Congress Faces Key Deadlines Following Recess

Williams & Jensen, PLLC

The House and Senate worked on several major bills over the summer months, but failed to make substantial progress on any of the major debt and government funding issues that must be addressed in the remaining months of 2013. When Congress returns on September 9th, the fall legislative agenda will be dominated by three major efforts: (1) legislation to continue funding the government past the end of fiscal year (FY) 2013; (2) Congressional action to raise the debt ceiling after the Treasury has exhausted “extraordinary measures” to continue paying the nation’s bills; and (3) an attempt led by House Ways and Means Committee Chairman, Dave Camp (R-MI), and Senate Finance Committee Chairman, Max Baucus (D-MT), to comprehensively reform the U.S. tax code.

Thus far, the House has opted to pass government funding bills at sequestration levels, while the Senate is proceeding to mark up bills at higher levels. Given these funding disparities, chances for a compromise on government spending appear remote. Congress has the option to pass short-term legislation continuing to fund the government at current levels, which would give negotiators additional time to work on a compromise.

Sequestration, including the two percent across-the-board cut to Medicare providers, has remained in place since April 1. Congress has provided some relief to certain programs that have been particularly impacted by sequestration, but the Medicare cut is not likely to be addressed except in the context of a larger deal that replaces the sequester with other spending reductions or revenue increases.

The other major issue that Congress must contend with in 2013 is the debt ceiling. At present, estimates have the U.S. government reaching its borrowing limit around November. Due to the proximity of this debate to the government funding negotiations, it is possible that Congress and the Administration will approach these issues together, and attempt to construct a deal that would continue to fund the government and raise the debt ceiling at the same time. This debate may play out similarly to earlier budget debates, with Republicans pushing for spending cuts and Democrats for tax increases. Other major issues, like the elimination of sequestration and funding for Affordable Care Act (ACA) implementation, are also expected to play a prominent role in these discussions.

Following the recess, Congress is set to continue work on a number of health care bills, including: legislation to replace the Medicare Sustainable Growth Rate (SGR) with a new physician payment model; legislation to implement a track and trace system for drugs; a bill providing new regulatory authority for the Food and Drug Administration (FDA) to inspect drug compounding facilities; and possible modifications to the ACA as both sides brace for the parts of the law set to take effect on January 1.

House Continues to Advance SGR Repeal Proposal

In July, the House of Representative’s Energy and Commerce Committee convened a markup of legislation to reform the Medicare physician fee schedule payment system. The Committee considered the Medicare Patient Access and Quality Improvement Act of 2013 (H.R. 2810), “a bill to amend title XVIII of the Social Security Act to reform the sustainable growth rate and Medicare payment for physicians’ services, and for other purposes.”

The legislation was introduced by Rep. Michael Burgess, MD (R-TX), and would repeal and replace the SGR with a new policy to change physician payment in two phases: (1) permanently repeal SGR and replace it with a five-year period of stable physician payments; and (2) create an Update Incentive Program that would link payments to quality of care. The legislation would also allow physicians to opt out of the fee for service (FFS) program and participate in alternative payment models (APMs). AAEM submitted comments to the Committee during the February and July periods in which it accepted input from stakeholder groups, and also weighed in with key members during the June Advocacy Day.

The Committee favorably reported the legislation by a roll call vote, with no members voting in opposition. The bipartisan vote may give Congress momentum to continue negotiations following the August recess, and vindicated the Committee’s strategy to focus first on the payment policy issues at hand and then make decisions regarding the difficult matter of offsetting the $139 billion cost of a permanent “doc fix” at a later date. However, after factoring in the other traditional Medicare “extenders” that are generally moved as part of a year-end package, the cost of a full SGR repeal package may rise above $170 billion. In recent years, Congress has enacted provider cuts to pay for a large share of the temporary fixes to SGR, but Congress faces pressure to find revenue in additional places to fund a package of this magnitude.

The issue of paying for the bill has still not been resolved, but Committee leadership has pledged that the legislation will be fully paid for when it comes before the full House for a vote. It is not expected that a bill will come to the floor earlier than October, given Congress’ focus on agency funding in advance of the fiscal year's end on September 30. A number of key House and Senate members have signaled they would like to continue working towards SGR repeal because of the discounted cost of a permanent fix, but in the current fiscal environment it will be very challenging to identify offsets that are palatable to both Senate Democrats and House Republicans.

The current “doc fix” expires December 31, 2013. Following this date, physicians would face an approximately 25 percent Medicare reimbursement cut without Congressional intervention. The Senate held hearings this year to examine the physician payment system, but has not yet initiated Committee proceedings on legislation to permanently repeal the SGR.
House Passes Bills Targeting ACA Health Insurance Mandates; Congress Continues to Monitor Implementation

In July, the House of Representatives passed legislation that would delay two key mandates included in the ACA. By a vote of 264-161, the House approved H.R. 2667, Authority for Mandate Delay Act, a bill authored by Rep. Tim Griffin (R-AR) that would delay until 2015 enforcement of the ACA’s requirement that large employers offer full-time employees the opportunity to enroll in minimum essential health care coverage. The legislation also delays the effective date of related reporting requirements. Thirty-five Democrats joined nearly all Republicans in supporting the legislation.

