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**One man’s Debt Ceiling is Another Man’s Debt Floor (with apologies to Paul Simon)**

As the July Washington Report was being written, the Congress was attempting to finalize action on legislation raising the federal debt limit and simultaneously mandate future reductions in federal spending. Although the legislation was signed by the President in “August” we are including information on this action in the July Washington Report.

On August 2nd, President Obama signed into law the Budget Control Act (BCA) of 2011, legislation authorizing a lifting of the federal debt ceiling. The legislation also establishes a framework for future “cuts” in the federal budget, as well as a mechanism to ensure that those future cuts actually occur.

Below are some key points on the Budget Control Act:

- Raises the debt ceiling sufficient to permit government borrowing through 2012;
- “Cuts” almost $2.4 trillion over the next 10 years;
- Establishes hard “caps” on domestic discretionary spending for the next two years; and,
- Requires Congress to vote on a balanced budget amendment this year.
The BCA calls for an immediate cut of approximately $914 Billion in federal spending (calculated over 10 years) in exchange for an immediate $900 Billion increase in the debt limit. The bill also authorizes the President to request an additional $1.2 Trillion increase in the debt limit but this is predicated upon cutting an additional $1.2 Trillion in federal spending (again calculated over 10 years). If Congress were to approve the Balanced Budget constitutional amendment and send it to the states for ratification, the legislation authorizes an additional $300 Billion raise in debt ceiling.

The BCA mandates the creation of a 12 member “super” committee called the Joint Select Committee on Deficit Reduction (Joint Committee), to recommend the cuts necessary to meet the targets established in the BCA. Membership on this Committee will be equally divided between the House and Senate and between Republicans and Democrats. Therefore, the Joint Committee will have 3 House Republicans and 3 House Democrats and 3 Senate Republicans and 3 Senate Democrats.

The Joint Committee must recommend cuts to Congress by November 23, 2011 and the Congress must act on those cuts no later than December 23rd with final passage no later than January 15, 2012.

The amount of the cuts adopted can be no less than the amount of the increase in the debt limit sought by the President.

If the Joint Committee fails to reach an agreement or the Committee reaches agreement but one or both houses of Congress fails to enact the recommended cuts, or Congress enacts some of the Joint Committee’s recommendations but the amount of the cuts is less than the amount required, then there would be an automatic across-the-board “sequestration” of federal spending sufficient to achieve the amount required.

If sequestration is triggered, the BCA stipulates that ½ of the across-the-board cuts must come from defense spending and ½ from domestic discretionary spending AND Medicare. Certain domestic programs are protected from sequestration (i.e. Social Security, Medicaid, Veterans benefits among them). Any mandatory sequestration for Medicare MUST come from provider payments and cannot come from beneficiaries. Further, the law stipulates that if sequestration is triggered, the amount of the sequestration related cuts in Medicare cannot exceed 2% of projected outlays.

There are no restrictions on what the Joint Committee can consider or recommend (including tax increases). In order for the Joint Committee to make a recommendation, it must be approved by 7 members of the Joint Committee. Although, an increase in taxes or the closing of tax loopholes can be considered and recommended by the Joint Committee, it is considered highly unlikely that a proposal that included such a proposal could get the 7 votes necessary to be reported out by the Joint Committee. In the event tax increases were included in the Joint Committee’s recommendations, special provisions included in the BCA make it extremely unlikely a tax increase recommendation could pass in the House of Representatives.
The Speaker of the House, Minority Leader in the House, Majority Leader of the Senate, and Minority Leader in the Senate must make their appointments within 14 days of the enactment of the Budget Control Act of 2011. Given that the President signed the bill into law on August 2nd, the Joint Committee membership will be announced no later than August 16th.

The Joint Committee would cease to exist at the end of January, 2012.

Been There, Done That

The mandatory spending reductions with a sequestration trigger is not a new approach to reducing federal spending. The concept is drawn largely from the Balanced Budget and Emergency Deficit Control Act of 1985 – also known as the Gramm (R-TX), Rudman (R-NH), Hollings (R-SC) Budget initiative.

