



MEDICARE REPORT



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Final Medicare Provisions in Deficit Reduction Act of 2005

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On Feb. 1, the House of Representatives gave final congressional approval to S. 1932, the Deficit Reduction Act of 2005 (DRA), a massive budget bill that projects to reduce federal spending by nearly \$40 billion over five years.

More than \$6 billion of that savings is expected to come from changes to Medicare, the federal health insurance program for the aged and disabled. Managed care organizations, hospitals, physicians, suppliers and beneficiaries all will be affected by these changes.

This analysis provides an overview of the most significant Medicare-related provisions, as well as one particularly significant Medicaid provision, in the bill.

The bill is expected to be sent to and signed by President Bush shortly. If signed, the bill would represent the first significant legislative changes to the Medicare program since the Medicare Modernization Act (MMA) was enacted two years ago. However, the new law would not in any way affect the Medicare prescription drug benefit implemented earlier this year.

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All Entities Receiving Medicaid Money

The new law will require all entities that receive at least \$5 million in Medicaid payments to establish written policies and procedures for all employees, contractors and agents about the organization's protocols for fraud detection and prevention as well as for informing them about the False Claims Act, whistleblower protections and other enforcement authority regulations. This provision is the first to explicitly require affected entities to have a compliance program. Compliance will be a "condition of payment," which means that any entity that does not comply may not be entitled to submit Medicaid claims; if it does submit claims without having complied, the entity could potentially be liable for submitting false claims under the False Claims Act.

Managed Care Organizations

Medicare Advantage Benchmarks and the Risk-Adjustment Budget Neutrality Component

Effective with the 2007 payment cycle, the DRA modifies the methodology for determining the benchmark for Medicare Advantage (MA) plans. Currently, the benchmarks for both local and regional Medicare Advantage plans are tied to the annual MA capitation rate, which equals the greatest of four pre-determined amounts:

- a minimum payment amount
- a blend of local and national rates
- the previous year's rate with a 2 percent increase

■ 100 percent of the per capita fee-for-service costs

The new methodology hinges on whether the Secretary of Health and Human Services, Michael Leavitt, rebases rates to the per capita fee-for-service costs that comprise the fourth pre-determined payment option. If the secretary does not rebase rates to 100 percent of per capita fee-for-service costs, then the 2007 benchmarks will equal 102 percent of the 2006 benchmarks. The figure then is adjusted by the 2006 rescaling factor for each area, excluding any national adjustment factor for coding intensity or risk adjustment budget neutrality.

Finally, the figure is increased by the national per capita MA growth percentage (excluding any error adjustments for years prior to 2004). If the secretary does rebase rates to 100 percent of per capita fee-for-service costs, then the 2007 benchmarks will equal the greater of the rebased rates or the amount determined under the methodology described above.

Another modification to the MA benchmark methodology is a mandatory phase-out of the budget neutrality component of the risk-based adjustment to be implemented between 2000 and 2007. As part of the process for determining the MA benchmarks, the secretary takes into account variations in the risk level of (and cost of providing health care to) plan enrollees based on factors such as age, disability status, gender and institutional status.

The Centers for Medicare & Medicaid Services (CMS) has been phasing in risk adjustment methodology since 2000 so that each year, the risk adjustment methodology applies to an increasingly larger portion of the Medicare Advantage payments to plans. In 2005, 50 percent of a plan's monthly MA payment reflected this risk adjustment; 75 percent of the 2006 monthly payment will be risk-adjusted, and by 2007, 100 percent of the payment will be risk-adjusted.

Since 2003, CMS has used its administrative authority to phase-in the risk adjustment methodology in a budget-neutral manner to limit the overall impact on payment rates. However, with the impending shift toward the new Medicare Advantage payment program that is intended to more accurately reflect MA plans' risk, CMS indicated it would administratively phase out the budget neutrality component of its risk-adjustment methodology between 2006 and 2010.

The DRA *statutorily requires* CMS to phase out the budget neutrality component of the risk-adjustment methodology between 2006 and 2010, including specifying the adjustments that must be made each year. Although the secretary maintains the authority to modify the adjustments as necessary to account for errors, to reflect new data or to adopt an improved risk-adjustment process, Congress' decision does limit CMS' administrative flexibility.

