Summary of Health-Related Provisions in the "Middle Class Tax Relief and Job Creation Act of 2012"

Averts Medicare Physician Payment Cuts, Slashes ObamaCare by $11.6 Billion, Eliminates Wasteful Spending

MEDICARE EXTENDERS

Section 3001 - Section 508 Hospital Payments –
Under Medicare's Inpatient Prospective Payment System (IPPS), payments are adjusted by a wage index that is intended to reflect the cost of labor in the area where the services are furnished compared to a national average. This provision extends higher wage payments to certain eligible hospitals, known as "Section 508 hospitals," through March 31, 2012, after which time the program will terminate. These special payments were created in 2003 and were intended to last for just three years. However, subsequent legislation allowed these hospitals to continue receiving the higher funding, without ever having to reapply for the higher wage rate despite the fact that the 1,200+ hospitals that go through the standard wage reclassification process have to reapply every three years. *CBO estimates this provision would increase spending by $100 million from 2012 through 2022.*

Section 3002 - Hospital Outpatient Hold Harmless Payments –
This provision eliminates an expansion that was created in ObamaCare and extends the outpatient hold harmless payments for eligible rural hospitals and sole community hospitals (SCHs) with fewer than 100 beds through December 31, 2012. The hold harmless payment provides a payment equal to 85 percent of the difference between an eligible hospital's outpatient prospective payment system (OPPS) and the hospital's costs. The provision also requires a study by the Department of Health and Human Services (HHS) on which types of hospitals truly need these payments in order to maintain beneficiary access to outpatient services. *CBO estimates this provision would increase spending by $100 million from 2012 through 2022.*

Section 3003 - Physician Payment Rates – This provision prevents a 27.4 percent cut in Medicare physician payment rates slated to begin on March 1, 2012, and instead freezes payment rates at their current level though December 31, 2012. This provision also requires the Government Accountability Office (GAO) and HHS to submit reports to assist Congress in the development of a long-term replacement to the current Medicare physician payment system. *CBO estimates this provision would increase spending by $18 billion from 2012 through 2022.*

Section 3004 - Physician Work Geographic Adjustment – This provision extends the floor on the adjustment to the work portion of payments for physician services that accounts for the geographic area where a physician practices. This provision increases payments to physicians in the 54 of the 89 Medicare geographic areas that would otherwise have an adjustment value below the floor. Additionally, the provision requires the Medicare Payment Advisory Commission (MedPAC) to examine whether any work geographic adjustment is needed, if so, at what level it should be applied, and the impact of the floor on beneficiary access to care. *CBO estimates this provision would increase spending by $400 million from 2012 though 2022.*

Section 3005 - Outpatient Therapy Caps – This provision extends the therapy caps exceptions process through December 31, 2012, with modifications that will require that the physician reviewing the therapy plan of care be detailed on the claim, reject all claims above the spending cap that do not include the proper billing modifier, and provide for a manual review of all claims for high cost beneficiaries to ensure that only medically necessary services are being provided. Furthermore, the spending caps ($1,880 in 2012), which have been in effect since 2006, would be extended to the hospital outpatient department setting to prevent a shift in the site of service to higher cost settings once enforcement of the current exceptions process begins. Exempting these services in the HOPD setting made sense when the hard therapy cap was in place, but it no longer makes sense with the exceptions process. Additionally, HHS is required to collect data to assist in reforming the payment system for therapy services. MedPAC is required to recommend improvements to the outpatient therapy benefit to reflect the individual needs of patients. *CBO estimates this provision would increase spending by $700 million from 2012 through 2022.*

Section 3006 - Payment for Technical Component of Certain Physician Pathology Services – This provision allows independent laboratories that have an arrangement with eligible hospitals to bill Medicare directly, as opposed to billing the hospital, for the surgical pathology services through June 30, 2012. This four-month extension provides time for the labs and hospitals to establish payment arrangements. Expiration after a reasonable transition period addresses concerns that Medicare is paying twice for the same service, which causes beneficiaries to make an extra co-payment. Minimal CMS oversight of the policy has also made Medicare susceptible to making inappropriate payments. Further, the GAO has recommended that this policy expire. *CBO estimates this provision would increase spending by less than $50 million from 2012 through 2022.*

