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# Medicare, Medicaid, and Other Health Provisions in the American Taxpayer Relief Act of 2012

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# Summary

Several policies that would have reduced spending and increased revenues were poised to take effect at the end of 2012; collectively, these were referred to by some as the "fiscal cliff." Had these policies taken effect, CBO projected that the ensuing fiscal contraction would have resulted in a recession in 2013. On January 2, 2013, the President signed H.R. 8, the American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240), which prevented most—but not all—of the fiscal cliff policies from going into effect. This Act was passed by the Senate on January 1, 2013 by a vote of 89-8, and by the House later that day, 257-167. Title VI of the Act extends several expiring provisions in the Medicare and Medicaid programs and makes other changes in federally funded health programs.

Provisions in Title VI of ATRA that will result in higher physician fee schedule payments include the override of the sustainable growth rate (SGR) update mechanism of the Medicare physician fee schedule that would have reduced payments had it taken effect, and the extensions of the physician work geographic adjustment. Other provisions preserved some Medicare hospital payments by extending adjustments for low-volume hospitals and the Medicare-dependent hospital program. Sections that addressed Medicare managed care include the extension of the Medicare Advantage special needs plans and reasonable cost contracts. Medicare beneficiaries will continue to have access to the exceptions process for outpatient therapy limits and outreach and assistance programs for low-income beneficiaries. Other health programs extended by the ATRA include the qualifying individual program, the transitional medical assistance program, the Medicaid and the State Children's Health Insurance Program (CHIP) express lane option, family-to-family health information centers, and special diabetes programs for Type I diabetes and for American Indians and Alaska Natives.

The Congressional Budget Office (CBO) estimates that the health provisions in H.R. 8 will result in a net increase in direct spending of $800 million over the ten-year period from FY2013 through FY2022. The physician payment override ("doc fix") and the various health-related extensions cumulatively add an estimated $29.3 billion to direct spending. CBO estimates that the other health provisions cumulatively result in offsets of all but $800 million as a result of the direct effects of the provisions and the interactions between provisions. While some sections of ATRA make changes to federal health programs that result in savings to the federal budget, other sections addressing federal health care programs have little or no impact on direct spending in the federal budget.

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# Overview

Several policies that would have reduced spending and increased revenues were poised to take effect at the end of 2012; collectively, these were referred to by some as the "fiscal cliff." Had these policies taken effect, CBO projected that the ensuing fiscal contraction would have resulted in a recession in 2013. On January 2, 2013, the President signed H.R. 8, the American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240), which prevented many—but not all—of the fiscal cliff policies from going into effect.[1] This Act was passed by the Senate on January 1, 2013 by a vote of 89-8,[2] and by the House later that day, 257-167.[3] Title VI of the Act extends several expiring provisions in the Medicare and Medicaid programs and makes other changes in federally funded health programs.

Many of the sections in Title VI of the ATRA extend current law provisions, resulting in higher Medicare provider payments or extending authorization and/or funding for expiring programs. Specifically, provisions in Title VI of ATRA that will result in higher physician fee schedule payments include the override of the sustainable growth rate (SGR) update mechanism of the Medicare physician fee schedule that would have reduced payments had it taken effect,[4] and the extensions of the physician work geographic adjustment. Other provisions preserved some Medicare hospital payments by extending adjustments for low-volume hospitals and the Medicare-dependent hospital program. Sections that addressed Medicare managed care include the extension of the Medicare Advantage special needs plans and reasonable cost contracts. Medicare beneficiaries will continue to have access to the exceptions process for outpatient therapy limits and outreach and assistance programs for low-income beneficiaries.

Other health programs extended by the ATRA include the qualifying individual (QI) program, the transitional medical assistance (TMA) program, the Medicaid and the State Children's Health Insurance Program (CHIP) express lane option, family-to-family health information centers, and special diabetes programs for Type I diabetes and for American Indians and Alaska Natives.

Some sections make changes to federal health programs that result in savings to the federal budget. Provisions addressing hospital care include modifications to documentation and coding for inpatient hospital services, changes in payment for certain radiology services furnished under the Medicare hospital outpatient department prospective payment system, and the rebasing of state disproportionate share allotments. Savings achieved from changes in payments for Medicare physician services include changes in the payment policies for multiple therapy service treatments and adjustments to the equipment utilization rate in the calculation of payments for advanced imaging services. Medicare managed care plans will see an adjustment for coding intensity that will be reflected in their capitation payments. Other Medicare provider payments will be affected by revisions to the end-stage renal disease (ESRD) bundled payment system, the payment of competitive prices for diabetic supplies, an adjustment for non-emergency ambulance transports

[1] For more information about the non-health titles of ATRA, see CRS Report R42884, *The "Fiscal Cliff" and the American Taxpayer Relief Act of 2012*, coordinated by Mindy R. Levit and CRS Report R42894, *An Overview of the Tax Provisions in the American Taxpayer Relief Act of 2012*, by Margot L. Crandall-Hollick.

[2] http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=112&session=2&vote=00251

[3] http://clerk.house.gov/evs/2013/roll659.xml

[4] The "doc fix" leaves the fee schedule payment rates unchanged through December 31, 2013. The update formula for Medicare physician payment would have required a reduction in the fee schedule for physician reimbursement of 26.5% as of January 1, 2013.

for ESRD beneficiaries, and the extension of the period, from three to five years, during which overpayments to providers can be identified.

Finally other ATRA sections that address other federal health care programs have minimal impact on direct spending, including the provisions in Title VI that repeal the Community Living Assistance Services and Supports program and establish a Commission on Long-Term Care.

