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A Guide to Regulation and Legislation

Regulatory Advisor

ATRA health care provisions

On January 2, 2013, President Obama signed the *American Taxpayer Relief Act* (ATRA) of 2012, and as a result avoided the "fiscal cliff" that would have resulted in significant tax increases and spending cuts. While much of the media focus on the ATRA has been on the tax increase and avoidance of spending cuts, the new law contains a number of health care provisions that are important to providers in all sub-industries.

Section 601 — Medicare physician payment update

Sustainable growth rate (SGR) fix

The scheduled cuts of 26.5 percent (due to the mandated SGR formula) have been avoided until December 31, 2013. Physician services will not receive an overall adjustment in 2013, but other payment modifications will impact physicians.

Reporting quality measures through qualified clinical data registry

The secretary of Health and Human Services will establish requirements for an entity to be considered a qualified data registry. In establishing the requirements, the following will be considered:

- Transparency of data elements, risk measures and specifications, and risk models and measures
- Required submission of data from participants with respect to multiple payors
- Ability to provide timely performance reports to participants at the individual level
- Support of quality improvement initiatives for participants

For 2014 and subsequent years, eligible professionals will be considered as satisfactorily reporting data if they report either through the certified registries or by using the current reporting protocols.

Section 602 — work geographic adjustment

The current "floor" for the work geographic adjustment factor (intended to compensate for the higher costs of providing care in certain areas) is extended from January 1, 2013, to January 1, 2014.

Section 603 — payment for outpatient therapy services

There are annual limits to how much therapy-related services beneficiaries can receive ($1,880 for physical therapy and speech therapy; $1,880 for occupational therapy in 2012). In situations where the therapy provider believes additional therapy is warranted, there is an exception process, which has been extended through 2013. This section refers to therapy services provided in non-hospital, outpatient departments through December 31, 2013. This provision also extends the therapy caps to therapy services provided in the hospital outpatient department through December 31, 2013.

Section 604 — add-on payments for certain ambulance services

Add-on payments for ground ambulance (2 percent for urban, 3 percent for rural, and approximately 23 percent for super rural ambulance) and air ambulance have been extended through December 31, 2013, and June 30, 2013, respectively.

Section 605 — extension of Medicare inpatient hospital payment adjustment for low-volume hospitals

Hospitals with less than 1,600 Medicare discharges and that are at least 15 miles or more away from the nearest like hospital are eligible for low-volume adjustments through September 30, 2013. (This provision was part of the *Affordable Care Act* (ACA), wherein the discharge threshold was expanded from 800 to 1,600, and the mileage restriction reduced from 25 miles to 15 miles, but it expired on September 30, 2012. ATRA extends the low-volume adjustments and expanded thresholds through September 30, 2013.)

Section 606 — extension of Medicare dependent hospital (MDH) program

MDH designation officially expired on October 1, 2012, and hospitals that qualified were transitioned to sole community hospital (SCH) designation. ATRA extends the MDH program by one year to October 1, 2013, for those who opt to transition back to MDH.

Sections 607 and 608 — Medicare Advantage and Medicare HMO provisions

Sections 607 and 608 extend the authority of certain Medicare Advantage plans to market to individuals with special needs through 2015. The marketing and servicing of these plans is primarily directed at dual eligibles, those with certain chronic conditions, and beneficiaries requiring institutionalized types of care services.

Medicare cost plans are similar to an HMO and pay traditional fee-for-service payment rates when beneficiaries seek care from out of network providers. The operating provisions of a Medicare cost plan in geographic areas where at least two Medicare Advantage coordinated care plans operate have been extended through 2014.

Section 609 — performance improvement

As part of the *Medicare Improvements for Patients and Provider Act of 2008* (MIPPA) the secretary of Health and Human Services entered into a contract to assist with certain procedures related to performance-based measurement. Although funding for this contract expired in 2012, this provision extends funding through 2013, and includes the additional considerations for HHS:

- MIPPA will develop a strategy to provide performance measurement data in a timely manner to Medicare providers, including utilization for services provided under Medicare Parts A, B, and D, and feedback on the quality of data submitted by the provider.
- This strategy will take into consideration the type of provider, frequency of providing data, risk adjustment methodologies, presentation format of data, and administrative costs of providing such data.
- The definition of "applicable provider" in this provision includes critical access hospitals, hospitals, physicians and any other provider the secretary of Health and Human Services determines should receive this type of information.
- Performance improvement is defined as improving quality, reducing per capita costs and any other criteria considered appropriate by the secretary of Health and Human Services.

