McDermott Will & Emery

Congress, President Agree to Extend Expiring Medicare and Medicaid Payments

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On February 17, 2012, Congress approved the Middle Class Tax Relief and Job Creation Act of 2012, ending debate over the extension of payroll tax reductions, unemployment insurance benefits, and numerous Medicare and Medicaid payment provisions, most of which were set to expire at the end of February. This White Paper provides an overview of the most significant Medicare- and Medicaid-related provisions in the act.

The U.S. Congress on February 17, 2012, concluded a protracted debate on whether and how to extend payroll tax reductions, unemployment insurance benefits, and numerous Medicare and Medicaid payment provisions, most of which were set to expire at the end of February. The agreement ends months of rancorous partisan negotiations that began in November 2011, and which were briefly suspended by a Christmas-eve deal that extended the expiring legislation for two months to allow for further negotiation. For more information on the Temporary Payroll Tax Cut Continuation Act of 2011, see McDermott's *On the Subject* "Congress, President Extend Endangered Medicare and Medicaid Programs," available at http://bit.ly/sGYgup.

The new legislation spares physicians, hospitals and other health care providers significant Medicare and Medicaid payment cuts, but also discontinues some payment programs, trims others, and calls for a variety of reports to inform Congress whether the remaining programs should continue to be extended in the future. The legislation provides relief for most of these programs only through the end of 2012, putting Congress on course to revisit all of these issues again at the end of the year. The reports that will be issued pursuant to this legislation will help shape the next debate and may embolden Congress to trim even more programs when they next come up for renewal.

This White Paper provides an overview of the most significant Medicare- and Medicaid-related provisions in the Middle Class Tax Relief and Job Creation Act of 2012, H.R.3630 (Tax Relief Act).

Provisions Extended 10 months

Physician Payment Update

Congress again avoided another massive cut (expected to be almost 28 percent) to Medicare payments to physicians by directing the Centers for Medicare and Medicaid Services (CMS) to continue to pay physicians at 2011 levels through 2012. In other words, physicians will see no change—neither an increase nor decrease—in payments from 2011 through 2012.

The American Medical Association and some in Congress sought to permanently resolve this perennial crisis by using funds available from the anticipated end of U.S. military engagement in the Middle East, but in the end Congress could only muster another 10-month patch, which nonetheless cost $18 billion.

Congress perhaps provided a glimpse of how it might seek to resolve this problem when it next comes around: Congress also directed the U.S. Department of Health and Human Services (HHS) and the U.S. Government Accountability Office (GAO) to conduct two studies concerning physician payment. HHS is to examine bundled and episode-based payment models, while GAO is to study private sector initiatives that link physician payment to quality, efficiency and care improvement. Both studies are due to Congress by January 1, 2013.

Hospital Outpatient Hold Harmless Protections

Medicare provides additional payments under the Hospital Outpatient Prospective Payment System (OPPS) to small rural hospitals (i.e., those with 100 or fewer beds) and hospitals designated as Sole Community Hospitals (SCHs). Both protections were set to expire at the end of February. Congress extended this "hold harmless" protection through 2012 but limited the entire program to hospitals with 100 or fewer beds. In other words, SCHs with more than 100 beds will see this protection expire February 29, 2012, and only those rural hospitals and SCHs with 100 or fewer beds will benefit from the protection between March 1 and December 31, 2012. The amount of such payments during this period in 2012 will be 85 percent of the difference between the amount paid to the hospital under OPPS and the amount that otherwise would have been paid under the pre-OPPS cost-based Medicare outpatient hospital payment system.

The new legislation also calls on HHS to study whether these and other types of hospitals need hold harmless payments to be viable. The report is due July 1, 2012.

Physician Work Geographic Adjustments

Medicare payments to physicians are geographically adjusted to reflect the varying cost of delivering physician services across areas. The adjustments are made by indices, known as the Geographic Practice Cost Indices (GPCI) that reflect how each geographic area compares to the national average.

In 2003, Congress established that for three years there would be a "floor" of 1.0 on the "work" component of the formula used to determine physician payments, which meant that physician payments would not be reduced in a geographic area just because the relative cost of physician work in that area fell below the national average. Congress has extended the work GPCI floor several times. The Tax Relief Act provides yet another extension through 2012. However, the new law also requires the Medicare Payment Advisory Commission (MedPAC) to study whether Medicare should be geographically adjusting work-related payments at all. That report is due in June 2013.

Therapy Services

Legislation enacted in 1997 created an annual per-Medicare beneficiary cap of $1,500 for outpatient therapy services, except when received from a hospital outpatient department. The $1,500 annual cap applied to physical and speech therapy combined, and separately to occupational therapy. From 1997 through the end of 2005, the caps were never imposed because Congress enacted a series of bills temporarily suspending the caps.