The DRA will also require the secretary to analyze differences in coding practices between Medicare Advantage plans and providers under the fee-for-service sector. Such differences in these coding practices, as well as changes in treatment and coding practices in the fee-for-service sector, must be incorporated into the risk adjustment methodology—and thus incorporated into the benchmark determination and monthly payments—for 2008, 2009 and 2010.

Rural PACE Provider Grant Program

The Program of All-Inclusive Care for the Elderly (PACE) provides comprehensive Medicare and Medic-

aid services to individuals over age 55 who are eligible for nursing-home level of care through a managed care delivery model. Typically public or private nonprofit entities, PACE organizations primarily operate in urban areas. These organizations receive a capitated fixed monthly payment intended to cover all of an enrollee's Medicare- and Medicaid-covered services as well as other necessary services.

The DRA establishes a grant program for the development of PACE programs in rural areas. The provision allocates up to \$7.5 million in site-development grants for as many as 15 qualified PACE providers (as defined under current law) by CMS in rural areas. Grants, which may be awarded in any amount up to \$750,000 through Federal Fiscal Year 2008, may be used for costs associated with developing and establishing a PACE program and delivering these services in a rural area.

The secretary also is directed to launch a technical assistance program to provide outreach and education to state agencies and organizations interested in developing PACE programs and to support rural PACE pilot sites.

Medicare Advantage Provider Stabilization Fund

As part of its revamping of Medicare Part C under the MMA, Congress established several financial incentives to encourage and maintain private health plans' participation in the Medicare Advantage program. One such incentive, the Medicare Advantage Regional Plan Stabilization Fund, is intended to enhance monthly payments to certain regional Medicare Advantage plans between 2007 and 2013.

Payments from the fund may be made to plans that enter a region not previously served by a Medicare Advantage plan, as well as plans that continue to serve a region with fewer than two participating Medicare Advantage plans that had below-average Medicare Advantage market penetration the previous year.

Congress appropriated \$10 billion to establish the fund as well as additional funding from savings from regional plans that submit a monthly bid amount—and therefore receive a monthly payment—less than the benchmark for their region.

The DRA *does not* include a provision to eliminate the MA Regional Plan Stabilization Fund approved by the Senate. The initial Senate-approved bill eliminated the Stabilization Fund entirely, in part because the high level of health plan participation in Medicare Advantage in 2006 arguably made the financial incentives unnecessary. However, the president threatened to veto the final version of the DRA if the Stabilization Fund was eliminated. The final version of the DRA maintains the full \$10 billion appropriation.

Hospitals

Inpatient Hospitals Service Payment Updates

Under current law, inpatient service payments to hospitals participating in Medicare's Hospital Quality Alliance will be inflated by the full rate of increase in the hospital market basket for 2005 through 2007. Hospitals that do not participate in these years receive a

lesser increase in Medicare payment equal to the market basket minus 0.4 percent.

The DRA increases the penalty for hospitals that fail to participate in Medicare's quality initiative. For fiscal year 2007 and after, payments to hospitals that do not report quality data will inflate by the market basket minus 2 percent. This penalty likely will affect few hospitals since the vast majority of hospitals self-reported quality data under this initiative in 2005. These changes also set the stage for CMS to expand the number of measures on which hospitals must report and to revise diagnosis-related groups to reflect hospital quality.

Disproportionate Share Hospital Payment Adjustments

The DRA clarifies the secretary's authority with respect to how low-income individuals who receive medical assistance under a section 1115 waiver program, such as TennCare, will be counted for purposes of determining disproportionate share hospital (DSH) payment adjustments. CMS promulgated such regulations in 2000 and 2003 defining the extent to which such individuals would be counted.

However, CMS permitted the counting on a prospective basis only. Numerous hospitals sued, in some cases successfully, to apply these changes retroactively. The DRA gives CMS authority to refuse to recalculate DSH payment amounts for years prior to its regulatory changes.

Medicare-Dependent Hospitals

Under current law, a hospital located in a rural area with fewer than 100 beds that treats a significant number (at least 60 percent) of inpatients entitled to Medicare Part A benefits may be designated as a Medicare-dependent hospital (MDH) and eligible for enhanced Medicare reimbursement. However, the MDH designation and attendant reimbursement benefits are set to expire in 2006.

The DRA extends the MDH designation and reimbursement benefits an additional five years. The DRA also improves reimbursement to MDHs in several ways.

