counts outpatient therapy services furnished in a critical access hospital toward the therapy caps and manual medical review thresholds through December 31, 2013. This provision will increase Medicare spending by $1 billion over 10 years.

- *Hospital Payment Extensions* – ATRA extends one year, through December 31, 2013, an add-on payment available to qualifying low-volume hospitals that have fewer than 1,600 Medicare discharges and that are at least 15 miles away from another acute care hospital. This provision will increase Medicare spending by $0.3 billion/10 years. ATRA also extends the Medicare-dependent hospital program for rural hospitals until October 1, 2013, increasing Medicare spending by $0.1 billion over 10 years.

- *Ambulance Add-On Payments* – ATRA extends the add-on payment for ground ambulance payments (including in super rural areas) through December 31, 2013, and the air ambulance add-on until June 30, 2013, and it requires an HHS study of ambulance service costs. The provision increases Medicare spending by $0.1 billion over 10 years.

- *Performance Improvement* – ATRA extends the authority for the HHS Secretary to contract with a consensus-based entity to make recommendations on a

national strategy and priorities for health care performance measurement. ATRA also includes new requirements for the Secretary to develop a strategy to provide utilization and quality data to hospitals, physicians, and other applicable Medicare providers in a timely manner to promote performance improvement (e.g., quality improvements and per-capita cost reduction). The provision also directs the Government Accountability Office (GAO) to conduct a study of private sector and Medicare information-sharing activities. The provision is expected to have minimal fiscal impact.

- *Other Medicare Extensions* – ATRA also extends for one year the authority of specialized Medicare Advantage (MA) plans for special needs individuals (institutionalized beneficiaries, dual eligible, and/or individuals with severe or disabling chronic condition) to restrict enrollment to certain populations, which increases spending by $0.3 billion over 10 years. Further, the law extends for an additional year the authority for Medicare reasonable cost contracts to operate in areas served by at least two MA coordinated care plans (minimal fiscal impact).

- *IPPS Documentation and Coding Adjustment* – ATRA requires the Secretary to continue to reduce Medicare inpatient prospective payment system (IPPS) payments to hospitals to account for changes in hospital documentation and coding practices associated with implementation of the Medicare severity diagnosis-related groups (MS-DRGs) system in FY 2008 that do not reflect real changes in patient case-mix. Specifically, the law authorizes the Secretary to make adjustments to payments for FYs 2014 through 2017 to fully offset $11 billion (which Congress asserts represents the full amount of the increase in aggregate payments from FYs 2008 through 2013 for which an adjustment was not previously applied). The legislation prohibits the Secretary from fully recouping past overpayments related to documentation and coding changes from FYs 2008 and 2009, but it does not change the Secretary's authority to make prospective documentation and coding adjustments. This provision is expected to reduce Medicare spending by $10.5 billion over 10 years – the single largest Medicare payment cut in the bill.

- *Revisions to the ESRD Bundled Payment System* – ATRA requires the Secretary to adjust the Medicare end-stage renal disease (ESRD) bundled payment amount to account for reductions in utilization of certain ESRD drugs and biologicals, since the Medicare ESRD payment bundle was expanded to include these items (for which Medicare previously had paid separately). The adjusted amounts, which also must reflect the most current data available on average sales prices for drugs and biologicals, will apply to services furnished on or after January 1, 2014. This provision responds to a recent GAO report that suggested that the bundled Medicare payment for dialysis care over-compensates dialysis facilities for ESRD drug costs. ATRA also: delays inclusion of "oral only" ESRD drugs in the ESRD bundled payment

until January 1, 2016; directs the Secretary to monitor the bone and mineral metabolism of individuals with ESRD; and requires the Secretary to conduct an analysis of ESRD case-mix payment adjustments. The ESRD provisions will reduce Medicare spending by $4.9 billion over 10 years.

- *Payment for Multiple Therapy Services* – ATRA increases the multiple procedure payment reduction (MPPR) that is applied to certain Part B outpatient therapy services. Under the MPPR policy, CMS reduces the practice expense component of the second and subsequent therapy services when more than one therapy service is furnished to a single patient in a single day. ATRA increases the MPPR reduction percentage to 50 percent effective April 1, 2013 (the MPPR previously was 25 percent in institutional settings, and 20 percent in office and other non-institutional settings). This provision will reduce Medicare reimbursement by $1.8 billion over 10 years.

- *Payment for Stereotactic Radiosurgery* – ATRA establishes a special payment rule for stereotactic radiosurgery furnished under the Medicare hospital outpatient PPS by hospitals that are not located in rural areas or are not classified as a rural referral center or sole community hospital, effective for services furnished on or after April 1, 2013. This provision is expected to save $0.4 billion over 10 years.

- *Equipment Utilization Rate for Advanced Imaging Services* – ATRA increases from 75 percent to 90 percent the equipment utilization rate assumption for calculating practice expense RVUs for the technical component portion of reimbursement for expensive (more than $1 million) diagnostic imaging equipment used in diagnostic CT and MRI services, effective beginning in 2014. This provision applies to services performed in physician offices and independent diagnostic testing facilities, and is expected to reduce Medicare spending by reducing the practice expense component of these advanced diagnostic procedures by approximately $0.8 billion over 10 years.