Congress allowed the caps to go into effect in 2006, but established an exceptions process whereby Medicare beneficiaries can request and be granted an exception to the caps, and receive an unlimited amount of therapy services to the extent deemed medically necessary by Medicare. The 2005 law authorized the exception process for only one year, but Congress has also repeatedly extended the exception process.

The Tax Relief Act extends the exceptions process through 2012 but also makes several significant revisions. First, effective October 1, 2012, if expenditures for a beneficiary exceed $3,700 for physical and speech therapy, or $3,700 for occupational therapy, subsequent claims for therapy will be subject to manual review. Moreover, the therapy caps and accompanying exceptions process now also apply to therapy services furnished in hospital settings.

The law also requires MedPAC and GAO to issue separate reports on how to improve Medicare's therapy service payment methodology and manual medical review of claims in excess of the caps. The MedPAC report is due June 15, 2013, while the GAO report is due May 1, 2013.

Ambulance Services

The Tax Relief Act extends several add-on payments for certain ambulance services that were otherwise set to expire on February 29, 2012.

Beginning July 1, 2008, Medicare increased the base Medicare reimbursement rate for ground ambulance trips originating in rural areas by 3 percent, and for ground ambulance trips originating in urban areas by 2 percent. Both payment enhancements were set to expire February 29, 2012. The Tax Relief Act continues these payment enhancements through 2012.

The Medicare statute also provides a "super" add-on payment for ambulance services in the "lowest population density" areas. CMS has set this add-on payment at 22.6 percent. The Tax Relief Act extends the add-on for ambulance service in these "super rural" areas through 2012.

The Tax Relief Act also extends through 2012 a provision that clarifies which areas of the country are deemed "rural" for purposes of determining eligibility of air ambulance services for Medicare reimbursement. Under the extension, any area that was designated as a rural area for purposes of making payments for air ambulance services furnished on December 31, 2006, shall be treated as a rural area for purposes of making payments under such section for air ambulance services furnished through 2012.

However, the new law requires MedPAC to study the appropriateness of these payments, and to issue a report by June 15, 2013.

Extension of the Qualifying Individual Program and Transitional Medical Assistance

Two programs for low-income beneficiaries of Medicaid are extended under the new law. The Qualifying Individual (QI) program is for certain "dual eligibles," and allows Medicaid to pay the Medicare Part B premiums for low-income Medicare beneficiaries who have incomes between 120 percent and 135 percent of the poverty level. Transitional Medical Assistance (TMA) is a program that permits eligible low-income families to continue being covered by Medicaid during a transitional period when wage earners are transitioning into gainful employment and increased earnings, which might otherwise make the families ineligible for Medicaid. The Tax Relief Act extends both the QI and TMA programs through 2012.

Provisions Extended Four Months

Section 508 Reclassifications

The Tax Relief Act may end special wage index reclassifications that currently benefit nearly 90 hospitals U.S.-wide. Special wage index reclassification criteria created by CMS pursuant to Section 508 of the Medicare Modernization Act of 2003 enabled approximately 120 hospitals to receive a higher wage index for a three-year period ending April 1, 2007. Although some assert that the original provision was intended to provide a one-time benefit, Congress extended these reclassifications seven times, the most recent of which provided this benefit through November 30, 2011. The Tax Relief Act extends these reclassifications through March 31, 2012, but a narrative explanation accompanying the bill explains that the decision to extend these reclassifications for four months (December 1, 2011, through March 31, 2012), rather than 10 months, like other provisions in the bill, reflects an agreement on the part of the conferees to no longer continue these reclassifications in the future. Nothing in the statutory language prevents Congress from revisiting this provision and extending it again in the future.

Payment for Technical Component of Certain Physician Pathology Services

In 1999, the Health Care Financing Administration (now CMS) established a policy that Medicare would only make payment to a hospital for pathology services furnished to hospital patients. To the extent that hospitals may have outsourced those pathology services to an independent lab, the hospital would be required to bill Medicare and receive payment, and then compensate the lab for the services it provided. Congress has repeatedly suspended implementation of this regulation. The most recent suspension was set to expire February 29, 2012, but is now extended by the Tax Relief Act through June 2012.

As with the Section 508 reclassifications discussed above, the fact that this program is being allowed to expire mid-year, rather than being extended through the remainder of 2012, reflects a decision on the part of at least some lawmakers that this relief should come to an end, and that the original regulation take effect.

Provisions Not Extended

Mental Health Services

Legislation enacted in 2008 increased Medicare payments for mental health services furnished by physicians by 5 percent for a period of 18 months. Congress extended the add-on payment three times, including most recently through February 2012. The Tax Relief Act provides no provision to extend this add-on payment, leaving it to expire February 29, 2012.