First, the DRA provides that MDHs will be reimbursed for inpatient services on the greater of prospective payment system (PPS) rates or PPS rates plus 75 percent (increased from the current 50 percent) of the amount by which the PPS rate is exceeded by a hospital-specific, cost-based rate.

Second, the new law permits MDHs to use 2002 (in addition to 1982 or 1987) as a cost year for purposes of determining the hospital-specific, cost-based rate. Finally, the DRA exempts MDHs from the 12 percent DSH payment adjustment limit that currently applies to most other rural hospitals.

Inpatient Rehabilitation Facilities

The DRA slows the implementation of recent changes made by CMS to the criteria a facility must meet to qualify for inpatient rehabilitation facility (IRF) status. CMS recently revised the criteria to require a facility to show that at least 75 percent of the patients admitted have one or more of 13 specified conditions. CMS has been phasing in the rule such that IRFs currently must

show 60 percent of patients have at least one of the conditions during the cost-reporting period beginning between July 1, 2005 and June 30, 2006.

For cost reporting periods beginning on or after July 1, 2006, CMS would have raised the requirement to 65 percent, and then to 75 percent effective for cost reporting periods beginning on or after July 1, 2007.

The IRF community complained the "75 percent rule" would make it too difficult for many existing IRFs to retain that designation. The DRA delays the entire implementation threshold by one year such that through June 30, 2007 IRFs will have to show only that 60 percent of patients have at least one of the conditions. The requirement would increase to 75 percent over the following two years.

The IRF community is likely to view this change as only a temporary reprieve and to continue fighting implementation of the 75 percent rule again next year.

Specialty Hospitals

The MMA amended the physician self-referral law (the Stark Law) to prohibit physician self-referrals to "specialty hospitals" for an 18-month period. The temporary ban on referrals expired June 8, 2005, but CMS has since announced it will not issue new provider numbers for specialty hospitals until January 2006 while the agency reviews its own hospital conditions of participation.

The DRA extends CMS' freeze on issuing new provider numbers for specialty hospitals for as much as another six months while CMS prepares a congressionally mandated plan to amend federal regulations to address perceived problems with specialty hospitals. If CMS fails to submit the final report within the six-month time period, then the suspension on enrollment will be extended an additional two months.

The DRA does not further amend the Stark Law or otherwise affect existing physician-owned specialty hospitals, giving these facilities renewed freedoms to expand services and investors. The temporary nature of the freeze ensures specialty hospitals will continue to be the subject of fierce congressional debate and lobbying.

Gainsharing Arrangements

The DRA requires CMS to develop and implement two two-year demonstration projects around hospital-physician gainsharing arrangements. Hospitals and physicians have been increasingly interested in pursuing these arrangements in the wake of favorable advisory opinions from the Inspector General of the U.S. Department of Health and Human Services, Daniel Levinson.

Despite the Inspector General's endorsement, several other regulatory obstacles, including the Stark Law, have remained. The new authority under the DRA expressly authorizes those arrangements that participate in the CMS demonstration and gives Congress and CMS more time to study whether changes to the Stark Law are prudent.

Small Rural Hospitals

Under current law, small (fewer than 100 beds) rural hospitals and sole community hospitals are eligible for

special payment protection under the outpatient prospective payment system. Qualifying hospitals are paid the greater of PPS rates or a cost-based rate. However, this special payment protection expired at the end of 2005.

Congress extended the hold-harmless protection for small rural hospitals for three years but reduced the supplemental payment amount to 95 percent of the difference between PPS rates and the cost-based rate in 2006, 90 percent in 2007 and 85 percent in 2008. The supplemental payment will expire in 2009 unless Congress acts to renew it. Congress did not extend the hold-harmless protection for sole community hospitals, and sole community hospitals that also qualify as small rural hospitals are expressly excluded from the hold-harmless protection.

Physicians and Related Practitioners

Physician Fee Schedule Update

The DRA delays implementation of a planned 4.4 percent payment reduction. Instead, payments will remain flat at 2005 levels through 2006, subject to adjustments announced by CMS in November 2005. Medicare carriers will be instructed on how to repay physicians for the difference between the payment amounts effective since the start of 2006 and newly inflated amounts effective retroactively to the start of 2006.

