

## Congressional Summary of Medicare Provisions and Offsets

This PDF is a summary of the legislative provisions and offsets (savings) to the American Taxpayer Relief Act of 2012 (HR 8). It outlines the details of provisions that will impact the Medicare program, including physical therapists. This summary will assist you in preparing for changes in how Medicare addresses payment levels and provisions, such as the therapy cap exceptions process. The Centers for Medicare and Medicaid Services will be issuing additional guidance in the coming days and weeks. For more information, please check [APTA's website](#) and visit [News Now](#).

### **Subtitle A - Medicare Extensions**

**Medicare Physician Payment Update.** This provision guarantees seniors have continued access to their physician and other providers by fixing the Sustainable Growth Rate (SGR) through the end of 2013. Medicare physician payment rates are scheduled to be reduced by 26.5% on December 31, 2012. This provision would avoid that reduction and extend current Medicare payment rates through December 31, 2013.

**Work Geographic Adjustment.** Under current law, the Medicare fee schedule is adjusted geographically for 3 factors to reflect differences in the cost of resources needed to produce physician services: physician work, practice expense, and medical malpractice insurance. This provision extends the existing 1.0 floor on the “physician work” index through December 31, 2013.

**Payment for Outpatient Therapy Services.** Current law places annual per beneficiary payment limits of \$1,880 for all outpatient therapy services provided by nonhospital providers, but includes an exceptions process for cases in which the provision of additional therapy services is determined to be medically necessary. This provision extends the exception process through December 31, 2013. The provision also extends the cap to services received in hospital outpatient departments only through December 31, 2013.

**Ambulance Add-On Payments.** Under current law, ground ambulance transports receive add-on to their base rate payments of 2% for urban providers, 3% for rural providers, and 22.6% for super-rural providers. The air ambulance temporary payment policy maintains rural designation for application of rural air ambulance add-on for areas reclassified as urban by OMB in 2006. This provision extends the add-on payment for ground including in super rural areas, through December 31, 2013, and the air ambulance add-on until June 30, 2013.

**Extension of Medicare inpatient hospital payment adjustment for low-volume hospitals.** Qualifying low-volume hospitals receive add-on payments based on the number of Medicare discharges. To qualify, the hospital must have less than 1,600 Medicare discharges and be 15 miles or greater from the nearest like hospital. This provision extends the payment adjustment until December 31, 2013.

**Extension of the Medicare-Dependent hospital (MDH) program.** The Medicare Dependent Hospital (MDH) program provides enhanced reimbursement to support rural health infrastructure and to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This greater dependence on Medicare may make these hospitals more financially vulnerable to

prospective payment, and the MDH designation is designed to reduce this risk. This provision extends the MDH program until October 1, 2013.

**Extension for specialized Medicare Advantage plans for special needs individuals.** Extends the authority of specialize plans to target enrollment to certain populations through 2015.

**Extension of Medicare Reasonable Cost Contracts.** This provision allows Medicare cost plans to continue to operate through 2014 in an area where at least two Medicare Advantage coordinated care plans operate.

**Performance Improvement.** Under the Medicare Improvement for Patients and Providers Act of 2008, HHS entered into a 5-year contract with a consensus-based entity for certain activities relating to health care performance. This provision continues this funding through 2013. This provision also requires HHS to develop a strategy for providing data on performance improvement in a timely manner.

**Extension of funding outreach and assistance for low-income programs.** This provision extends the funding for one year for State Health Insurance Counseling Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and The National Center for Benefits Outreach and Enrollment.

## **Subtitle B - Other Health Provisions**

**Extension of the Qualifying Individual Program.** The Qualifying Individual (QI) program allows Medicaid to pay the Medicare Part B premiums for low-income Medicare beneficiaries with incomes between 120% and 135% of poverty. Under current law, QI expires December 31, 2012. This provision extends the QI program until December 31, 2013.

**Extension of Transitional Medical Assistance.** Transitional Medical Assistance (TMA) allows low-income families to maintain their Medicaid coverage as they transition into employment and increase their earnings. Under current law, TMA expires December 31, 2012. This provision extends TMA until December 31, 2013.

**Extension of Medicaid and CHIP Express Lane option.** The CHIP Reauthorization Act of 2009 created a new option that allows state Medicaid and CHIP offices to rely on data from other state offices, like SNAP and school lunch programs, in making income eligibility determinations for children, called Express Lane Eligibility (ELE). The authority to use ELE expires on September 30, 2013. This provision would extend ELE authority through September 30, 2014.