The Congressional Budget Office (CBO) estimates that the health provisions in H.R. 8 will result in a net increase in direct spending of $800 million over the ten-year period from FY2013 through FY2022.[5] The physician payment override or "doc fix" ($25.2 billion in direct spending over 10 years) and the various health-related extensions ($4.1 billion) cumulatively add $29.3 billion to direct spending. CBO estimates that the other health provisions cumulatively result in offsets of all but $800 million as a result of the direct effects of the provisions and the interactions between provisions.

This report provides short descriptions of the health-related provisions contained in Title VI of the ATRA. Below is a text box providing the common acronyms for public laws referred to in this report.

**Common Acronyms for Public Laws**

ACA: Patient Protection and Affordable Care Act (P.L. 111-148)
ARRA: American Recovery and Reinvestment Act of 2009 (P.L. 111-5)
BBA97: Balanced Budget Act of 1997 (P.L. 105-33)
BIPA: Benefits Improvement and Protection Act of 2000 (P.L. 106-554)
CHIPRA: Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3)
DRA: Deficit Reduction Act (P.L. 109-171)
MMEA: Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309)
MMA: Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173)
MCTRJCA: Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96)
MMSEA: Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173)
SSA: Social Security Act
TEFRA: Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248)

# Summary of Health Related Provisions in H.R. 8

## Title VI—Medicare and Other Health Extensions

### Subtitle A—Medicare Extensions

#### *§601. Medicare physician payment update.*

The Sustainable Growth Rate (SGR) is the statutory method for determining the annual updates to the Medicare physician fee schedule. The SGR system was established because of the concern that the Medicare fee schedule itself would not adequately constrain overall increases in spending

[5] For CBO estimates used in this report, see Congressional Budget Office, Revised January 9, 2013, Detail on Estimated Budgetary Effects of Title VI (Medicare and Other Health Extensions) of H.R. 8, the American Taxpayer Relief Act of 2012, as passed by the Senate on January 1, 2013, available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/SenateHR8-TitleVI_0.pdf.

for physicians' services. Generally, under the SGR formula, if expenditures over a period are less than the cumulative spending target for the period, the annual update is increased. However, if spending exceeds the cumulative spending target over a certain period, future updates are reduced to bring spending back in line with the target.

In the first few years of the SGR system, the actual expenditures did not exceed the targets and the updates to the physician fee schedule were close to the Medicare economic index (MEI, a price index of inputs required to produce physician services). Beginning in 2002, the actual expenditures exceeded allowed targets, and the discrepancy has grown with each year. However, with the exception of 2002, when a 4.8% decrease was applied, Congress has enacted a series of laws to override the reductions. The SGR-determined update for Medicare physician payment required a reduction in the Medicare physician fee schedule (MPFS) payment rates of 26.5% beginning on January 1, 2013.[6]

This ATRA provision averts the reduction and maintains the Medicare physician fee schedule (MPFS) payments at their current rates through December 31, 2013. The conversion factor for 2014 and afterwards will be computed as if the modification to the conversion factor in this section had never applied.

The Physician Quality Reporting System (PQRS) was established by the Centers for Medicare & Medicaid Services (CMS) to reward eligible professionals for reporting specified quality data to the agency. This provision requires the Secretary of Health and Human Services (the "Secretary")[7] to deem those eligible professionals who satisfactorily participate in a qualified clinical data registry as having met the quality reporting requirements for PQRS for 2014 and subsequent years. The provision also requires the Secretary to establish requirements for a qualified clinical data registry and in so doing to consider, among other things, whether an entity has mechanisms in place to ensure transparency and to support quality improvement initiatives for participants. Measures used in the qualified clinical data registries may be endorsed by the National Quality Forum (NQF). These measures are not subject to the process for measure selection being carried out by multi-stakeholder groups.[8] In defining the requirements for the qualified clinical data registries, the Secretary must consult with interested parties and establish a process to determine whether the requirements have been met. The Government Accountability Office (GAO) is also required to conduct a study on the potential of clinical data registries to improve the quality and efficiency of care in the Medicare program, including through payment incentives. GAO must submit to Congress a report on this study by November 15, 2013, along with recommendations for legislative and administrative action.

*The CBO score for the override of the Medicare physician payment update is $21.1 billion for FY2013-FY2017 and $25.2 billion for FY2013-FY2022, while the score for the advancement of the qualified clinical data registries is $100 million for both the five- and ten-year period.*

## *§602. Work geographic adjustment.*

The Medicare physician 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. The geographic adjustments are indices—known as Geographic Practice Cost Indices (GPCIs)—that reflect how each area compares to the

[6] For details, see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by Jim Hahn and Janemarie Mulvey.

[7] All references to Secretary in this report refer to the Secretary of the Department of Health and Human Services.

[8] See SSA §1890A(a) or §1890(b)(7).

national average in a "market basket" of goods. A value of 1.00 represents the average across all areas. These indices are used in the calculation of the payment rate under the Medicare physician fee schedule. A series of bills set a temporary floor value of 1.00 on the physician work index beginning January 2004 and continuing through December 31, 2012.

This ATRA provision extends the 1.00 floor for the physician work geographic index through December 31, 2013.

*The CBO score is $500 million for both FY2013-FY2017 and for FY2013-FY2022.*

### *§603. Payment for outpatient therapy services.*

BBA97 established two annual per beneficiary payment limits for all Medicare-covered outpatient therapy services provided by *non-hospital providers,* to be applied separately (1) for physical therapy services and speech-language pathology services, and (2) for occupational therapy services. Initially set at $1,500 by BBA97 to apply beginning in 1999, these limits were suspended from 2000-2005. The DRA re-implemented the limits beginning in 2006 and required the Secretary to implement an exceptions process throughout 2006 for services meeting specified criteria for medically necessary services. A series of legislative acts have extended the exceptions process and increased the limits each year since then. The 2012 annual cap was $1,880 for each of the two categories of therapy services.