Imaging and Ambulatory Surgery Center Services

Medicare's hospital, physician and ambulatory surgery center (ASC) payment systems have been criticized for not relating to one another and paying widely divergent amounts for similar procedures across various settings. While hospitals typically are paid more than ASCs and physician offices for comparable services, there are numerous instances where Medicare pays these non-hospital settings more.

The DRA addresses these concerns by capping reimbursements for surgical procedures furnished in ASCs and certain imaging services furnished in physician offices and diagnostic testing facilities at the amount paid to a hospital for the same service. Since hospitals usually are paid more than non-hospitals, the consequences of this change will be felt by a relatively small number of imaging and surgical services.

However, in the case of surgical services, the impact maybe felt disproportionately by a few specialties, such as ophthalmology and urology, where ASC reimbursements have a greater tendency to be higher than corresponding hospital reimbursement amounts. These changes will be effective January 1, 2007, for both services.

Therapy Services

Legislation enacted in 1997 capped annual payments for all outpatient therapy services provided by non-hospital providers at \$1,500 per beneficiary. The payment limits apply to physical, speech and occupational therapy. However, subsequent legislation delayed implementation of the therapy caps until 2006.

Under the DRA the therapy caps go into effect. However, the legislation establishes an exceptions process whereby beneficiaries can request and be granted an exception from the cap and receive an unlimited amount of therapy services deemed medically necessary by Medicare. Although the caps do not apply to therapy services furnished by or under arrangement from hospitals, the implementation of the caps is relevant to hospitals considering provider-based status for outpatient therapy settings.

Now that there will be a payment differential between hospital-based and freestanding providers of therapy services, hospital entities furnishing therapy services may need to seek provider-based status for such entities.

Durable Medical Equipment Suppliers

Medicare permits beneficiaries to rent, rather than purchase, certain items of durable medical equipment (DME), such as hospital beds. Under current law, after using the equipment for 10 months, beneficiaries must be given the option to purchase the equipment. If they choose the purchase option, Medicare continues to make rental payments for three additional months, and then title to the equipment transfers to beneficiaries after the thirteenth month. If the purchase option is not chosen, the supplier retains ownership, and beneficiaries can continue to use the equipment. Medicare makes rental payments to the supplier for up to five additional months.

Title to rented items now automatically transfers to the beneficiary after the thirteenth month of consecutive rental. This change converts the current option to rent DME into a rent-to-own program; beneficiaries now will effectively purchase all items of DME kept for the full thirteen months. The DRA likewise limits Medicare rental payments for home oxygen equipment to 36 months at which time title to the equipment transfers to the beneficiary.

Home Health Agencies

Payments made to home health agencies (HHAs) in 2006 were inflated by 2.8 percent. However, the DRA terminates the planned inflation adjustment so payments to home health agencies will remain flat at 2005 levels (subject to other adjustments in previous CMS announcements). It is not clear how CMS will collect the overpayments made during the first month of 2006, which were made at the higher inflated rate.

Under legislation enacted in 2000, Medicare increased payments made under the home health PPS by 10 percent for home health services furnished in the home of beneficiaries living in rural areas during the two-year period from April 1, 2001, through March 31, 2003. The MMA extended the add-on, but at 5 percent, for these services through April 1, 2005. The DRA extends the 5 percent rural add-on for an additional year effective January 1, 2006.

Additionally, the DRA establishes a voluntary quality data reporting process for HHAs. While voluntary, beginning in 2007, HHAs that do not report data will receive payments based on a market basket minus 2 percent inflation adjustment.

Skilled Nursing Facilities

Medicare reimburses certain providers for unpaid Medicare beneficiary coinsurance and deductibles, *i.e.*, bad debt. Skilled nursing facilities (SNFs) currently receive 100 percent of Medicare beneficiary bad debt; hospitals receive only 70 percent. The DRA reduces bad debt reimbursements to SNFs to 70 percent for allowable bad debts attributable to Medicare coinsurance for those individuals not dually eligible for Medicare and Medicaid. Bad debt payments for the Medicare and

Medicaid dual eligible patients will remain at 100 percent.

Dialysis Facilities

Current law requires CMS to annually update payments for dialysis services, but only the add-on component of the payment formula is updated. The DRA requires CMS to inflate the composite rate component of the payment formula by 1.6 percent for services beginning January 1, 2006.