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American Taxpayer Relief Act of 2012: Physician Cuts Averted, Hospitals to Carry Portion of Price Tag [Ober|Kaler]

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Avoiding sending American taxpayers over the so-called "fiscal cliff," Congress enacted the American Taxpayer Relief Act of 2012 (the "Act") that was signed into law on January 2, 2013. Of biggest note, the Act included a provision to avoid implementation of the statutory reduction of Medicare payments to physicians of approximately 26.5% required under the Sustainable Growth Rate (SGR) (Section 601). Congress has enacted similar "doc fixes" in the past to delay implementation of the flawed SRG adjustment. While this temporary fix will cause physicians to breathe a sigh of relief and will stave off the potential for drastic reduction in physician participation in Medicare for at least one more year, it comes at a price for hospitals, as its $25.2 billion dollar price tag is funded, in part, by the following purported cost-saving measures:

- Implementation of documentation and coding adjustments for inpatient prospective payment system (IPPS) hospitals to recoup purported overpayments associated with the transition to Medicare Severity Diagnosis Related Groups (MS-DRGs). (Section 631). According to the Congressional Budget Office (CBO) Report this will cost hospitals approximately $10.2 billion in the next five years.`
- Rebasing of the state disproportionate share hospital (DSH) allotment effective in 2021 resulting in approximately $4.2 billion in savings. (Section 641).

In addition, the Act includes a provision extending one aspect of the statute of limitations for Medicare to recoup non-fraudulent overpayments from providers from three years to five years. (Section 638). A discussion of this provision can be found in the accompanying article entitled "Extension of Time for Overpayment Recoveries in Fiscal Cliff Law Not as Broad as it Sounds."

Below is a short list of other key provisions of the Act that impact health care providers:

Physicians

- Extension of the floor on the Medicare physician work geographic practice cost index through December 31, 2013. (Section 602).

Therapy Providers

- Extension of the outpatient therapy caps ($1,900 for speech-language/physical therapy combined, and $1,900 for occupational therapy) and exceptions process through December 31, 2013. (Section 603).
- Increasing the multiple procedure payment reduction for therapy services performed on the same day from 25% to 50%, effective April 1, 2013. (Section 633).

Ambulance Providers

- Extension of the following ambulance payment provisions: (1) 3% increase for ground transports originating in rural areas and 2% for transports originating in urban areas; (2) treatment of air ambulance services as rural in any area designated as rural as of December 31, 2006, through June 30, 2013; and (3) increases in the base rate for ground transports originating in areas within the lowest 25th percentile of all rural areas (i.e., “super rural” bonus). (Section 604).
- 10% reduction in fee schedule payment for non-emergency transports for ESRD patients requiring renal dialysis services. (Section 637).

Hospitals

- Extension of payment adjustments for qualifying low-volume hospitals and Medicare-dependent hospitals. (Sections 605 and 606).

Imaging Services

- Equalizing payments for stereotactic radiosurgery procedures furnished under the Medicare outpatient prospective payment system (OPPS). (Section 634). Stereotactic radiosurgery is a specialized form of radiation therapy that targets well-defined tumors without effecting nearby tissues. CBO estimates this will save Medicare approximately $400 million in the next ten years.
- Adjustment of the equipment utilization factor used in setting payment for imaging services in Medicare from 75% to 90%. (Section 635).

Dialysis Providers

- Rebasing Medicare end stage renal disease (ESRD) bundled payments to incorporate findings relating to changes in behavior and utilization of dialysis drugs as set forth in a report issued by the Government Accountability Office (GAO). (Section 632). CBO estimates this will result in $4.9 billion in savings to the Medicare program over the next ten years.

Miscellaneous Provisions

- Implementation of a competitive bidding process for diabetic testing supplies, including diabetic test strips. (Section 636).