McDermott Will & Emery

Congress, President Extend Endangered Medicare and Medicaid Programs

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The Temporary Payroll Tax Cut Continuation Act of 2011 extends numerous expiring Medicare and Medicaid programs, thus sparing physicians, hospitals and other health care providers significant Medicare and Medicaid payment cuts. This *On the Subject* provides an overview of the most significant Medicare- and Medicaid-related provisions in the Temporary Continuation Act.

Physicians, hospitals and other health care providers were spared significant Medicare and Medicaid payment cuts last week by the Temporary Payroll Tax Cut Continuation Act of 2011 (Temporary Continuation Act), legislation that delays the expiration of nearly a dozen tax, Medicare and Medicaid programs. The legislation, H.R.3765 was approved by both chambers of Congress and signed by President Obama on December 23, 2011.

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Physician Payment Update

The most prominent change made by the Temporary Continuation Act is the provision halting a scheduled 27.4 percent reduction in Medicare physician payments, which otherwise would have taken effect January 1, 2012.

The Medicare statute requires that the Medicare physician fee schedule be revised upward or downward every year depending on the results of a complex formula known as the sustainable growth rate (SGR). Each year for the past ten, the SGR formula has required that Medicare's payments to physicians be decreased, but Congress has repeatedly stepped in to enact superseding legislation overriding the reductions. However, each time Congress delays implementation of the reductions, the reductions commanded by the formula the next year are compounded. In 2002, physician payment rates were to be reduced by 4.8 percent pursuant to the SGR formula. By 2011, the

reduction had grown to 25 percent. In 2012, had Congress not intervened, the reduction would have been more than 27 percent.

The Temporary Continuation Act extends 2011 payment rates for two months. In other words, physicians will see no change – neither an increase nor decrease – in payments from December 2011 through February 29, 2012.

Extension of Section 508 Reclassifications

The Temporary Continuation Act extends, until November 30, 2011, the geographic wage index "reclassifications" applicable to approximately 120 hospitals. Qualifying hospitals will receive a higher wage index and increased Medicare reimbursements as a result.

These special reclassifications were originally established under Section 508 of the Medicare Modernization Act of 2003 for a one-time, three-year period expiring April 1, 2007. However, like many of the other provisions extended by the Temporary Continuation Act, Congress has extended these reclassifications six times. The most recent extension expired September 30, 2011. The Temporary Continuation Act extends the reclassifications retroactively to October 1, 2011, but only continues them through November 30, 2011. As such, these reclassifications remain expired, but hospitals benefiting from these reclassifications are now eligible for retroactive reimbursement for an additional two months.

Floor on "Physician Work" Component Used to Calculate Geographic Adjustments to Physician Payment Rates

Medicare payments to physicians are geographically adjusted to reflect the varying cost of delivering physician services across areas. The adjustments are made by indices, known as the Geographic Practice Cost Indices (GPCI) that reflect how each geographic area compares to the national average.

In 2003, Congress established that for three years there would be a "floor" of 1.0 on the "work" component of the formula used to determine physician payments, which meant that physician payments would not be reduced in a geographic area just because the relative cost of physician work in that area fell below the national average. Congress

has extended the work GPCI floor several times. However, that most recent extension was set to expire at the end of 2011. The Temporary Continuation Act extends the existing 1.0 floor on the physician work component through February 2012.

Exceptions Process for Medicare Therapy Caps

Legislation enacted in 1997 created an annual per-Medicare beneficiary cap of $1,500 for outpatient therapy services, except when received from a hospital outpatient department. The $1,500 annual cap applied to physical and speech therapy combined, and separately to occupational therapy. From 1997 through the end of 2005, the caps were never imposed because Congress enacted a series of bills temporarily suspending the caps.

Congress allowed the caps to go into effect in 2006, but established an exceptions process whereby Medicare beneficiaries can request and be granted an exception to the caps, and receive an unlimited amount of therapy services to the extent deemed medically necessary by Medicare. The 2005 law authorized the exception process for only one year, but Congress has also repeatedly extended the exception process. The Temporary Continuation Act extends the exceptions process for an additional two months through February 2012. The per beneficiary cap amount has increased pursuant to a statutory inflation adjustment such that the caps in 2011 were $1,870 each.

Payment for Technical Component of Certain Physician Pathology Services

The Temporary Continuation Act extends the ability of independent laboratories to directly receive payments from Medicare for the technical component of pathology services performed for a hospital patient. The issue involved goes back to 1999 when the Health Care Financing Administration (now CMS) established a policy that Medicare would only make payment to the hospital for pathology services furnished to hospital patients. To the extent that hospitals may have outsourced those pathology services to an independent lab, the hospital would be required to bill Medicare and receive payment, and then compensate the lab for the services it provided. Congress has repeatedly suspended implementation of the regulation. The most recent suspension was set to expire as of January 1, 2012, but now is extended by the Temporary Continuation Act through February 2012.

Extension of Ambulance Add-ons

The Temporary Continuation Act extends several add-on payments for certain ambulance services. Beginning July 1, 2008, Medicare has paid an add-on amount of an additional 3 percent of the base Medicare reimbursement rate for ground ambulance trips originating in rural areas. This add-on payment was set to expire as of December 31, 2011, but is continued by the Temporary Continuation Act until March 1, 2012. Similarly, beginning July 1, 2008, ground ambulance services that originate in urban areas also are increased by an add-on payment of 2 percent; the Temporary Continuation Act continues this payment enhancement until March 1, 2012.