Essentially, Gramm, Rudman, Hollings (G-R-H) established hard budget caps for discretionary spending (both defense and non-defense) as well as entitlement spending (Medicare and Medicaid). During the life of the G-R-H, the Appropriations Committees were held to strict budget caps and the Congressional Committees charged with overseeing entitlement programs were given hard targets for reducing spending on entitlement programs. If the Congress failed to enact the legislation necessary to achieve the hard targets, automatic across the board spending reductions were to be enacted for defense spending, non-defense discretionary spending and entitlement spending, etc.

G-R-H proved highly effective in forcing Congress to exercise fiscal discipline and enact changes in various programs necessary to stay within the budget caps. For several years, the Medicare program saw significant reductions in aggregate spending as a result of the G-R-H requirements.

It should be noted, however, that the budget targets for entitlement programs such as Medicare are based upon projected spending. And, by definition, projected spending is based upon a variety of assumptions the actuaries make about program growth.

For example, when calculating future growth in Medicare spending, the Congressional Budget Office (CBO) estimates the impact of inflation on Medicare Part A. Existing formulas built into the Medicare program translate those inflation assumptions into automatic increases in payments for hospitals, nursing homes, home health agencies, etc. This projected increase is then built into projected spending for Medicare by the CBO.

During the time when the G-R-H was in effect, Congress would routinely alter the inflation adjustment formula to simply provide a smaller annual increase for hospital payments than CBO had assumed in their estimate. By statutorily reducing the
assumed inflation adjustment, Congress was able to significantly “cut” long-term Medicare expenditures in the aggregate even though hospitals would still get an increase. So in Congressional parlance, a reduction in the amount of an increase constitutes a “cut” in Medicare spending.

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**How does enactment of the BCA Affect the SGR situation?**

It is estimated that physician fee schedule payments will be reduced by approximately 29.4 percent effective January 1, 2012 as a result of the Sustainable Growth Rate formula. As you know, in the past, Congress has routinely stepped in at the last minute to prevent these cuts from occurring. However, the enactment of the BCA and the sequestration trigger included in the legislation will make it more difficult for Congress to use the types of budgetary gimmicks it has used in the past to “pay for” a temporary SGR fix.

The problem Congress confronts each year when attempting to deal with the SGR is how to pay for a fix. As noted in the previous article the Congressional Budget Office makes an estimate each year for future Medicare spending. Part of the model the CBO uses to calculate future spending assumes that the SGR related cuts will occur. So the current CBO projection for Medicare spending in 2012 assumes that the 29.4 percent reduction will occur.

CBO estimates that a permanent fix of the SGR formula, would cost more than $300 billion over the next 10 years. In other words, Medicare spending, in the aggregate will be $300 billion higher by 2021 than is currently projected if Congress eliminates the SGR formula and replaces it with something else (although we don’t know what that “something else” will be). Therefore, in order for Congress to fix the SGR, cuts totaling $300 billion over 10 years, would have to be enacted.

Under the BCA, tens of billions of dollars in cuts in future Medicare aggregate spending are mandated and these would be in addition to any cuts necessary to “pay for” an SGR fix.

While it is entirely likely that Congress will use the “reduction in the amount of the increase” mechanism to meet the BCA target, all of these reductions will have to come from future hospital payments, nursing home payments, home health payments and other Part A provider payments because there is no projected increase in Part B physician payments – only projected decreases due to the SGR.

Because of the timing of the SGR cut and the timing of the Congressional schedule for consideration of the Joint Committee’s spending reduction recommendations, it is anticipated that a major effort will be made to have the new Joint Committee address both the BCA cuts and the SGR situation as part of their deliberations.
HBMA anticipates being actively engaged in both the BCA and SGR deliberations that will be occurring over the next 4 – 5 months.

Bi-Partisan Group of officials Want IPAB repealed

Not to be forgotten in all of the budget/debt ceiling news is the looming spectre of the Independent Payment Advisory Board (IPAB) established by the Patient Protection and Affordable Care Act (ACA).

It appears that the Independent Payment Advisory Board has accomplished something many thought impossible – bipartisanship in Washington, DC.

Recently, a bi-partisan group of lawmakers testified before Congress that IPAB was ill-conceived and should be repealed. Even more interesting than the bringing together of Republicans and Democrats, opponents of IPAB come from the conservative and liberal wings of their respective parties.