MCTRJCA set the annual threshold at $3,700 to be applied separately for the two categories of therapy services effective October 1, 2012. However, this increased amount applied to therapy service received *both in physicians' offices and hospital outpatient departments* for the first time. The condition was to expire coincident with the expiration of the exceptions process.

This ATRA provision extends the exceptions process through December 31, 2013, extends the application of the cap and threshold to therapy services furnished in a hospital outpatient department (OPD) and counts outpatient therapy services furnished in a Critical Access Hospital (CAH) towards the cap and threshold. This change will not affect the payment method for outpatient therapy services provided by CAHs. ATRA also extends the mandate that Medicare perform manual medical review of therapy services furnished January 1, 2013 through December 31, 2013, for which an exception is requested when the beneficiary has reached a dollar aggregate threshold amount of $3,700 for therapy services.

*The CBO score is $700 million for FY2013 and $300 million for FY2017 with no changes in direct spending for other years; the total score is $1 billion FY2013-FY2022.*

### *§604. Ambulance add-on payments.*

The SSA provides for bonus payments for ground ambulance services that originate in a qualified rural area (or super area) furnished on or after July 1, 2004, and before January 1, 2013. The super rural areas are those with the lowest population densities that collectively represent a total of 25% of the population. The Centers for Medicare and Medicaid Services (CMS) established the super rural bonus as a 22.6% increase in the payment. Subsequently, the Medicare rate for ground ambulance services otherwise established for the year was increased an additional 3% for rural ambulance services and 2% for other areas for the period July 1, 2008, until January 1, 2013. Urban areas that had been designated as rural on December 31, 2006, are treated as rural for purposes of payments for air ambulance services during this period as well.

ACA directed the Medicare Payment Advisory Commission (MedPAC) to study the appropriateness of the temporary add-on payments, their effect on providers' Medicare margins and the need to reform the ambulance fee schedule to build the add-on payments into the base

rate. In its November, 2012, meeting, MedPAC commissioners voted to: (1) allow the three temporary add-ons payments to expire; (2) rebalance the relative values for ambulance services in the fee schedule in a budget neutral fashion; and (3) replace the permanent rural short-mileage add-on for ground ambulance transports with a new adjustment directing increased payment to ground transports originating in geographically isolated low-volume areas, in order to target payments in rural areas to protect access.

This ATRA provision extends the 2% urban ambulance add-on payment, the 3% rural ambulance add-on payment and the 22.6% super rural add on payment for another year, until January 1, 2014. The air ambulance provision (where transports originating in certain urban areas are paid as rural air ambulance services) is extended until July 1, 2013. The Secretary is required to conduct (1) a study that analyzes data on existing cost reports for ambulance services provided by hospitals and critical access hospitals (CAHs) including variation by the characteristics of the providers, due to Congress by October 1, 2013; and (2) a study on the feasibility of obtaining cost data on a periodic basis from all ambulance providers and suppliers, due to Congress by July 1, 2014. The Secretary is directed to consult with the industry on the design of the cost collection efforts among other requirements.

*The CBO score is $100 million for FY2013-FY2017 and $100 million for FY2013-FY2022.*

### *§605. Extension of Medicare inpatient hospital payment adjustment for low-volume hospitals.*

MMA §406 established the low-volume adjustment for inpatient hospital payment in SSA §1886(d)(12) beginning with discharges for FY2005. The Secretary was given discretion to establish the adjustment based on the empirical relationship between cost per case and volume, up to a 25% increase. A low-volume hospital was defined in statute as a hospital (1) that is more than 25 road miles from another inpatient prospective payment system (IPPS) hospital and (2) has fewer than 800 total discharges. The determination of the low-volume adjustment was not subject to judicial review. The Secretary determined that only hospitals with fewer than 200 total discharges that were more than 25 road miles from another like hospital warranted the adjustment. These hospitals received the full 25%, but there were only 2 hospitals that qualified for those payments in FY2010.

ACA §3125 provided for temporary modifications to the low-volume adjustment for FY2011 and FY2012 for those hospitals with fewer than 1,600 Medicare discharges that were more than 15 road miles from another IPPS hospital. The adjustment was structured so that hospitals with 200 or fewer Medicare discharges can receive as much as a 25% adjustment. The adjustment is phased out gradually (linearly), with no adjustment for hospitals with 1,600 or more Medicare discharges. Medicare dependent hospitals (MDHs) and sole community hospitals (SCHs) paid on the basis of their hospital specific amounts were eligible for these low-volume payments. According to MedPAC, 529 hospitals received the about $400 million for the low volume adjustment in FY2011.

This ATRA provision extends the temporary modifications to the low-volume adjustment through September 30, 2013, retroactive to October 1, 2012.

*The CBO score is $300 million for FY2013-FY2017 and $300 million for FY2013-FY2022.*

### *§606. Extension of the Medicare-dependent hospital (MDH) program.*

Medicare dependent hospitals (MDHs) are small rural hospitals with a high proportion of patients who are Medicare beneficiaries. Specifically, the hospitals have at least 60% of acute inpatient

days or discharges attributable to Medicare in FY1987 or in two of the three most recently audited cost reporting periods. As specified in regulation, they cannot be a sole community hospital (SCH) and must have 100 or fewer beds. MDHs receive special treatment, including higher payments, under Medicare's inpatient prospective payment system. The sunset date for the MDH designation has been periodically extended by legislation and expired September 30, 2012.

