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## Health Care

The continued inability of the Congress to agree to a long-term deficit control strategy poses risks to any industry that relies on government agencies, write Mark Harkins and Erica Stocker, professional advisers with the law firm McDermott Will & Emery LLP. This is of particular concern to the health care industry, as it seems more and more likely that Congress is capable of only providing short-term fixes to vexing problems, they add.

### Congressional Dysfunction Imperils Health Care System

BY MARK HARKINS AND ERICA STOCKER

**C**ongress's inability to attend to the basic functions of government, funding and spending affects more than just middle-class taxpayers and federal government workers. Every regulated industry is impacted, perhaps none more than the health care industry.

#### Bogging Down Appropriations

The Constitution in Title I, Article 9, in the section titled "Limits on Congress" states, "*No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law; and a regular Statement and Account of the Receipts and Expenditures of all public Money shall be published from time to time.*" The process that has developed in the nearly 225 years since this document was enacted to enable the functioning of government has become cumbersome and com-

*Mark Harkins is a professional adviser in the law firm of McDermott Will & Emery LLP and is based in the firm's Washington, D.C., office. He has extensive experience with the federal appropriations and budgeting process, financial services, science, Ways and Means and Homeland Security issues. Erica Stocker is also a professional adviser in the law firm of McDermott Will & Emery LLP, based in the Washington office. Erica focuses primarily on health care, including provider reimbursements, quality of care and patient safety.*

plex with major implications for how federal programs are run or, in many cases, not run. The health care industry is affected more than most by this dysfunction.

About every four years a few things happen in Washington, D.C.: the Redskins have a winning record, the Electoral College elects a president, and each of the 12 or 13 appropriations bills is passed individually and signed into law. For the appropriations bills this was true for fiscal years 1995, 1998, 2002 and 2006 (all but the District of Columbia received a separate vote). While fiscal 2010 was better than most, only half the bills received separate votes. This means three out of every four years, a large section of the federal government is funded through omnibus appropriations bills that contain varying degrees of detail.

The last time the entire federal government was funded on Oct. 1 (the beginning of a fiscal year) was fiscal 1995. When approval of appropriations bills miss the Oct. 1 date by a month or two (or even six) agencies cannot properly plan and budget for the full year. This has broad implications for the implementation of new initiatives or the phasing out of older, obsolete programs.

Much has been written on the quagmire through which Congress slogs to determine how much funding to provide each portion of government. Omnibus bills, in which multiple large departments are lumped into one take-it-or-leave-it piece of legislation, limit the input of the Appropriations subcommittee members with the most knowledge of individual agencies and put the power into the hands of a few key members and staff. Using omnibus legislation also tends to limit the time members and the public have to review appropriations

bills, allowing items that may be less desirable to one constituency or another to be “hidden” in the thousands of pages.

## Health Care Industry’s Influence

The move toward omnibus appropriations—and President Obama’s drive to modify the United States health care system—have driven up the number of health care organizations that lobby or employ lobbyists. Health care organizations understand that Washington, D.C., is extremely important to their business model, and they are investing to influence that model accordingly.

The Center for Responsive Politics, a nonprofit, independent and nonpartisan tracker of money in politics, runs a website called Open Secrets, which aggregates publicly available data into a searchable format. One of their major databases lays out lobbying expenses by industry since 1998. That year, nearly 800 health care organizations paid \$167 million to 1,750 in-house or contract lobbyists.

In 2009, a little more than a decade later and in the throes of a recession, those numbers had increased: nearly 1,800 organizations serviced by 3,500 lobbyists at a cost of \$552 million! In the last two years those numbers have fallen off a bit with fewer than 1,500 organizations serviced by 3,000 at a pace of \$500 million per year.

## How the Process Works

Starting about 18 months before a fiscal year begins, federal agencies begin the process of determining their needs for the future. Agency budget officials ask for input from those in the various programs as they put together the department’s submission that will go into the president’s budget request that they try to have completed and to the Office of Management and Budget (OMB) by August (14 months before the fiscal year begins).

Over the next three to four months, OMB works with the agencies to finalize each one’s budget in the context of the entire federal government budget request, which the president presents to Congress the first Monday in February (this date slides to April in the first year of an administration, as it did in 2001 and 2009).