The Medicare statute also provides a "super" add-on payment for ambulance services in the "lowest population density" areas. CMS has set this add-on payment at 22.6 percent. The Temporary Continuation Act extends the add-on for ambulance service in these "super rural" areas until March 1, 2012.

Finally, the Temporary Continuation Act extends a provision from 2008 that clarifies which areas of the country are deemed "rural" for purposes of determining eligibility of air ambulance services for Medicare reimbursement. Under the extension, any area that was designated as a rural area for purposes of making payments for air ambulance services furnished on December 31, 2006, shall be treated as a rural area for purposes of making payments under such section for air ambulance services furnished through February 29, 2012.

Extension of Physician Fee Schedule Mental Health Add-on Payment

The 5 percent increase in payment rates by Medicare for certain mental health services will continue through February 29, 2012. Congress originally enacted legislation to effectuate the additional 5 percent for an 18-month period that ended December 31, 2009. The add-on payment was then extended twice before through the end of 2011; it is now extended a third time through February 2012.

Hospital Outpatient Hold Harmless Protections

Medicare provides additional payments under the Hospital Outpatient Prospective Payment System (OPPS) to small rural hospitals (*i.e.,* those with fewer than 100 beds)

and hospitals designated as sole community hospitals. However, that protection was set to expire at the end of 2011. This "hold harmless" protection is now extended by the Temporary Continuation Act through February 29, 2012. The amount of such payments during this period in 2012 will be 85 percent of the difference between the amount paid to the hospital under OPPS and the amount that otherwise would have been paid under the pre-OPPS cost-based Medicare outpatient hospital payment system.

Minimum Payments for Bone Mass Measurement Tests

Under legislation implemented in 2007, Medicare payments to physicians for the technical component of certain advanced imagining services (such as CT and MR scans) cannot exceed the payment Medicare makes to a hospital for the same service when furnished on an outpatient basis. Certain screening services, including diagnostic and screening mammography and bone density measurement tests furnished using dual-energy x-ray absorptiometry have been exempt from this cap (diagnostic and screening mammography is permanently exempt; bone density measurement has been only temporarily exempt, and the latest exemption was set to expire December 31, 2011). The Temporary Continuation Act now extends the exemption for bone density measurement tests through February 2012.

Extension of the Qualifying Individual Program and Transitional Medical Assistance

Two programs for low-income beneficiaries of Medicaid are extended under the new law. The Qualifying Individual (QI) program is for certain "dual eligibles," and allows Medicaid to pay the Medicare Part B premiums for low-income Medicare beneficiaries who have incomes between 120 percent and 135 percent of the poverty level. Transitional Medical Assistance (TMA) is a program that permits eligible low-income families to continue being covered by Medicaid during a transitional period when wage earners are transitioning into gainful employment and increased earnings, which might otherwise make the families ineligible for Medicaid. The Temporary Continuation Act extends both the QI and TMA programs through February 29, 2012.

Outlook

The Temporary Continuation Act was enacted after a major political showdown between Republicans and Democrats that nearly resulted in many of these programs expiring. Legislation approved largely along party lines by the House of Representatives on December 12, 2011, would have suspended the offending physician payment formula for two years, and provided physicians with a 1 percent increase in Medicare payments in each of calendar years 2012 and 2013. However, the House legislation, H.R.3630, would not have extended many of the programs that were extended by the Temporary Continuation Act, and would have paid for the physician payment increase by decreasing payments to hospitals. Specifically, the House bill would have reduced hospital outpatient payments for evaluation and management services to be equal to the Medicare payment for the same service when furnished in a physician office, and it would have reduced the reimbursement hospitals and other providers can receive for bad debts from 70 percent to 55 percent, phased in over 3 years.

The House bill also would have re-opened physician hospital ownership restrictions imposed under the Affordable Care Act (ACA) to allow physician-owned hospitals that were under construction, but did not have Medicare provider numbers as of December 31, 2010, to open and operate and qualify for grandfather protection; the bill also would have made it significantly easier for hospitals that were grandfathered under the ACA provisions to expand capacity (presently, grandfathered hospitals are allowed to expand bed and/or capacity only if they meet very limited criteria).

On December 17, the Senate, with overwhelming bipartisan support (89-10), approved a different version of H.R.3630, which was substantially identical to the Temporary Continuation Act. The House initially refused to embrace the Senate's version, but then ultimately relented under considerable political pressure. The House enacted a new bill, H.R.3765, under the condition that the Senate would negotiate a longer extension bill in 2012.

Given the short-term nature of these extensions, the House and Senate will now negotiate the differences between their competing versions of H.R.3630. House Republican leaders seem willing to allow many of these programs to expire, and despite a lopsided bipartisan vote in the Senate, many Senators are also questioning whether some of these programs should continue to endure.

In addition, the House and Senate are likely to consider whether to extend other Medicare provider payment programs that are set to expire at varying points in 2012, including payment adjustments for low-volume hospitals (October 1, 2012), Medicare-dependent Small Rural Hospitals (October 1, 2012) and reasonable costs payments for clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas (July 1, 2012).

The McDermott Difference

McDermott Will & Emery lawyers and government strategies professionals are actively engaged and prepared to advise clients with respect to these and other Medicare and Medicaid payment programs. If you have questions regarding the Temporary Continuation Act or the above referenced programs, please contact your regular McDermott Will & Emery lawyer or an author:

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