This ATRA provision extends MDH designation through September 30, 2013, retroactive to October 1, 2012.

*The CBO score is $100 million for FY2013-FY2017 and $100 million for FY2013-FY2022.*

### *§607. Extension for specialized Medicare Advantage plans for special needs individuals.*

The MMA established a new type of Medicare Advantage (MA) coordinated care plan focused on individuals with special needs. Special needs plans (SNPs) are allowed to target enrollment to one or more types of special needs individuals including (1) institutionalized, (2) dually eligible, and/or (3) individuals with severe or disabling chronic conditions. Among other changes, ACA §3205 extended SNP authority through December 31, 2013 and temporarily extended authority through the end of 2012 for SNPs that do not have contracts with state Medicaid programs to continue to operate, but not to expand their service area.

This ATRA provision extends SNP authority through December 31, 2014, and also temporarily authorizes SNPs that do not have contracts with state Medicaid programs to continue to operate, but not to expand their service areas.

*The CBO score is $300 million for FY2013-FY2017 and $300 million for FY2013-FY2022.*

### *§608. Extension of Medicare reasonable cost contracts.*

Reasonable cost plans are Medicare managed care plans that are reimbursed by Medicare for the actual cost of providing services to enrollees. Cost plans were created in TEFRA. The BBA97 included a provision to phase-out the reasonable cost contracts, however, the phase-out has been delayed over the years through congressional action. After January 1, 2013, the Secretary could not extend or renew a reasonable cost contract for a service area if (1) during the entire previous year there were either two or more MA regional plans or two or more MA local plans in the service area offered by different MA organizations, and (2) these regional or local plans met minimum enrollment requirements.

This ATRA provision extends for one year—from January 1, 2013, to January 1, 2014—the length of time reasonable cost plans may continue operating regardless of any other MA plans serving the area.

*The CBO score is between $50 million and −$50 million for both FY2013-FY2017 and FY2013-FY2022.*

### *§609. Performance improvement.*

MIPPA §183 requires the Secretary to have a contract with a consensus-based entity (e.g., National Quality Forum or NQF) to carry out specified duties related to performance improvement and measurement. These duties include, among others, priority setting, measure endorsement, measure maintenance, and annual reporting to Congress.

This ATRA provision extends funding for this contract through FY2013 (September 30, 2013) and amends the duties of the consensus-based entity by removing the requirement that it promote the development of electronic health records to enable transmission of performance measurement information.

CMS has established a number of value-based purchasing initiatives in the Medicare program to encourage, and in some cases to reward, providers for meeting or making progress toward quality goals or benchmarks. These programs, in many cases, require providers to submit quality data to CMS.

This ATRA provision requires the Secretary to develop a strategy to provide performance improvement data to applicable Medicare providers (including CAHs, hospitals, and physicians, among others); such data must include feedback on the quality data submitted by the providers, as well as utilization data. The Secretary is required to consider a number of factors in developing this strategy, including among others, the type of provider receiving the data, risk adjustment methods, and the meaningful presentation of the data. The Secretary must submit the strategy, not later than one year after enactment, to relevant committees of Congress and make it publicly available; in addition, the Secretary is required to update the strategy based on stakeholder feedback, no later than 18 months after enactment. GAO is also required to conduct a study, not later than eight months after enactment, on private sector performance improvement data sharing activities, including among other things, how Medicare and private sector entities share data with providers and how Medicare can improve its data sharing practices.

*The CBO score is between $50 million and −$50 million for both FY2013-FY2017 and FY2013-FY2022.*

### *§610. Extension of funding outreach and assistance for low-income programs.*

MIPPA §119 appropriated $25 million for FY2008 and FY2009 for low-income Medicare beneficiary outreach and education activities through the following programs: State Health Insurance Counseling and Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and the Administration on Aging (AoA).[9] ACA §3306 extended these programs and appropriated an additional $45 million for these and other programs such as Medicare Part D low income subsidy outreach and the Medicare Savings Program. ACA §3306 appropriations were available for obligation through 2012.

This ATRA provision extends MIPPA §119 authorities through FY2013 and appropriates the following amounts for low-income Medicare beneficiary outreach and assistance programs: SHIPs, $7.5 million; AAAs, $7.5 million; ADRCs, $5 million; and the Contract with the National Center for Benefits and Outreach Enrollment, $5 million.

*The CBO score is between $50 million and −$50 million for both FY2013-FY2017 and FY2013-FY2022.*

## Subtitle B—Other Health Extensions

### *§621. Extension of the qualifying individual (QI) program.*

The BBA97 required states to pay Medicare Part B premiums for a new group of low-income Medicare beneficiaries – Qualifying Individuals (QIs) – with income between 120% and 135% of

[9] For more information on Medicare low-income outreach programs, see CRS Report RL33880, *Funding for the Older Americans Act and Other Aging Services Programs*, by Angela Napili and Kirsten J. Colello.

the Federal Poverty Limit (FPL). BBA97 also provided for Medicaid payment for QIs through an annual transfer from the Supplementary Medical Insurance Trust Fund (Part B) to be allocated to states. States (and the District of Columbia) receive 100% federal funding to pay QI's Medicare premiums up to the federal allocation, but no additional matching beyond this annual allocation.

This ATRA provision reauthorizes the QI program through December 2013 and appropriates $485 million for the second through the fourth quarters of FY2013 (January 1, 2013 – September 30, 2013) and $300 million for the first quarter of FY2014 (October 1, 2013 through December 31, 2013).