- *Pricing for Retail Diabetic Supplies* – ATRA sets Medicare payment amounts for retail diabetic supplies at the national mail order competitive bidding single-payment amounts, effective as of the date of implementation of the national mail order competition for diabetic supplies (July 1, 2013). CMS has not yet announced the payment amounts that will apply under the mail order competitive bidding program. Note that under the competitive bidding program rules, only suppliers that are successful bidders and that sign a contract with CMS will be eligible to furnish mail order diabetes supplies to Medicare beneficiaries as of July 1, 2013; the requirement to use a contract supplier will not apply to retail/storefront diabetes supplies. ATRA also modifies the DME covered-item update to apply to retail diabetic supplies a 9.5 percent reduction made in 2009 to mail-order diabetic supplies. The reduction will be applied beginning April 1, 2013 (and then presumably will be superseded by the competitive bidding pricing). CBO estimates that the

diabetic supplies policy will reduce Medicare reimbursement by $0.6 billion over 10 years.

- *Non-Emergency Ambulance Transports for ESRD Beneficiaries* – ATRA provides for a 10 percent reduction in the fee schedule amount for non-emergency basic life support services involving transport of an individual with ESRD for renal dialysis services furnished by a provider of services, or a renal dialysis facility, effective for services furnished on or after October 1, 2013. This provision decreases Medicare spending by $0.4 billion over 10 years.

- *Collection of Overpayments* – ATRA amends the "without fault" overpayment provisions by extending the time period from three years to five. By way of background, CMS explains the previous rule as follows: "There are special rules that apply when an overpayment is discovered subsequent to the third year following the year in which notice was sent that the amount was paid. Ordinarily, the provider or beneficiary will be considered without fault unless there is evidence to the contrary. In the absence of evidence to the contrary, the FI or carrier will not recover the determined overpayment." This provision is expected to increase Medicare spending by $0.5 billion over 10 years.

- *Medicare Advantage Coding Intensity Adjustment* – ATRA increases the coding intensity adjustment, which modifies the MA demographic adjustment to reflect changes in treatment and coding practices in the fee-for-service (FFS) sector, and reflects differences in coding patterns between Medicare Advantage plans and Medicare FFS providers. This provision will reduce spending by $2.5 billion over 10 years.

- *Elimination of Funding for the Medicare Improvement Fund* – ATRA eliminates funding for the "Medicare Improvement Fund," which was established by the Medicare Improvements for Patients and Providers Act of 2008 to finance improvements to the Medicare FFS program. This provision reduces spending by $1.7 billion over 10 years.

- *Rebasing of State DSH Allotments* – ATRA provides special rules for calculating state disproportionate share hospital (DSH) allotments for FYs 2021 and 2022, which results in savings of $4.2 billion over 10 years.

- *Repeal of CLASS Program/New Commission on Long-Term Care* – ATRA repeals the Affordable Care Act's (ACA) defunct Community Living Assistance Services and Supports (CLASS) program, which was intended to be a national voluntary, self-financed program to provide insurance for long-term care services and supports. The Obama administration announced in October 2011, however, that it was suspending implementation of the program because it could not identify a benefit plan that was both actuarially sound and consistent with the statutory requirements. In its place, ATRA establishes a Commission on Long-Term Care to "develop a plan for the establishment, implementation, and financing of a comprehensive, coordinated, and

high-quality system that ensures the availability of long-term services and supports." The targeted populations for assistance include elderly individuals, individuals with substantial cognitive or functional limitations, other individuals who require assistance to perform activities of daily living, and individuals desiring to plan for future long-term care needs. These provisions are expected to have minimal fiscal impact.

- *Consumer Operated and Oriented Plan Program Contingency Fund* – ATRA modifies the ACA's Consumer Oriented and Operated Plans (CO-OPs) program, which provides loans to encourage the creation of consumer-governed, private, nonprofit health insurance issuers. ATRA directs the Secretary to establish a fund to provide assistance and oversight to health insurance issuers that have been awarded grants or loans under the program. This program is funded by a portion of unobligated CO-OP funds; the rest of the unobligated CO-OP funding is rescinded. The provision is expected to save $0.2 billion over 10 years.

- *Other Health Program Extensions* -- ATRA extends through December 31, 2013, the Qualifying Individual (QI) program (which allows Medicaid to pay the Medicare Part B premiums for certain low-income Medicare beneficiaries), and the Transitional Medical Assistance (TMA) program (which allows low-income families to keep Medicaid coverage as they transition into employment). ATRA also extends funding for various state health insurance programs, area agencies on aging, aging and disability resource centers, and a contract with the National Center for Benefits and Outreach Enrollment (minimal fiscal impact). In addition, ATRA extends the authority of states to use an "Express Lane" agency to make income eligibility determinations for children, continues the Family to Family Health Information Center program, and extends programs that support research for type I diabetes and diabetes treatment and prevention initiatives for American Indians and Alaska Natives. Together these provisions are expected to cost approximately $1.7 billion over 10 years.

The text of ATRA is available at http://www.gpo.gov/fdsys/pkg/BILLS-112hr8eas/pdf/BILLS-112hr8eas.pdf. We will continue to report on Medicare/Medicaid budget developments impacting the health care industry at http://www.healthindustrywashingtonwatch.com/.

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1. Note that while we have included the CBO's 10-year budgetary effect estimates, in some cases the changes in spending are concentrated in the FY 2013-2014 time period. The complete CBO score for the Medicare/health provisions is posted at http://www.cbo.gov/sites/default/files/cbofiles/attachments/SenateHR8-TitleVI.pdf.