Section 610 — extension of funding for outreach and assistance for low-income programs

Through MIPPA and the *Affordable Care Act* (ACA) Congress provided funding for State Health Insurance Counseling Programs (SHIP), Area Agencies on Aging (AAAs), and Aging and Disability Resource Centers (ADRCs). This provision extends funding for these outreach/low income programs through 2013 at a rate of $7.5 million,

$7.5 million, and $5 million respectively. In addition, this provision provides $5 million in funding to the National Center for Benefits and Outreach Enrollment.

Sections 621 – 625 — Medicaid and low-income-related provisions

Qualifying individual program (QIP)

This program allows various states' Medicaid programs to pay for certain low-income beneficiaries Medicare Part B premiums. To be eligible, beneficiaries must have income thresholds at 120 to 135 percent of the federal poverty level (FPL). Through 2012, the QIP provided 100 percent of the federal funding to states for the Part B premiums of eligible beneficiaries. ATRA extends this federal funding through 2013 ($485 million from January 1, 2013, to September 30, 2013, and $300 million from October 1, 2013, to December 31, 2013).

Extension of transitional medical assistance (TMA)

TMA is a provision that allows Medicaid recipients with income levels of 185 percent of FPL and below to retain their Medicaid coverage as they transition back into the workforce and increase their earnings. TMA was set to expire on December 31, 2012, but this extends the program through December 31, 2013.

Extension of Medicaid and CHIP express lane option

The *CHIP Reauthorization Act of 2009* created an expedited process for verifying income eligibility determinations for children to qualify for Medicaid CHIP benefits. The provision allows state Medicaid CHIP offices to rely on data received from other states, such as free and reduced school lunch programs, thus streamlining eligibility processes. The ability to use the express lane option is scheduled to expire on September 30, 2013, but this provision extends it to September 30, 2014.

Extension of family-to-family health information centers

These centers are intended to provide a link for families with children with special needs. They help parents navigate the medical system and make informed decisions about their children's special health care needs. There is one family-to-family health information center in each state, and funding for these centers is extended through 2013.

Extension of special diabetes program for type I diabetes and for Indians

American Indians and Alaskan Natives suffer from higher incidences of diabetes. The special research programs studying these populations in an attempt to better understand type I diabetes are now funded through 2014 to ensure the program continues seamlessly.

Section 631 — Inpatient Prospective Payment System (IPPS) documentation and coding adjustment for implementation of Medicare Severity Diagnosis Related Groups (MS-DRGs)

Due to overpayments associated with the transition from DRG to MS-DRGs, the secretary of Health and Human Services is authorized to continue to recoup excess payments during the federal fiscal years of 2014, 2015, 2016, and 2017 to fully offset an estimated $11 billion of additional payments to hospitals that have not yet been recouped from 2008 – 2013.

Section 632 — revisions to the Medicare end-stage renal disease (ESRD) bundled payment system reflect findings in Government Accountability Office (GAO) report

The GAO found that the Centers for Medicare and Medicaid Services (CMS) was overpaying for ESRD services. Section 632 allows the Secretary of Health and Human Services to adjust the bundled payment rates for ESRD services based on utilization rates of certain drugs and biologicals. The provision also delays the implementation of oral-only drugs into the ESRD bundled payment system until January 1, 2016. The GAO must update its report no later than December 31, 2015.

Section 633 — treatment of multiple service payment policies for therapy services

Section 633 adjusts the multiple procedure discount for certain therapy services provided by physicians and other health care providers from a 25 percent discount to a 50 percent discount beginning with services provided on and after April 1, 2013.