*The FY2013 CBO score is $0.6 billion and in FY2014 $0.2 billion. The CBO score is $0.8 billion for FY2013-FY2017 and $0.8 billion for FY2013-FY2022.*

### §622. Extension of Transitional Medical Assistance (TMA).

Under federal law, states are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation, called transitional medical assistance (TMA), requires four months of TMA for families who lose Medicaid eligibility due to increased child or spousal support collections, as well as those who lose eligibility due to an increase in earned income or hours of employment. §303(a)(1) of the Family Support Act of 1988 (P.L. 100-485) expanded work-related TMA and requires states to provide at least six, and up to 12, months of coverage. Since 1996, these work-related TMA requirements have been funded by short-term extensions.

This ATRA provision extends work-related TMA through December 31, 2013.

*The CBO score is $0.6 billion for both the FY2013-FY2017 and the FY2013-FY2022 periods.*

### §623. Extension of Medicaid and CHIP Express Lane option.

CHIPRA created a state plan option for "Express Lane" eligibility whereby states are permitted to rely on a finding from specified "Express Lane" agencies (e.g., those that administer programs such as Temporary Assistance for Needy Families, Medicaid, CHIP, and Food Stamps) for (1) determinations of whether a child has met one or more of the eligibility requirements necessary to determine his or her initial eligibility, (2) eligibility redeterminations, or (3) renewal of eligibility for medical assistance under Medicaid or CHIP.

This ATRA provision permits states to rely on "Express Lane" eligibility determinations through September 30, 2014.

*The CBO score is between $50 million and −$50 million for both FY2013-FY2017 and FY2013-FY2022.*

### §624. Extension of Family-to-Family Health Information Centers.

The Family-to-Family Health Information Centers program, administered by the Health Resources and Services Administration (HRSA), provides grants to family-staffed organizations that provide health care information and resources to families of children with special health care needs. ACA §5507 appropriated $5 million for each of FY2009 through FY2012 for Family-to-Family Health Information Centers.

This ATRA provision extends this appropriation an additional year, through FY2013.

*The CBO score is between $50 million and −$50 million for both FY2013-FY2017 and FY2013-FY2022.*

### *§625. Extension of Special Diabetes Program for Type I diabetes and for Indians.*

The BBA97 authorized two diabetes-related programs through the Public Health Act. The first, authorized in §330B, provides funding for the National Institutes of Health[10] to award grants for research into the prevention and cure of Type I diabetes. The second, authorized in §330C, provides funding for the Indian Health Service (IHS)[11] to award grants for services related to the prevention and treatment of diabetes for American Indians and Alaska Natives who receive services at IHS-funded facilities.[12] BBA97 appropriated funding for both programs from FY1998 through FY2002; funding years were expanded and amounts appropriated were increased in subsequent legislation (BIPPA, P.L. 107-360, and MMSEA). Most recently, MMEA extended each program's annual appropriation of $150 million for FY2011 through FY2013.

This ATRA provision extends the annual appropriation of $150 million for each program until FY2014.

*The CBO score is $0.3 billion for FY2014 and $0.3 billion for FY2013-FY2022.*

## Subtitle C—Other Health Provisions

### *§631. IPPS documentation and coding adjustment for implementation of MS-DRGs.*

CMS modified its patient classification system and introduced Medicare severity-diagnosis related groups (MS-DRGs) into the Medicare inpatient prospective payment system (IPPS) starting in FY2008. In the FY2008 IPPS rule, CMS established prospective budget neutrality adjustments of a reduction of −1.2% in FY2008, −1.8% in FY2009 and −1.8% in FY2010 because of anticipated increases in measured severity of illness attributable to documentation or coding improvements (DCI) associated with the new MS-DRGs. The TMA, Abstinence Education, and QI Programs Extension Act of 2007 (P.L. 110-90) reduced the adjustment to −0.6% in FY2008 and −0.9% in FY2009, but permitted retrospective offsets to IPPS rate increases in FY2010, FY2011, and FY2012 to account for DCI increases in FY2008 and FY2009 above these amounts. The law did not address the additional −1.8% decrease originally established by CMS for FY2010; CMS did not implement any DCI adjustment for FY2010.

In FY2011, CMS estimated that an additional −5.8% adjustment was warranted for DCI that increased payments in FY2008 and FY2009 (to recoup payments retroactively). Also, an additional −3.9% adjustment was necessary to eliminate the full effect of DCI for FY2008 and FY2009 on future payments (a prospective adjustment). CMS reduced the FY2011 update by −2.9%, half the amount of the retroactive recoupment adjustment and did not apply a prospective adjustment. In FY2012, CMS implemented a −2.9% retroactive adjustment (which had a net zero effect after adding back the 2.9% reduction from the previous year). CMS also implemented a −2.0% prospective reduction (leaving a −1.9% prospective adjustment for future years). In FY2013, the prospective DCI for FY2008 and FY2009 is addressed with a −1.9% adjustment.

[10] For more information on the National Institutes of Health, see CRS Report R41705, *The National Institutes of Health (NIH): Organization, Funding, and Congressional Issues*, by Judith A. Johnson and Pamela W. Smith.

[11] For more information on the Indian Health Service, see CRS Report R41152, *Indian Health Care: Impact of the Affordable Care Act (ACA)*, by Elayne J. Heisler.

[12] IHS-funded facilities refer to facilities operated directly by the IHS, by an Indian Tribe, a Tribal Organization, or an Urban Indian Organization as these terms are defined in §4 of the Indian Health Care Improvement Act (25 U.S.C. §1604).

After reversing the prior year's adjustment of −2.9%, the FY2013 documentation and coding adjustment is +1.0%.