Interestingly, one of the consistent unifying themes for both the left and right on this issue is the usurpation of Congressional authority and oversight of the Medicare program.

During a recent hearing about this issue before the House Energy and Commerce Health Subcommittee, the Chairman of the Subcommittee, Joe Pitts (R-PA) suggested that the Board would have more influence over the future direction of health care and health policy than Congress or any government agency. Ironically, supporters of IPAB agreed with Pitts’ assessment but argued that this is exactly what was intended and, more importantly, what is needed if the federal government hopes to get health care spending under control.

It is expected that members of the IPAB will be announced in the not-too-distant future by President Obama and they will begin their work in 2012. Initially, the Board will make observations and recommendations about the future direction of healthcare delivery and health policy but by 2014, the “recommendations” will begin to take on greater and greater authority.

Opponents of IPAB argue that eventually, the Board will have virtually unrestrained authority to make cuts in Medicare or Medicaid healthcare provider payments and therefore make decisions about the future direction of healthcare in this country. And although the ACA provides for some Congressional oversight of the Board’s work, IPAB opponents argue that the mechanisms for exercising that oversight are very constrained and ultimately meaningless.

Initially, the Board is authorized to make suggested cuts in Medicare spending but Congress would have to adopt those recommendations using the normal legislative
process. In this regard, the Board is no different than the current Medicare Payment Advisory Commission (MedPAC). However, beginning in 2014, IPAB’s "recommendations" would take effect automatically unless Congress votes to block or change them within a relatively short period of time and with numerous restrictions to change an IPAB "recommendation".

The coalition of Republicans and Democrats opposed to IPAB argue this would effectively remove their ability to control Medicare funding. Supporters of IPAB say that recent history would suggest that neither party has demonstrated an ability to control Medicare spending and therefore an independent body, insulated presumably from the political pressures to which Congress is subjected, is just what is needed to make decisions in the best interest of the Medicare program and not what is in the best interest of “special interests”.

Several bills have been introduced in Congress to either repeal IPAB outright or severely restrict the Board’s authority. The bill that appears to have generated the most support is one introduced by Representative Phil Roe (R-TN). Roe was a physician prior to being elected to Congress in 2008.

Roe’s bill, H.R. 452, the Medicare Decisions Accountability Act of 2011 has 198 Republican and Democratic cosponsors. A similar bill has been introduced in the Senate by Senator John Cornyn (R-TX). S. 668, the Health Care Bureaucrats Elimination Act has 32 cosponsors, however, unlike Representative Roe’s bill, all of Senators who have joined with Cornyn on this IPAB repeal initiative are Republicans.

New Health Plans on the Horizon

A little noticed provision in the Affordable Care Act authorizes the federal government to provide billions of dollars in start-up and capitalization funding for new state-based Health Insurance Cooperatives (CO-OPs).

On July 18th, the Centers for Medicare and Medicaid Services (CMS) announced it was taking the steps necessary to “encourage the creation of Consumer Operated and Oriented Plans (CO-OPs)” According to CMS, these new, private non-profit, consumer-governed health insurance plans will “help increase competition and give consumers and small businesses additional affordable health insurance choices.”

CMS is proposing standards for CO-OPs, as well as the requirements a CO-OP must meet in order to qualify for loans to help start-up and capitalize these new health plans. Approximately $3.8 Billion in federal loans will be available to these new entities. Because these are loans and not grants, all of the money must be repaid with interest. Loans will only be made to nonprofit entities that demonstrate a high probability of becoming financially viable.
Despite the stated “high probability of becoming financially viable” requirement, CMS estimates that there will be a 40% default rate for the start-up and capitalization loans.

Loosely modeled after the Rural Electric CO-Ops familiar in many rural areas of the country, these health insurance CO-Ops are intended to “give consumers and small businesses control over their own health insurance.” And, because these CO-Ops must be private, non-profit insurers governed by their members, the expectation is that these plans will offer more affordable consumer-friendly health insurance options than those available from for-profit insurance companies.

Under the CMS proposed standards, CO-OPs will be required to use any profits the plan generates “to benefit it members, including actions to lower premiums, improve health benefits, improve the quality of members’ health care, expand enrollment, or otherwise contribute to the stability of coverage for members.”