The House considered a second bill, H.R. 2668, Fairness for American Families Act, authored by Rep. Todd Young (R-IN). The legislation would delay the ACA’s requirement that individuals maintain minimum essential healthcare coverage until 2015. The House approved the bill by a vote of 251-174, with 22 Democrats voting in the affirmative and one Republican voting in opposition.

Both bills were introduced and brought to the floor following the Department of the Treasury’s announcement on July 2nd that the ACA’s employer healthcare insurance mandate would be delayed until 2015. The White House issued a veto threat on both bills, and the Senate is not expected to take action on either bill.

Despite the delay of the employer mandate, newly confirmed Centers for Medicare and Medicaid Services (CMS) Administrator, Marilyn Tavenner, told Congress that key ACA deadlines would be met over the next several months. Tavenner said that the final health insurance exchange application will be finished by August 31, and that insurance rates for the Federal exchanges will be published in September. She also indicated that health insurance exchanges will be open for enrollment by the scheduled October 1 deadline. Congressional Republicans have continued to express doubts that components of the law will be implemented on time, and have argued that the decision to delay the employer mandate is evidence that it is behind schedule.

Other provisions of the law, including Medicaid pay parity with Medicare for primary care providers, have also faced delays. CMS issued the Final Rule in November 2012, which outlined the physician groups that are eligible for the pay boost. The two-year pay parity was set to take effect on January 1, 2013, but as of July less than 15 states had implemented the pay increase.

Over one-fourth of Republicans in the House and Senate have written letters urging opposition to any government funding bills that continue to include money for ACA implementation. The Senate effort to deny further funding for the ACA is led by Senators Mike Lee (R-UT), Ted Cruz (R-TX), and Marco Rubio (R-FL). The effort would not impact mandatory spending under the law, such as the Medicaid expansion, but would cut...
off further Federal funding for items such as outreach programs, marketing and promotion of the law, and additional rule-making. Congressional Democratic leadership has said they will block efforts to defund the ACA.

**House Passes School Access to Emergency Epinephrine Act**

In July, the House passed H.R. 2094, the School Access to Emergency Epinephrine Act. The legislation would encourage states to enact laws that require schools to plan for severe allergic reactions by allowing the Department of Health and Human Services (HHS) to give funding preference to states for asthma-treatment grants if they meet the following requirements: (1) maintain a supply of epinephrine; (2) allow trained school personnel to administer epinephrine; and (3) implement a plan to ensure that trained personnel are available during all hours of the school day. Under the legislation, states must also certify that their laws have been reviewed to ensure that liability protections are afforded to school staff who have been trained to administer epinephrine. Last year, the House Judiciary and House Energy & Commerce Committees advanced a number of medical liability reform bills, which were later approved by the full House. The Senate did not act on any of these bills, as they did not have the support of Senate Democratic leadership. The liability protections included in this bill represent a compromise between House Republicans and Democrats. Once the bill is introduced in the Senate, advocates hope the bill can be passed by a unanimous consent agreement, given the bipartisan support for this legislation in the House. AAEM lobbied for passage of this bill in the House and will continue to do so in the Senate.

**CMS Issues Proposed Rule on OPPS and ASC Payment Rates**

On July 8, the Centers for Medicare & Medicaid Services (CMS) released the proposed rule for calendar year (CY) 2014 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Policy Changes and Payment Rates. According to a CMS press release, the proposed rule would “update Medicare payment policies and rates for hospital outpatient department and ASC services, and update and streamline programs that encourage high-quality care in these outpatient settings consistent with policies included in the Affordable Care Act.”

Compared to CY 2013, CMS projected that next year’s OPPS payments are projected to increase by $4.37 billion (+9.5%), and Medicare payments to ASCs are projected to rise by approximately $133 million (+3.5%). Broadly, the rule proposes expanding the categories of services packaged into a single payment for primary service under OPPS, and would add seven additional categories of supporting services under the OPPS.

Notably, the rule proposes to replace the five levels of outpatient visit codes with a single Healthcare Common Procedure Coding System (HCPCS) code, which would be applied to outpatient visits — one for clinic visits and one each for 24 hour and non-24 hour emergency department visits. CY 2013 Type A Emergency Department HCPCS codes 99281-99285 would be replaced in CY 2014 by a single code (GXXXA), and Type B Emergency Department HCPCS codes G0380-G0384 would be replaced by one code (GXXXB). CMS offered the following rationale for this proposed change: “CMS believes that by combining the five current levels of codes to one level, it will remove incentives that hospitals may have to provide medically unnecessary services or expend additional, unnecessary resources to achieve a higher level of visit payments under the OPPS. CMS also believes that a single payment code will reduce administrative burden and can be easily adopted by hospitals and will allow for a large universe of claims to be utilized for rate setting.” CMS is accepting comments on the proposed rule until September 6, 2013. CMS intends to publish the final rule around November 1, 2013.

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Having the support of physicians from many specialties can help us resolve some of EM’s most important problems. Currently, AAEM has no seats in the American Medical Association (AMA) House of Delegates (HOD). Help us reach our goal of 50% of AAEM members also holding membership in the AMA so we can add our voice to the deliberations with a seat in the HOD.

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