This ATRA provision will permit additional adjustments to the base rates in FY2014 through FY2017 to recoup $11 billion in overpayments associated with DCI in FY2008, FY2009, and FY2010 that have not yet been recovered. The Secretary will not have the authority to recoup additional amounts associated with DCI for FY2008 and FY2009. This adjustment will not affect the Secretary's authority to apply a prospective adjustment for DCI with respect to FY2010 discharges.

*The CBO score is −$10.2 billion for FY2013-FY2017 and −$10.5 billion for FY2013-FY2022.*

### §632. Revisions to the Medicare ESRD bundled payment system to reflect findings in the GAO report.

For beneficiaries with end-stage renal disease (ESRD) receiving dialysis services, Medicare reimburses providers for each dialysis treatment performed using a single predetermined rate that is adjusted for patient characteristics (e.g., age and body mass index) and area wage differences. Prior to the MIPPA, Medicare provided dialysis payment on a per treatment basis, also known as the "composite rate," which covered a bundle of dialysis-related services, tests, and drugs; however, the composite rate did not include certain ESRD-related drugs, such as erythropoiesis stimulating agents (ESAs), and such drugs were separately billable. MIPPA included a provision to expand the composite rate to include previously separately billable drugs starting in 2011. As required by MIPPA, CMS calculated the Medicare bundled payment rate for dialysis treatments based on the prices and utilization of dialysis-related services, tests, and drugs within the composite rate and the previously separately billable ESRD drugs and services in 2007. As further required by MIPPA, GAO issued a report that found that utilization of ESRD drugs in 2011 was 23% lower, on average, than it was in 2007 – the year CMS derived utilization rates for the 2011 bundled payment rate.[13] The decrease in overall ESRD drug utilization was driven, for the most part, by a substantial decrease in ESA use.

This ATRA provision requires CMS to reduce the Medicare bundled payment rate for dialysis treatment in CY2014 to reflect CY2012 utilization rates. Additionally, this provision requires the Secretary to conduct an analysis of the case-mix payment adjustments being used and to make appropriate revisions no later than January 1, 2016. Further, this provision delays including oral-only ESRD-related drugs in the ESRD bundled payment rate for two years, from January 1, 2014 to January 1, 2016, and requires GAO to update its existing report on issues associated with including oral-only ESRD drugs in Medicare's bundled payment for dialysis treatment prior to January 1, 2016.

*The CBO score is −$1.5 billion for FY2013-FY2017 and −$4.9 billion for FY2013-FY2022.*

### §633. Treatment of multiple service payment policies for therapy services.

Medicare Part B pays for physician services (office visits, surgical procedures, anesthesia services, and a range of other diagnostic and therapeutic services) based on the Medicare physician fee schedule, which lists the more than 7,400 unique covered services and their payment rates. Following recommendations from GAO and MedPAC, CMS has established and implemented multiple procedure payment reduction (MPPR) policies to adjust payment to more

[13] U.S. Government Accountability Office, *End-Stage Renal Disease: Reduction in Drug Utilization Suggests Bundled Payment Is Too High*, GAO-13-190R, December 7, 2012, http://www.gao.gov/products/GAO-13-190R.

appropriately reflect efficiencies gained when certain services are provided together, for example, when multiple similar services are performed on the same patient during the same visit. These payment reductions reflect efficiencies that typically occur in either the practice expense (PE) or professional work component or both when services are furnished together.

ACA §3134 added §1848(c)(2)(K) of the SSA, which specifies that the Secretary must identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. In the 2013 Medicare physician fee schedule final rule, CMS established a new MPPR to the PE component of payment of select therapy services paid under the MPFS, with payment for the second and subsequent services to be reduced 25%. This reduction is similar to that currently applied to multiple surgical procedures and to diagnostic imaging procedures.

This ATRA provision specifies that, beginning April 1, 2013, the reduction will be increased from 25% to 50%.

*The CBO score is −$700 million for FY2013-FY2017 and −$1.8 billion for FY2013-FY2022.*

### *§634. Payment for certain radiology services furnished under the Medicare hospital outpatient department prospective payment system.*

Medicare pays for various types of stereotactic radiosurgery services (SRS) provided in a hospital outpatient department under its outpatient prospective payment system (OPPS). A complete course of treatment of cranial lesion(s) or one session provided by a multi-source Cobalt 60 based instrument (or Gamma Knife) is identified by code 77371 and assigned to Ambulatory Payment Code (APC) 0127 for an unadjusted payment of $7,910.51 as of January 1, 2013. One course of linear accelerator based SRS is identified by code GO173 and assigned to APC 0067 for an unadjusted payment of $3,300.64.

This ATRA provision establishes that the payment rate for Gamma Knife SRS will be reduced to the payment amount for linear accelerator based SRS, starting April 1, 2013. This payment reduction will not apply to hospitals in rural areas, rural referral centers, or SCHs.

*The CBO score is −$0.1 billion for FY2013-FY2017 and −$0.4 billion for FY2013-FY2022.*

### *§635. Adjustment of equipment utilization rate for advanced imaging services.*

Under the Medicare physician fee schedule, some services have separate payments for the technical component and the professional component. For example, imaging procedures generally have two parts: the actual taking of the image (the technical component), and the interpretation of the image (the professional component). Medicare pays for each of these components separately when the technical component is furnished by one provider and the professional component by another. When both components are furnished by one provider, Medicare makes a single global payment that is equal to the sum of the payment for each of the components.