The goal of the program is to create a CO-OP in every state. Once up and running, the CO-OP plans will be available for purchase through either the Affordable Health Insurance Exchanges or the Small Business Health Option Program (SHOP) Exchanges mandated by the Patient Protection and Affordable Care Act. However, unlike private insurance products that will have to be certified by the federal government to be available through either of the Exchanges, CO-OP insurance plans will not be subject to federal government certification and will automatically be available in the Exchanges.

CO-OP insurance products are not new. According to CMS, approximately 2 Million people currently obtain their health insurance through a co-operative insurance entity. Existing CO-OP insurance entities are ineligible for these start-up or capitalization loans.

And Speaking of Exchanges

On July 11, the Department of Health and Human Services (HHS) issued proposed rules outlining the mechanisms states must use in establishing Affordable Health Insurance Exchanges. The establishment of these Exchanges was mandated as part of the Patient Protection and Affordable Care Act (ACA).

As envisioned by HHS, an Exchange is “a State-based competitive marketplace where individuals and small businesses will be able to purchase affordable private health insurance.” Under the new proposed federal standards, each state would have the opportunity to tailor its Exchange to meet its state-specific needs.

Exchanges are, in effect, seen as a “one-stop shop” where individuals and small business can get information about their health insurance options, enroll in health insurance plans available through the Exchange, determine eligibility for federal tax
credits for purchasing health insurance as well as determine eligibility for Medicaid or a state’s Children’s Health Insurance Program.

Under the proposed rule, Exchanges would:

* Certify, recertify, and decertify health plans offering coverage through the Exchange, called qualified health plans;
* Assign ratings to each plan offered through the Exchange on the basis of relative quality and price;
* Provide consumer information on qualified health plans in a standardized format;
* Create an electronic calculator to allow consumers to assess the cost of coverage after application of any advance premium tax credits and cost-sharing reductions;
* Operate a website and toll-free telephone hotline offering comparative information on qualified health plans and allowing consumers to apply for and purchase coverage if eligible;
* Determine eligibility for the Exchange, tax credits and cost-sharing reductions for private insurance, and other public health coverage programs, and facilitating enrollment of eligible individuals in those programs; and
* Determine exemptions from requirements on individuals to carry health insurance, grant approvals to individuals relating to hardship or other exemptions.

This proposed rule is intended to provide guidance to the states on how best to establish their Exchanges, including the purpose, scope, and operation of Exchanges and allow interested parties to comment on the contents of the proposed rule.

Although seemingly contradictory, HHS maintains that the rulemaking would establish a mechanism for state flexibility but yet create Exchange program that would be “standardized across the country.”

HHS also took this opportunity to announce the creation of the Small Business Health Options Program (SHOP). According to HHS, SHOP will “provide a way for small employers to offer their employees a choice of health plans like those offered by large employers.” SHOPs are intended to give small employers and their employees greater bargaining power, a bigger risk pool, and choices among affordable health plans.

Although employers would still be able to purchase health insurance coverage for the company’s employees outside of an Exchange, employers using the Exchange could choose the range of plans they want to make available to company employees, decide on a contribution toward the coverage and then allow employees to select the plans that best meets their needs and resources.

Employers using the Exchange could offer multiple plans from several insurance companies, but would receive a single bill and write a single check to the Exchange.
As noted above, under the proposed standards, an Exchange must “certify” a health plan before it can be sold through the Exchange as a “qualified health plan.”

In order to become certified, a health plan must meet certain minimum standards as outlined in this proposed rule. The minimum standards encompass several different areas including marketing and network adequacy (to the extent the plan is a network based plan). Exchanges can adopt additional criteria including affordability and quality.

Even though a health plan may meet the Exchanges marking and network adequacy requirements, an Exchange can reject an applicant if the Exchange determines that offering a particular plan is “not in the best interest of individuals or small businesses”.

The ACA mandates the establishment of an Exchange in every state but the law also allows the state to opt out of creating an Exchange. If a state opts out of creating an Exchange, the federal government would then be authorized to create a federally supported and operated Exchange in that state.

