



MEDICARE REPORT



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Congress Approves, Bush Signs Medicare, Medicaid, SCHIP Changes

By ERIC ZIMMERMAN

In one of its final acts before adjourning for the year, Congress approved a modest bill (S. 2499) that averts a 10.1 percent reduction in Medicare payments to physicians, extends the State Children's Health Insurance Program (SCHIP) that provides health insurance to millions of low-income children, and makes various other changes that provide payment and regulatory relief to dozens of other Medicare and Medicaid stakeholders. President Bush signed the legislation on Dec. 29, 2007.

The legislation is mostly good news for physicians, hospitals, and other health care service providers and payers, as well as program beneficiaries. However, it may be the items that were "on the table" but ultimately not included in the measure that are most significant and revealing about where Congress may be headed when it returns for its second session in mid-January.

Physician Services. The centerpiece of the legislation is a provision that blocks the Centers for Medicare & Medicaid Services from implementing a 10.1 percent

reduction in Medicare payment amounts for physician services.

Medicare statute requires CMS to adjust the payments to physicians up or down depending on how actual expenditures compare to a variety of inflation indices.

In recent years, the update formula has repeatedly required negative updates; for 2008, the payment formula required that payments for physician services be reduced by 10.1 percent (this following a formula-driven payment reduction of 5 percent in 2007).

Because the update formula repeatedly requires that physician payments be reduced, Congress has been forced to intervene each year since 2003 to block the payment reductions.

The Act marks the fourth time Congress has had to intervene in this manner.

Specifically, the Act blocks CMS from implementing the 10.1 percent cut and instead requires that payments be increased by 0.5 percent for the first six months of 2008.

The Act also authorizes CMS to continue to pay a 1.5 percent bonus to physicians and other eligible professionals who report quality information consistent with measures established by CMS, and to make a 5 percent incentive payment to physicians who furnish services in scarcity areas.

Additionally, the bill extends for six months a provision that sets a minimum 1.0 geographic adjustment

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factor used to determine locality-specific payments, which otherwise would have expired at the end of 2008.

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Of perhaps greatest interest is what Congress was unable to accomplish. In August 2007, the House approved a far-reaching Medicare, Medicaid and SCHIP extension package that would have replaced the formula-driven payment reductions for two years with a 0.5 percent increase and replaced the update formula with a complex multi-tiered and specialty-specific update methodology.

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Consequently, Congress will be required to revisit this topic in short order, or CMS will implement substantial payment reductions come July 1, 2008.

Independent Laboratories. The bill extends a change originally made by the Benefits Improvement and Protection Act of 2000 (BIPA), and twice extended by subsequent legislation, that permits independent laboratories with arrangements with hospitals in effect as of July 22, 1999, to bill for the technical component of pathology services provided to inpatients or outpatients of such hospitals. This special exception is now extended through June 30.

The bill also extends a special exception that pays hospitals with fewer than 50 beds located in low-density population rural areas 100 percent of reasonable costs, rather than under a fee schedule, for clinical diagnostic laboratory tests furnished under Part B. This special treatment expired in July 2007, but now will be available through June.

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. Subsequent legislation delayed implementation of the therapy caps until 2006.

The Deficit Reduction Act of 2005 established a one-year 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.

Congress acted in 2006 to extend the exceptions process through 2007. Under the Act, the exceptions process is now extended an additional six months through June 30.

Long-Term Care. The Act provides much-sought-after relief for long-term care hospitals (LTCHs) from a variety of new payment restrictions and reductions.

Under the new legislation, CMS will be blocked for a period of three years from applying new restrictions on the number of patients LTCHs can admit from nearby general acute care hospitals before incurring payment penalties (commonly referred to as "the 25 rule"), which CMS had sought to expand earlier in 2007. CMS also will be blocked for a period of three years from applying a new short-stay outlier payment adjustment that the agency also had established earlier in the year.

However, this relief comes at a steep price. The legislation imposes a three-year moratorium on establishment and enrollment of new LTCHs or satellites, and on any increase in beds at existing facilities. LTCHs that are under development (as determined by specified indicia) are exempt from the moratorium.