CMS's original method for calculating the Medicare fee schedule reimbursement rate for advanced imaging services assumed that imaging machines are operated 25 hours per week, or 50% of the time that practices are open for business.[14] Citing evidence showing that the utilization rate is 90%, rather than the 50% previously assumed, MedPAC recommended that CMS use the higher utilization rate in the calculation of fee schedule payments for advanced

[14] A lower equipment use rate results in a higher payment for these services, since the fixed costs are spread over fewer procedures.

imaging services and CMS adopted a 90% use rate assumption in its 2010 final rule for Medicare physician payments. The ACA changed the utilization rate assumption for calculating the payment for advanced imaging equipment from 50%, as assumed in prior years, to 75% for 2011 and in subsequent years, overriding the CMS 2010 final rule that applied a 90% use rate assumption.

This ATRA provision requires the Secretary to apply a 75% use rate in calculating payment rates for advanced imaging services through 2013, and a 90% use rate for 2014 and subsequent years. These changes will not be taken into consideration in the Secretary's periodic review and adjustments in relative values.

*The CBO score is −$300 million for FY2013-FY2017 and −$800 million for FY2013-FY2022.*

### *§636. Medicare payment of competitive prices for diabetic supplies and elimination of overpayment for diabetic supplies.*

Medicare Part B has generally paid for most durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) on the basis of fee schedules. The MMA required the Secretary to establish a Competitive Acquisition Program (or Competitive Bidding) to replace the Medicare fee schedule for DMEPOS. Under Competitive Bidding, the Medicare payments for specified covered items are based on the bids of winning suppliers in competitive bidding areas. Payment rates based on competitive bidding are being used in the first nine competitive bidding areas as of January 1, 2011. Payment rates based on the second round of competition are set to be in place by July, 2013 in an additional 91 metropolitan areas. The second round of competition includes a national mail-order component for diabetic testing supplies. The national mail-order competition is to take place in the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam and American Samoa.

This ATRA provision requires the payments for diabetic supplies determined under the mail-order competitive bidding program to also be applied to non-mail-order diabetic testing supplies. In addition, within 30 days of enactment, but before payments based on competitive bidding are applied, the Secretary must recalculate and apply new payment rates to non-mail-order diabetic supplies taking into account a 9.5% reduction in the payment update for 2009 that did not apply to those items in 2009.

*The CBO score is −$0.6 billion for both FY2013-FY2017 and FY2013-FY2022.*

### *§637. Medicare payment adjustment for non-emergency ambulance transports for ESRD beneficiaries.*

MedPAC has found that there has been a higher increase in basic life support (BLS) nonemergency services (transports) relative to other kinds of ambulance services and that there is a wide variation across states, particularly with respect to transports to and from dialysis facilities.

This ATRA provision will reduce the fee schedule payment by 10% for BLS nonemergency transports of beneficiaries with ESRD for dialysis services by an ambulance provider or a renal dialysis facility starting October 1, 2013.

*The CBO score is −$0.2 billion for FY2013-FY2017 and −$0.4 billion for FY2013-FY2022.*

### *§638. Removing obstacles to collection of overpayments.*

SSA §1870 addresses return of beneficiary and provider and supplier overpayments. In general, providers are required to return incorrect (overpayments) within 60 days of receiving these payments once the overpayments are identified.[15] Prior to ATRA, under SSA §1870(c), the Secretary had until up to three years to identify the overpayments.

This ATRA provision extends the period during which the Secretary can identify overpayments, from three to five years.

*The CBO score is −$0.2 billion for FY2013-FY2017 and −$0.5 billion for FY2013-FY2022. The CBO score for FY2013 is −$0.1 billion.*

### *§639. Medicare advantage coding intensity adjustment.*

Under the Medicare Advantage program, private plans are paid a per-person monthly amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plan. In general, MA plan payments are risk-adjusted to account for the variation in the cost of providing care. Risk adjustment is designed to mitigate variation in the cost of treating different beneficiaries – adjusting for the increased cost of treating older and sicker beneficiaries as well as the reduced cost of treating younger and healthier beneficiaries – and thus discourage plans from preferential enrollment of healthier individuals. DRA required the Secretary to adjust for patterns of diagnosis coding differences between MA plans and providers under Parts A and B of Medicare for plan payments in 2008, 2009, and 2010. The ACA required the Secretary to conduct further analyses on the differences in coding patterns and adjust for those differences after 2010. Starting in 2014, the ACA specifies minimum coding intensity adjustments. In 2014, ACA requires that the adjustment be at least the value of the adjustment in 2010 plus 1.3 percentage points; for 2015 to 2018, the adjustment will be not less than the adjustment for the previous year increased by 0.25 percentage points; and starting in 2019, the coding intensity adjustment will not be less than 5.7%.

The ATRA provisions increases the statutorily defined minimum adjustment in 2014 from 1.3 percentage points above the 2010 adjustment, to 1.5 percentage points above the 2010 adjustment. ATRA also increases the floor for the 2019 adjustment from not less than 5.7%, to not less than 5.9%.

*The CBO score is −$1.1 billion for FY2013-FY2017 and −$2.5 billion FY2013-FY2022.*

### *§640. Elimination of all funding for the Medicare Improvement Fund.*

The MIPPA created a new SSA §1898, which established a Medicare Improvement Fund (MIF) available to the Secretary to make improvements under the original Medicare fee-for-service program under Parts A and B for Medicare beneficiaries. Although the original legislation established that $19.9 billion would be made available to the MIF from the Parts A and B trust funds for each year from FY2014 through FY2017, the amounts have been modified several times by other legislation, including ARRA and ACA, effectively leaving $275 billion in FY2015. For FY2020 and each subsequent fiscal year, funds in the amount of the Secretary's estimate of the aggregate reduction in Medicare expenditures during the preceding fiscal year resulting from

[15] ACA §6402(a) defined overpayments as any funds that a person receives or retains under Medicare or Medicaid to which the person, after applicable reconciliation, is not entitled under such title—SSA Title XVIII or Title XIX. When Medicare pays for non-covered services or pays too much for covered services, Medicare contractors are required to initiate recovery of these funds from providers, who usually receive Medicare payments, but can include beneficiaries, if they received the payment or the provider is determined to be without fault.

the reduction in payment to providers and plans that do not meet the electronic health record "meaningful use" criteria are to be transferred to the MIF.