At that point, the budget baton is in congressional hands (where many say it is dropped). If all goes according to plan, the House and Senate pass separate budget resolutions, blueprints for the next year’s budget, in March and come together in April to pass a joint resolution. The President does *not* sign the joint resolution, as it is only a working document for Congress to make it easier to enact spending and revenue bills.

From February through April, congressional committees review the president’s request and make their suggestions to the appropriate spending and revenue-raising committees. On the appropriations side, in May, June and July the House passes individual bills and sends them to the Senate. The Senate tends to pass their versions in June, July and early September. The process ends with conference reports sent to the president for his signature, hopefully before Oct. 1.

Concurrently, multiple committees in both chambers consider changes to mandatory programs such as veterans’ benefits, farm programs, feeding programs and

health care programs. In addition, the tax-writing committees put forth their ideas for how to change the tax code to either generate or give back the revenue defined in the Budget Resolution.

## Effect of Super Committee’s Failure

As this process—along with unbudgeted wars and a financial meltdown—has led to profligate spending and huge budget deficits, Congress and the president decided to create a “super committee” to reform the budget process and bring the federal budget into balance. This groundbreaking group of 12 legislators—known officially as the Joint Select Committee on Deficit Reduction—was tasked with finding \$1.5 trillion in deficit reducing options over a 10-year period, either from cutting spending and future obligations (keep this in mind) or raising revenue.

The group was equally divided between House and Senate, Republican and Democrat—and utterly failed. Democrats were willing to give on some spending and future obligations, while Republicans were willing to give on some revenue, but neither side believed the other was willing to give enough.

Unfortunately, because the Joint Committee failed to produce a deficit reduction package of any kind, a series of across-the-board cuts, known as a sequester, are now on deck to be triggered. The sequester would result in \$1.2 trillion in automatic cuts divided over nine years, allocated throughout the federal government by the OMB. The first round would take effect in January 2013. The cuts are divided equally between domestic (including a maximum 2 percent across-the-board cut to Medicare) and defense spending.

The 2013 start date gives Congress one year to intervene by modifying or repealing the sequester, which defense advocates including House and Senate Armed Services committee leaders have vowed to do. However, President Obama has already issued a veto threat for any sequester-reducing legislation that makes its way to his desk.

## Picture This.

Here is another way to think of this dilemma. It’s Thanksgiving, and you make a huge pie that you think will feed everyone. In past years, you have determined how much of that pie is needed to feed each of the families that is visiting and you mark the pie accordingly into five areas, one for your parents, one for your brother’s family, one for your sister’s family, one for your in-laws, and one for your family.

The problem is, everyone is three years older than the last time you hosted. That means a lot more teenagers with their voracious appetites. You try to get someone else to bring another pie, but you and your spouse (the super committee) can’t agree whose family should bring the extra (no new revenue). Your spouse thinks everyone should just eat less, because it is better for your waistline.

Once everyone arrives, it becomes obvious there is not going to be enough pie, especially for your in-laws, because your five teenage nephews have grown substantially (health care). Your brother’s family did not bring two of their kids because they are away on a semester in Europe (winding down of hostilities in Iraq and Afghanistan).

Again, you could rearrange how much pie each group gets, but you and your spouse can't agree, again because your brother's family still has three boys and they have grown. Because you can't reach agreement on how to change the portions, everyone ends up with the same size portions they had before—meaning your in-laws, with their larger appetites, have to fight amongst themselves from the same amount of pie they had in the past.

If the joint committee could have reached an agreement, some of the defense portion of the pie could have been re-designated to the health care portion of the pie. But since no agreement was reached, members of each family unit have to fight it out, a much more difficult situation. Because you have volunteered to host for the next nine years, this problem is only going to get worse. If you and your spouse had agreed, the two of you could have made the changes. Now, you have to get everyone's input, and at least half of them have to agree if future changes to pie divisions are to be allowed.