Bone Mass Measurement Tests

Under legislation enacted in 2007, Medicare payments to physicians for the technical component of certain advanced imagining services (such as CT and MR scans) cannot exceed the payment Medicare makes to a hospital for the same service when furnished on an outpatient basis. However, certain screening services, including diagnostic and screening mammography and bone density measurement tests furnished using dual-energy x-ray absorptiometry have been exempt from this cap. The provision exempting bone density measurement services is set to expire February 29, 2012. The Tax Relief Act provides no provision to extend this exemption further. Effective March 1, 2012, Medicare payments to physicians for the technical component of bone density measurement tests cannot exceed the payment Medicare makes to a hospital for the same service.

Offsets

One interesting and somewhat unusual feature of the new legislation is that it reduces Medicare provider payments to "pay for" the continuation of the payment increases described above. In other words, Congress required health service providers to accept payment cuts to maintain certain other payment increases. In some instances, one provider sector was made to pay for increases given to other provider sectors. For example, as described in more detail below, clinical laboratories will see a substantial reduction in their payments, but realized no other direct benefit from this legislation.

Bad Debt

Medicare pays certain providers a portion of beneficiaries' unpaid coinsurance and deductible amounts. Hospitals generally are paid 70 percent of these bad debts, while critical access hospitals, rural health clinics, federally qualified health clinics, community mental health clinics, health maintenance organizations reimbursed on a cost basis, competitive medical plans, health care prepayment plans and end-stage renal disease facilities are paid 100 percent of uncollected amounts. Medicare also pays skilled nursing facilities 100 percent of bad debts for Medicare beneficiaries who are eligible for Medicaid (dual eligibles) and 70 percent of the uncollected allowable costs for all other beneficiaries. The Tax Relief Act reduces Medicare's bad debt payment to 65 percent for all eligible provider types. Where payments will be reduced from 100 percent to 65 percent, those reductions will be phased in over three years: 88 percent in 2013, 76 percent in 2014, and 65 percent in 2015.

Clinical Laboratories

The Tax Relief Act reduces Medicare payments for clinical laboratory services paid under the Clinical Laboratory Fee Schedule by 2 percent beginning in 2013.

Outlook

The Tax Relief Act emanated from a major political showdown between Republicans and Democrats in December 2011. Legislation approved largely along party lines by the House of Representatives on December 12, 2011, would have suspended the offending physician payment formula for two years, and provided physicians with a 1 percent increase in Medicare payments in each of calendar years 2012 and 2013. However, the House legislation would not have extended many of the other payment programs, and would have paid for the physician payment increase by decreasing payments to hospitals even further than under the Tax Relief Act. For example, the House bill would have reduced hospital outpatient payments for evaluation and management services to be equal to the Medicare payment for the same service when furnished in a physician office, and it would have reduced the reimbursement hospitals and other providers can receive for bad debts from 70 percent to 55 percent.

The House bill also would have re-opened physician hospital ownership restrictions imposed under the Affordable Care Act (ACA) to allow physician-owned hospitals that were under construction but did not have Medicare provider numbers as of December 31, 2010, to open and operate and qualify for grandfather protection; the bill also would have made it significantly easier for hospitals that were grandfathered under the ACA provisions to expand capacity (presently, grandfathered hospitals are allowed to expand bed and/or capacity only if they meet very limited criteria).

On December 17, 2011, the Senate, with overwhelming bipartisan support (89–10), approved a different version of H.R.3630 that would have extended most of the expiring provisions for two months. The House initially refused to embrace the Senate's version, but then ultimately relented under considerable political pressure. The House and Senate each enacted a new bill, H.R.3765, that extended the expiring provisions for two months, and the two chambers agreed to negotiate a longer extension bill in 2012. The new Tax Relief Act is the result of that agreement and the ensuing negotiations.

Many legislators and stakeholders hoped that the negotiations would have resulted in a long-term resolution. Now lawmakers will be forced to revisit these issues in 10 months. Lawmakers will also have to evaluate whether to extend other Medicare provider payment programs that are set to expire at varying points in 2012, including payment adjustments for low-volume hospitals (October 1, 2012), Medicare-dependent small rural hospitals (October 1, 2012) and reasonable costs payments for clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas (July 1, 2012). Given the current willingness of Congress to allow several payment programs to expire, and to initiate a series of studies to determine whether others should be extended again, providers should brace for more even more Medicare cuts in 2013.

The McDermott Difference

McDermott Will & Emery lawyers and government strategies professionals are actively engaged and prepared to advise clients with respect to these and other Medicare and Medicaid payment programs. If you have questions regarding the Tax Relief Act or the above-referenced programs, please contact your regular McDermott Will & Emery lawyer or an author:

Teddy Eynon: +1 202 756 8021 teynon@mwe.com

Andrea Bergman +1 202 756 8306 abergman@mwe.com

Karen S. Sealander: +1 202 756 8024 ksealander@mwe.com

Eric Zimmerman: +1 202 756 8148 ezimmerman@mwe.com

For more information about McDermott Will & Emery visit www.mwe.com