This ATRA provision eliminates the remaining funds from the MIF, including the provision for future amounts beginning in FY2020 as specified above, although it does not repeal the section that creates the fund.

*The CBO score is −$300 million for FY2013-FY2017 and −$1.7 billion for FY2013-FY2022.*

### §641. Rebasing of State DSH allotments.

The Medicaid statute requires states to make disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income patients.[16] The federal government provides each state an annual DSH allotment, which is the maximum amount of federal matching funds that each state can claim for Medicaid DSH payments. The ACA included a provision directing the Secretary to make aggregate reductions in Medicaid DSH allotments equal to $500 million in FY2014, $600 million in FY2015, $600 million in FY2016, $1.8 billion in FY2017, $5.0 billion in FY2018, $5.6 billion in FY2019, and $4.0 billion in FY2020. MCTRJCA extended the FY2020 DSH reduction to FY2021.

This ATRA provision also extends the FY2020 DSH reductions to FY2022. It does not make changes for funding in FY2023, so that states' DSH allotments will revert to their pre-ACA reduced levels with the annual inflation adjustments for FY2014 to FY2023.

*The CBO score is $0 for FY2013-FY2017 and $4.2 billion for FY2013-FY2022.*

### §642. Repeal of CLASS program.

Title VIII of the ACA established a federally administered voluntary Long-Term Care (LTC) insurance program entitled the Community Living Assistance Services and Supports (CLASS) program. ACA created a new Title XXXII of the Public Health Service Act (PHSA), which established a process for the Secretary to develop the CLASS program to provide a cash benefit that eligible enrollees could use to purchase various long-term services and supports (LTSS).

This ATRA provision repeals PHSA Title XXXII. In doing so, it makes certain conforming statutory changes to Title VIII of the ACA and to the Medicaid statute. It also rescinds the unobligated balance of ACA's funds for the National Clearinghouse for Long Term Care Information. Title VIII of the ACA had extended $3 million in mandatory funding under the DRA for the Clearinghouse in each of fiscal years 2011 through 2015.

*The CBO score is between $50 million and −$50 million for both FY2013-FY2017 and FY2013-FY2022.*

### §643. Commission on Long-Term Care.

This ATRA provision establishes a Congressional Long-Term Care Commission, which is required to develop a plan for the establishment, implementation, and financing of long-term services and supports (LTSS) system. For the purposes of developing the plan, the Commission must provide recommendations for addressing the interaction of LTSS with existing programs, such as Medicare and Medicaid, and private insurance, among other things. The Commission is to be comprised of 15 members with certain members appointed by the President and others by

[16] For more information about Medicaid DSH and the DSH allotment reductions, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*, by Alison Mitchell.

specified Congressional leaders, no later than 30 days after enactment. Membership includes individuals who represent the interests of LTSS stakeholders and organizations, as described. It authorizes the Senate to disburse necessary Commission expenses, as requested, and sets forth various staffing and ethical standards and powers of the Commission in carrying out its duties. No later than six months after appointment, the Commission will vote on a report based on the developed plan and any proposals for legislative action, referred to as the Commission bill. If approved by a majority vote of Commission members, the Commission bill will be transmitted to the President and other specified Congressional leaders; the proposal and vote will also be made publicly available. If approved by a majority, the Commission bill must be introduced in the Senate and the House. The Commission will be terminated 30 days after the Commission vote.

*The CBO score is $0 for both FY2013-FY2017 and FY2013-FY2022.*

### *§644. Consumer Operated and Oriented Plan program contingency fund.*

The ACA established the Consumer Operated and Oriented Plan (CO-OP) program with the intent to facilitate the creation of new non-profit health insurance cooperatives in each state that will offer private health insurance coverage. The CO-OP program provides start-up and solvency loans to eligible non-profit organizations that must be repaid with interest according to the timeframe specified in ACA.[17] The Secretary began awarding loans in January 2012.[18] As enacted, ACA authorized $6 billion for the CO-OP program. Some of the program's funds were rescinded, reducing the authorization to $3.4 billion.[19]

This ATRA provision directs the Secretary to create a fund to be used to provide assistance and oversight to the organizations that were awarded CO-OP program loans prior to the date of enactment of ATRA. The fund will contain 10% of any unobligated CO-OP monies. The provision rescinds all other unobligated CO-OP program funds.

*The CBO score is −$0.2 billion for both FY2013-FY2017 and FY2013-FY2022.*

[17] The start-up loans must be repaid within five years, and the solvency loans must be repaid within 15 years (from the date of disbursement).

[18] A list of all of the non-profit organizations that have been awarded loans to date is available at http://www.healthcare.gov/news/factsheets/2012/02/coops02212012a.html.

[19] The Department of Defense and Full-Year Continuing Appropriations Act, 2011 (P.L. 112-10) rescinded $2.2 billion from the CO-OP program, and the Consolidated Appropriations Act, 2012 (P.L. 112-74) rescinded an additional $400 million.

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