### Sequestration's Impact on Health Care

The threatened sequester is critically important in the area of current health care spending and future budget determinations. The fastest growing portion of the federal budget belongs to health care programs such as Medicare and Medicaid. It was hoped that the joint committee, with its mandate to look at the entire federal apparatus, would have been able to balance health care expenditures against unrelated items, such as the decrease in defense spending on the wars in Iraq and Afghanistan. Their inability to advance any plan means that health care programs will probably have to fight other health care programs for resources.

As the joint committee slogged through its negotiations, the health care industry did not come together with a unified voice. In fact, multiple projections and opinions about the impacts of potential deficit reduction provisions existed even among providers in the same sector.

For example, in an October letter to the joint committee co-chairs, the American Hospital Association (AHA) and American Nurses Association (ANA) noted that the maximum 2 percent cut to Medicare reimbursements as a result of sequestration would amount to the loss of 194,000 nursing and other hospital jobs nationwide. At the same time, individual health systems looking at their own financials decided the sequester might be the preferred option, especially compared with the Medicare changes that were being considered by the joint committee—such as cuts to graduate medical education reimbursements, reductions to bad debt reimbursements and eliminating rural hospital payment add-ons.

Moving forward following the joint committee's stalemate, health care providers will have to consider several scenarios when determining their financial plans and advocacy strategies:

- (1) Sequestration begins in 2013, exactly the way it was written in the Budget Control Act;
- (2) Sequestration is altered to lessen the impact on the Pentagon; or
- (3) Congress reaches a bipartisan agreement to achieve \$1.2 trillion in deficit reduction within the next year, in order to stave off sequestration.

No matter what occurs with sequestration, Congress still must grapple with potential Medicare cuts to physicians this year, given the looming 27.4 percent cut to physicians' reimbursements that will occur Jan. 1 without congressional intervention, commonly referred to as the "doc fix" (244 DER A-6, 12/20/11).

The proposed Medicare cuts previously discussed by the joint committee and the need for another doc fix are nothing new, but their relevance is now heightened in this sensitive political era in which the focus is largely on deficit reduction.

### Kicking the Can Down the Road.

Our nation's health care spending continues to grow, and lawmakers will eventually have to stop kicking the can down the road on large-scale deficit-reduction efforts—particularly when it comes to proposals to reform Medicare and Medicaid. It is widely understood that there is no political appetite for such large-scale reform as we enter into 2012, but as election year politics subside, providers shouldn't keep such realities far from the front of their minds. In that vein, it is worth monitoring lawmakers' reactions to the recently-released Medicare proposal by Sen. Ron Wyden (D-Ore.) and Rep. Paul Ryan (R-Wis.).

The doc fix issue has plagued Congress for the past decade and will continue to do so in future years without a permanent solution. This problem has existed ever since the statutory formula for determining physicians' annual Medicare reimbursement rates, known as the sustainable growth rate (SGR) system, began projecting negative payment updates (cuts to reimbursement rates) for physicians. With the exception of the first year that the SGR produced such a scenario, lawmakers have stepped in annually to temporarily prevent the cuts from taking effect—some years providing physicians with small percentage payment increases, other years providing a flat zero percent update (no cuts, no increases) to reimbursement rates.

Compounding the issue is the fact that the SGR has projected larger and larger reimbursement reductions in recent years, making the temporary patches more and more costly to administer. The Congressional Budget Office (CBO) has estimated that a two-year fix to address the impending 27 percent cut will cost \$38.6 billion. Permanently remedying the SGR issue will cost upwards of \$300 billion.

The House addressed the issue with a two-year fix that will prevent the 27 percent cut and will provide physicians with a 1 percent payment increase—to the tune of \$38.9 billion. The end-of-year legislative package—H.R. 3630—also includes other Medicare provider payment provisions that are set to expire at the end of 2011 or by mid-2012. Such provisions have been routinely extended for years (some are more than a decade old) in order to prevent negative impacts on patients' access to care 244 DER A-15, 12/20/11).