The legislation also creates a new definition of an LTCH that requires these entities to meet new facility criteria, including requirements that all LTCHs have a patient review process that screens patients prior to admission for appropriateness of admission, validates within 48 hours of admission that patients meet LTCH admission criteria, regularly evaluates patients throughout their stay for continuation of care in an LTCH and assesses the available discharge options when patients no longer meet such continued stay criteria.

Congress debated but was unable to agree on patient criteria designed to define patients who would be eligible for LTCH services.

Instead, Congress directed the secretary of health and human services to study the issue and report to Congress within 18 months.

The legislation also revokes a 0.71 percent inflation adjustment for LTCH services. The legislation provides comparable relief for inpatient rehabilitation facilities (IRFs) that have objected for years to the requirement that at least 75 percent of patients admitted must have one or more of 13 specified conditions for a facility to qualify for IRF status. CMS had been phasing in this rule, but legislation enacted in 2005 temporarily froze the patient threshold at 60 percent through June 30, 2007.

The Act permanently pegs the patient admission requirement at 60 percent and allows for a broader range of patients to be counted for this purpose.

For general acute care hospitals, the Act extends by 12 months a provision included in the Medicare Modernization Act of 2003 that reclassified approximately 120 hospitals for purposes of the wage index geographic adjustment factor. Under the Act, these reclassifications will be effective through Sept. 30.

Drugs, Biologicals, Devices. Under current law, brachytherapy devices consisting of radioactive sources (or seeds) are paid on the basis of a hospital's cost for such a device, but only through 2007. The Act extends payment for brachytherapy sources on the basis of costs through June 30.

The Act also directs CMS to revise the way it calculates payment amounts for most drugs and biologicals covered under Part B of the program. For purposes of calculating average sales prices for a given product, CMS presently volume weights pricing information by National Drug Codes.

Under the new law, CMS will weight pricing information by billing and payment (HCPCS) code. Although a technical change, reimbursements for approximately half of the Part B drugs could change as a result, with most changes being reductions.

The Act also modifies reimbursement methodologies for inhalation drugs or biologicals furnished through durable medical equipment, which primarily affects generic albuterol and will result in a lower payment amount for that product.

Managed Care Organizations. Managed care organizations and the Medicare Advantage program were at the center of this year's Medicare storm. Legislation approved by the House in August 2007 would have cut approximately \$50 billion from the Medicare Advantage program.

The president's subsequent threat to veto any bill that substantially gutted the Medicare managed care program sent lawmakers scrambling to find alternative funding sources for the bill and, ultimately, to scale back the scope of the entire package.

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The Act reduces monies available in the Medicare Advantage stabilization fund to encourage health plans to enter into and remain in the MA regional program.

Specifically, the Act delays the initial availability of the stabilization fund until 2013 and reduces the amount available to \$1.79 billion.

The Act also restricts expansion of and enrollment into Medicare Advantage plans for beneficiaries with special needs.

Key Items Not in Bill. The legislation is notable not only for what was included, but also for what was omitted. Legislation approved by the House in August 2007, which formed the starting point for negotiations between Congress and the White House, was considerably bolder and broader.

For example, the House-approved measure would have done the following:

- outlawed physician ownership of hospitals;
- increased the cap on payments for hospitals that qualify for a disproportionate share hospital adjustment from 12 percent to 18 percent;
- reduced market basket inflation adjustments by 0.25 percentage points for hospital inpatient and outpatient services;
- extended the Medicare secondary payer period from 30 months to 42 months for end-stage renal disease services; and
- extended supplemental payments for certain ambulance and hospital services furnished in rural areas.

Given the short-term nature of this legislation, Congress likely will be forced to consider these issues again in mid-2008 and, at that time, may revisit many of the issues left out of this Act.

However, the political tensions that limited Congress's ability to advance sweeping Medicare reforms in 2007 will likely be present again in 2008 and may be exacerbated by the impending presidential election.

Despite pressure to extend these provisions and include others from various stakeholders, Congress and the Bush administration again may only be able to agree on a narrow range of items.