Section 634 — payment for certain radiology services furnished under the Medicare hospital outpatient department prospective payment system

Payment rates are reduced for hospital-based sterotactic radiosurgery (identified as Healthcare Common Procedure Coding System (HCPCS) Code 77371 and reimbursed under APC 0127), to that of linear accelerator based stereotactic radiosurgery (identified as HCPCS code G0173 and reimbursed under Ambulatory Payment Classification (APC) 0067). (This is a form of radiation therapy that focuses high powered x-rays to the targeted area of the body with the abnormality, and avoids damaging surrounding tissues.)

Section 635 — adjustment of equipment utilization rate for advanced imaging services

In establishing payment rates for certain advanced imaging services (CT scan, MRI, etc.), CMS has established assumed utilization rates to recognize that these pieces

of equipment would not be utilized 100 percent of the time. In the 2010 final physician fee schedule (PFS) rule, the utilization rate rose from 50 to 90 percent, in effect reducing the payment for such services. The ACA adjusted this 90 percent utilization rate down to 75 percent.

This provision retains the 75 percent utilization factor for 2012 and 2013, but changes it back to the 90 percent utilization rate effective January 1, 2014, and subsequent years.

Section 636 — Medicare payment of competitive prices for diabetic supplies and elimination of overpayment for diabetic supplies

This section incorporates competitive bidding into payment for certain diabetic supplies to pharmacies, including test strips. Medicare payment will be equal to the single payment amounts established under the national mail order competition for diabetic supplies.

Section 637 — Medicare payment adjustment for non-emergency ambulance transports for ESRD beneficiaries:

This section reduces ambulance payments by 10 percent for non-emergency transportations services provided by ambulance to ESRD beneficiaries on or after October 1, 2013.

Section 638 — removing obstacles to collections of overpayments

This provision expands the federal government's timeline to recoup overpayments from three years to five years, and is effective upon passage of this law. This will have potentially significant implications to the recovery audits in process, as well as other overpayments.

Section 639 — Medicare Advantage coding intensity adjustment

Included in the Medicare Advantage law is an annual comparison of payment rates between Medicare Advantage and traditional Medicare fee-for-service. This comparison includes thresholds for applying coding adjustments. ATRA increases the adjustment threshold to the 2010 adjustment plus 1.5 percent for 2014 Medicare Advantage adjustment rate). In addition, for 2019 and each subsequent year, the adjustment factor will be 5.9 percent instead of current law 5.7 percent. The intent of this provision of the *Social Security Act* is to ensure that adjustments to payments due to coding changes in the fee-for-service environment are properly transitioned to the Medicare Advantage payment system.

Section 640 — elimination of all funding for Medicare improvement fund

This section eliminates all of the 2015 funding ($275 million) for the Medicare improvement fund.

Section 641 — rebasing of state disproportionate share (DSH) allotments

This provision recalculates the Medicaid allotments to states for Medicaid disproportionate share (DSH) payments, using funding levels achieved through the ACA provisions. Subsequent year allotments are determined based on the rebased amounts and adjusted for various provisions within the law, including the consumer price index.

Section 642 — repeal of the Community Living Assistance Services and Supports (CLASS) program

This provision eliminates the CLASS program, which was established by the ACA to help beneficiaries gain affordable long-term care assistance and avoid having to choose between assistance and poverty to receive this assistance. The effectiveness of the CLASS program has been questioned and various reports submitted to Congress questioning its financial viability.

Section 643 — commission on long-term care

This provision establishes a commission 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 for individuals in need of such services.

The commission is expected to consist of 15 members, appointed not later than 30 days after enactment.

Section 644 — consumer operated and oriented plan (CO-OP) program contingency fund

The ACA contained provisions making certain nonprofit health insurance plans eligible to receive federal loans and grants to fund the establishment of these CO-OPs. ATRA rescinds any remaining funds that have not yet been allocated, and establishes a 10 percent contingency fund (based on the unallocated funds) to be used to continue providing assistance to those CO-OPs that have been established.

Conclusion

The health care industry is in the midst of turbulent times, and the regulations are rapidly changing. Access to accurate information is the first step to positioning your organization for future success. The CLA Regulatory Advisor will keep you informed as new legislation is enacted.

Contacts

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