In announcing the guidelines for the establishment and operation of these state-based Exchanges, CMS also noted that they will be issuing additional guidance and proposed rules in the near future governing:

(1) Standards for individual eligibility for participation in the Exchange, advance payments of the premium tax credit, cost-sharing reductions, related health programs, and appeals of eligibility determinations;
(2) Standards outlining the Exchange process for issuing certificates of exemption from the individual responsibility requirement;
(3) Defining essential health benefits, actuarial value and other benefit design standards; and
(4) Standards for Exchanges related to quality.

If you would like to review the Exchange proposed rule, go to Health Insurance Exchange.

CMS Releases 2012 Physician Fee Schedule Proposed Rule

On June 30th, the Centers for Medicare and Medicaid Services (CMS) issued a Notice of Proposed Rulemaking (NPRM) proposing numerous changes in the Medicare Physician Fee Schedule (MPFS). This is an annual process.

Members of the HBMA Government Relations Committee and staff have been reviewing the NPRM since it’s release and are in the process of developing comments for the Association to submit on behalf of the membership. HBMA members are
encouraged to review the proposed changes as some of the changes directly impact certain specialties more than others.

For example, CMS is proposing to expand a number of initiatives originally designed to reduce Medicare payments for the technical component of certain imaging services to the technical component of other medical specialties (in particular pathology) and extend some of these "technical component" payment reduction initiatives to the professional component of imaging services.

Individuals and organizations wishing to comment on the NPRM must have those comments submitted to CMS by 5:00pm on August 30th.

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HBMA Comments on HIPAA reporting proposal

On July 31, the Healthcare Billing and Management Association submitted comments on a Department of Health and Human Services Notice of Proposed Rulemaking that seeks to establish new standards for the accounting and reporting of HIPAA Privacy Disclosures.

If adopted, the new standards would require all providers and business associates to maintain a full and complete accounting of ALL disclosures of Personal Health Information (PHI) and make available to patients a written report on all PHI disclosures.

In its comments, it was noted that HBMA and its members “believe strongly in the protection of all patients’ private information and transparency in how PHI is used and disclosed.” In making this observation; however, HBMA noted that any PHI reporting and disclosure requirements imposed on providers and their business associates must take into consideration the cost to the provider and business associate as well as the potential and value such reporting.

In evaluating the NPRM, it appears that HHS assumes that existing software is able to identify when PHI has been accessed and by whom. In addition, HBMA noted that HHS assumes that the HIPAA “minimum necessary” rules have already been incorporated into existing practice management software. HBMA in its comments sought to dispel this assumption.

Unfortunately, based upon these erroneous assumptions, HHS believes that the cost and burden to providers and business associates will be minimal.

HBMA is very concerned that the medical billing and practice management software industry has not yet developed and offered capabilities that meeting existing HIPAA expectations, let alone the far more sophisticated requirements contemplated under the proposed rule. Further, the few products that are available are not well-suited for physician’s practices and the cost of the software is prohibitively expensive.
After providing detailed information on the financial and administrative burden the new standards could potentially place on providers and business associates, HBMA outlined 3 recommendations for consideration by HHS:

1. The proposed rules be withdrawn. Perhaps in five years, after practice management and EMR systems have evolved further and affordable, more sophisticated capabilities can be incorporated into those systems, the proposed capabilities may begin to appear and/or have a likely chance of being successfully developed and delivered.

2. If OCR remains interested in assuring access to this additional data about patients’ PHI, we recommend an initiative to develop a classification/coding protocol for “reasons.” This development would logically be initiated through existing industry standards organizations, such as WEDI, ANSI X12, SNIP, etc. Based on past history, this process will take three to five years unless it is expedited as a high priority.

3. In the event that these regulations are to be implemented, we strongly recommend that the implementation be deferred until at least 2015 or later in order to allow time for the highly complex and almost certain negative economic impact of the transition to 5010 and ICD-10 CM.

It is not clear when HHS may move to issue a final rule.

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<td>R2251CP</td>
<td>Pharmacy Billing for Drugs Provided Incident to a Physician Service This CR rescinds and fully replaces CR 7109.</td>
<td>08/15/2011</td>
</tr>
</tbody>
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