### Extensions Under More Scrutiny.

Earlier this fall, the House Ways and Means Health Subcommittee held a hearing to discuss expiring Medicare provider payment issues. While witnesses made strong arguments in favor of providing continued extensions, committee members made clear that such extensions should fall under more scrutiny than has been the case in the past. Such extensions under discussion have included:

- Section 508 hospital reclassifications—named after that section of the 2003 Medicare Modernization Act (MMA) that has allowed certain hospitals to receive wage index reclassifications in order to attract and retain the necessary workforce at their facilities;
- Exceptions to the \$1,500 per beneficiary, per year Medicare Part B cap for outpatient therapy services (outpatient physical therapy, occupational therapy and speech-language pathology);
- Ambulance add-on payments, including adjustments for rural and urban ground ambulance services and increases for ambulance trips originating in “super rural areas”;
- Hold-harmless transitional outpatient payments (TOPs) for certain rural and sole community hospitals to provide financial stability during their transition to the outpatient prospective payment system; and
- Enhanced reimbursements to small hospitals in qualified rural areas for outpatient clinical laboratory services, known as reasonable cost reimbursement methodology.

It is interesting to note that H.R. 3630 did not include Section 508, TOPs protections, or reasonable cost reimbursements for clinical laboratories, though it did include a two-year extension of the outpatient therapy caps exceptions process and an extension of the expiring ambulance payment provisions.

Most recently, the Senate passed a short-term extenders package on Dec. 17 that would prevent the 27 percent cut from going into effect for two months, but would not provide the one percent increase. The measure includes all of the aforementioned Medicare extenders (including those not in the House bill) and does not include health-related offsets.

The two chambers are still in a standoff, as the Senate overwhelmingly approved its short-term patch while the House is instead insisting on going to Conference on H.R. 3630 to reach a longer-term deal. The endgame on Capitol Hill has changed daily, further exacerbating our point that health care providers continue to face a great deal of uncertainty when making financial plans for the future—even a very near future that is two weeks away!

### **How Uncertainty Hurts HHS**

When the standard appropriations process is not followed and agencies get funded week to week, planning becomes impossible. When an agency does not receive their annual budget before mid-November, it impacts the budget cycle for the next year. In the current situation, the vast majority of the federal government, in-

cluding all of the Department of Health and Human Services (HHS) as well as the Department of Defense, must provide final budget document for fiscal 2013 to OMB right now. But these departments did not find out what their 2012 budgets were until Dec. 16. While there is time to modify the information in the president’s request for 2013, it is being done in a rushed manner which never makes for good policy.

For mandatory spending such as Medicare reimbursements, year-to-year (or even month-to-month) fixes to reimbursement levels raise anxieties for providers and patients. If reimbursement rates to physicians were reduced 27 percent in January, why would providers continue seeing Medicare patients? And if Congress must resort to addressing the doc fix retroactively, how long could the Centers for Medicare and Medicaid Services (CMS) hold off on processing claims, and how long could some smaller practices survive without those reimbursements (244 DER A-6, 12/20/11)? With the Medicare population (those over age 65) being one of the fastest growing, failure by Washington to address the problem could lead to dramatic delivery shortages.

Congress, yet again, produced a funding bill at the last moment. In the upcoming election year, Republican leaders in the House have indicated a strong desire to return to “regular order,” the consideration of each appropriations bill as a separate vehicle instead of a large omnibus. Time will tell if the fiscal year 2013 cycle is the first one since fiscal 2002 to accomplish this feat. Regardless, everyone with an interest in the health care industry would benefit from a stable, thought out policy and funding process.

### **Conclusion**

With regard to overall deficit reduction, Congress still has one year to act on a large-scale \$1.2 trillion compromise, including a post-election lame duck session in late 2012. However, now that the joint committee option has lapsed, any such package will not have the procedural protections that the Budget Control Act provided to afford the opportunity for smooth passage in the House and Senate.

The continued inability of the Congress to agree to a long-term deficit control strategy poses risks to any industry that relies on government agencies. This is of particular concern to the health care industry as it seems more and more likely that Congress is capable of only providing short-term fixes to vexing problems. Funding to fix problems in the short term stays in the industries affected, meaning a fix to one health care problem tends to come from another health care component. Without inspired leadership from some quarter, expect this dynamic to stay in place through the next election when politicians will again try to glean the intent of a divided electorate, an electorate with limited choices and an imperfect way to send a message.