**Extension of Family-to-Family Health Information Centers.** This provision continues the Family to Family Health Information Centers (F2F HIC) to assist families of children/youth with special health care needs in making informed choices about health care in order to promote good treatment decisions, cost-effectiveness and improved health outcomes. This provision will help families navigate the health care system so that their children can get the care and benefits they need through Medicaid, SCHIP, SSI, early intervention services, private insurance and other programs. In addition, F2F HICs provide leadership and training for health care providers and policymakers to promote family-centered “medical home” for every child. There is one F2F HIC in every state and the District of Columbia. The total cost of this provision is \$5 million per year.

**Extension of Special Diabetes Program for Type 1 diabetes and for Indians.** Funds research for type 1 diabetes and supports diabetes treatment and prevention initiatives for American Indians and Alaska Natives. The Special Diabetes Program (SDP) expires at the end of 2013, but early reauthorization is critical to the continuation of the existing research initiatives. This provision would extend the SDP for 1 year.

### **Provisions and Offsets**

**Documentation and Coding (DCI) adjustment.** This provision will phase in the recoupment of past overpayments to hospitals made as a result of the transition to Medicare Severity Diagnosis Related Groups (MS-DRGs). Savings: \$10.5 billion.

**Rebase End Stage Renal Disease (ESRD) payments.** This provision incorporates recommendations from the General Accountability Office by re-pricing the bundled payment to take into account changes in behavior and utilization of drugs for dialysis. Savings: \$4.9 billion.

**Therapy Multiple Procedure Payment reduction.** This provision further reduces payment for subsequent therapies when therapies are provided on the same day. Savings: \$1.8 billion.

**Payment for Certain Radiology Services.** This provision would equalize payments for stereotactic radiosurgery services provided under Medicare hospital outpatient payment system. Savings: \$0.3 billion.

**Adjustment of Equipment Utilization Rate for Advance Imaging Services.** This policy would increase the utilization factor used in the setting of payment for imaging services in Medicare from 75% to 90%. Savings: \$0.8 billion.

**Competitive Prices for Diabetic Supplies.** This proposal would apply competitive bidding to diabetic test strips purchased at retail pharmacies. Savings: \$0.6 billion.

**Adjust Payment Adjustment for Non-Emergency Ambulance Transports For ESRD Beneficiaries.** This provision reduces the payment rates for ambulance services by 10% for individuals with ESRD obtaining non-emergency basic life support services involving transport, based on a recent General Accountability Office report. Savings: \$0.3 billion

**Increase statute of limitations for recovering overpayments.** This provision increases the statute of limitations to recover overpayments from 3 to 5 years, based on recommendations from the Office of Inspector General at the Department of Health and Human Services. Savings: \$0.5 billion.

**Medicare Improvement Fund.** This provision eliminates funding for the Medicare Improvement Fund. Savings: \$1.7 billion.

**Rebase Medicaid Disproportionate Share Hospital (DSH) payments to extend the changes from the Affordable Care Act (ACA) for an additional year.** This proposal rebases DSH allotments to maintain the level of changes achieved in the ACA, and determines future allotments off of the rebased level using current law methodology. Savings: \$4.2 billion.

**Repeal of CLASS program.** The provision repeals the Community Living Assistance Services and Supports (CLASS) program established by the Affordable Care Act. This provision has no scoring implications.

**Commission on Long Term Care.** The provision establishes the Commission on Long Term Care to develop a plan for the establishment, implementation, and financing of a high quality system that ensures the availability of long-term services and supports for individuals. This provision has no scoring implications.

**Coding Intensity Adjustment.** Under current law, Medicare Advantage plans receive risk-adjustment payments that are further adjustment to reflect differences in coding practices between Medicare fee-for-service and Medicare Advantage. This provision increases this coding intensity adjustment. Savings: \$2 billion.

**Consumer Operated and Oriented Plan (CO-OP).** This provision will rescind all unobligated CO-OP funds under section 1332(g) of the Affordable Care Act. This provision also creates a contingency fund of 10% of the current unobligated funds to be used to further assist currently approved co-ops that have already been created. The provision does not take away any obligated CO-OP funds. Savings: \$2.3 billion.