Section 3007 - Ambulance Add-On Payments – This provision would extend through December 31, 2012, the following add-on payments: two percent for urban ground ambulance services, three percent for rural ground ambulance services, and an increase to the base rate for ambulance trips originating in qualified "super rural" areas as calculated by the Secretary (currently 22.6 percent). It also requires two reports – one from GAO on ambulance provider costs and another from MedPAC on whether or not the ambulance fee schedule should be reformed. These studies will help inform Congress as to whether these add-on payments should be continued in future years. This provision also extends a policy that allows air ambulance services originating in certain rural areas to continue to receive a 50 percent add-on payment to their base rate.
CBO estimates these provisions would increase spending by $100 million from 2012 through 2022.

OTHER HEALTH PROVISIONS

Section 3101 – Qualifying Individual (QI) Program – This provision would extend the Medicare QI program, which provides federal reimbursement for states to cover Part B premiums for seniors with incomes between 120 and 135 percent of poverty, through December 31, 2012. *CBO estimates that this provision would increase spending by $600 million from 2012 through 2022*.

Sec 3102 – Extension of Transitional Medical Assistance (TMA) - This provision would extend TMA, through December 31, 2012, for low-income families transitioning into employment. *CBO estimates this provision would increase spending by $1.1 billion from 2012 through 2022.*

OFFSETS

Section 3201 - Reducing Bad Debt Payments – Under current law, Medicare reimburses hospitals and skilled nursing facilities (SNFs) for 70 percent of the beneficiary cost-sharing they are unable, or unwilling, to collect ("bad debt"). Certain other providers, such as federally qualified health centers (FQHCs) and dialysis centers, are reimbursed 100 percent for the bad debt. SNFs are reimbursed 100 percent for the bad debt resulting from the treatment of "dual eligible" beneficiaries, those enrolled in both Medicare and Medicaid. Although CMS requires providers to take reasonable steps to collect bad debt, this generous reimbursement policy is believed to discourage providers from doing as much as they could. This provision would phase down the bad debt reimbursements to 65 percent beginning in FY2013 for providers who are currently being reimbursed at 70 percent, while phasing in the reduction to 65 percent over three years for those who are reimbursed at 100 percent of their bad debt. President Obama recommends that bad debt payments be reduced to 25 percent. *CBO estimates this provision would reduce spending by $6.9 billion from 2012 through 2022.*

Section 3202 - Resetting Clinical Laboratory Payment Rates – This provision reduces payment rates for clinical laboratory services by two percent in 2013. As the two percent reduction is applied after the update is calculated, the resulting 2013 update amount becomes the new reset base on which the 2014 update will be applied. The two percent reduction is less than the ten percent cut MedPAC suggested as part of its October 2011 package of potential policies to offset the cost of a comprehensive SGR fix. *CBO estimates this provision would reduce spending by $2.7 billion from 2012 through 2022.*

Section 3203 - Medicaid Disproportionate Share Hospital (DSH) Allotments - This provision would rebase the DSH allotments for FY2021. *CBO estimates this provision would reduce spending by $4.1 billion from 2012 through 2022.*

Section 3204 – Correcting the Medicaid "Federal Disaster" Matching Rate - This provision eliminates funding for the "Louisiana Purchase" contained in ObamaCare beginning in FY2014. *CBO estimates this provision would reduce spending by $2.5 billion from 2012 through 2022.*

Section 3205 - Reduction in the Prevention and Public Health Fund

This provision reduces funding in the so-called "Prevention and Public Health Fund," also known as the "Harkin Fund," which was created in ObamaCare, which provides the Secretary of HHS unlimited authority to spend above and beyond appropriated levels for any activity authorized by the Public Health Service Act. *CBO estimates this provision would reduce spending by $5 billion from 2012 through 2022.*