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Medicare and Medicaid Extenders Act: Significant Changes for Health Care Providers

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The Medicare and Medicaid Extenders Act of 2010 (MMEA) was signed into law on December 15, 2010, sparing hospitals, physicians and other health service providers from numerous significant payment cuts. The legislation also makes several important technical corrections to the health reform laws enacted earlier this year.

This white paper provides an overview of the most significant Medicare- and Medicaid-related provisions in the new Act.

Physician Payment Update

The most prominent change made by MMEA is the provision halting a scheduled 25 percent reduction in Medicare physician payments, which otherwise would have taken effect January 1, 2011.

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 nine years, 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. In 2011, had Congress not intervened, the reduction would have been 25 percent.

MMEA, which extends the current payment rates for a full year through the end of 2011, was the fifth congressional intervention to be enacted in 2010. Last June, Congress passed the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PACMB), which prevented physician payment reductions until December 1, 2010. Then, just prior to the passage of MMEA, Congress passed the Physician Payment and Therapy Relief Act of 2010, which contained a mere one-month extension, freezing payment rates through December 31, 2010. Last summer's PACMB legislation not only blocked a 21.3 percent reduction in physician payment rates then mandated by the SGR, but it also provided a 2.2 percent increase. That additional 2.2 percent was continued during December by the one-month extension, and will be sustained in Medicare's 2011 physician payment rates under MMEA.

The Congressional Budget Office estimates that Medicare will spend approximately $14.9 billion more in 2011 for physician payments than it otherwise would have without MMEA. Many policymakers recognize that the growing disparity between actual physician payment rates and the rates that would be imposed by the SGR makes implementing a long-term or permanent solution politically difficult.

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 locations. 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 "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, including most recently in the health reform law. However, that most recent extension was for one year only, and was set to expire at the end of 2010. MMEA extends the existing 1.0 floor on the physician work component through the end of 2011.

Extension of Section 508 Reclassifications

MMEA extends, until September 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 MMEA, Congress has extended these reclassifications five times, including most recently in the health reform legislation. The most recent extension expired September 30, 2010. MMEA extends the reclassifications retroactively to September 30, 2010, and continues them until September 30, 2011.

Exceptions Process for Medicare Therapy Caps

Legislation enacted in 1997 created an annual per-Medicare beneficiary cap of $1500 for outpatient therapy services, except when received from a hospital outpatient department (HOPD). The $1500 annual cap applied to physical and speech therapy combined, and separately to occupational therapy. During the period 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 could 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. The health reform law extended the exception process through the end of 2010.

MMEA extends the exception process for another year through December 31, 2011. The per-beneficiary cap amount has increased pursuant to a statutory inflation adjustment such that the caps in 2010 were $1860.

Payment for Technical Component of Certain Physician Pathology Services

MMEA extends the ability of independent laboratories to directly receive payments from Medicare for the technical component (TC) of pathology services performed for a hospital patient. The issue involved goes back to 1999, when the Health Care Financing Administration (now CMS) announced in its Final Rule for calendar year 2000 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 and the lab would be required to resolve the payment logistics. Initially an administrative decision was made to delay implementation of the new regulation in order to allow independent labs and hospitals time to negotiate their arrangements. Following the administrative delay, a series of legislative moratoria continued to suspend implementation of the regulation.

The most recent suspension was set to expire as of January 1, 2011, but now is extended by MMEA through the end of 2011.

Extension of Ambulance Add-ons

MMEA extends several add-on payments for ground ambulance services and extends a provision regarding rural air ambulance services, as well. For certain ground ambulance trips originating in rural areas, Medicare has paid, beginning July 1, 2008, an add-on amount of an additional 3.0 percent of the base Medicare reimbursement rate. This add-on payment was set to expire as of December 31, 2010, but is continued by MMEA until January 1, 2012. Similarly, beginning July 1, 2008, ground ambulance services that originate in non-rural areas also are increased by an add-on payment of 2.0 percent; MMEA continues this payment enhancement through January 1, 2012.

The Medicare statute also provides a “super” add-on payment for ambulance services in the “lowest population density” areas. The Secretary of Health and Human Services has set this add-on payment at 22.6 percent. MMEA extends the add-on for ambulance services in these “super rural” areas through January 1, 2012.

Finally, MMEA 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 December 31, 2011.

Extension of Physician Fee Schedule Mental Health Add-on Payment

The 5.0 percent increase in payment rates by Medicare for certain mental health services will continue through December 31, 2011. Congress originally enacted legislation to effectuate the additional 5.0 percent for an 18-month period that ended December 31, 2009. The add-on payment was then extended until the end of 2010 by the health reform legislation, and is now extended again through 2011.

Outpatient Hold Harmless Provision

Medicare provides additional payments under the 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 2010. This hold harmless protection is now extended by MMEA through 2011. The amount of such payments in 2011 will be 85.0 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.

Extension of Medicare Reasonable Costs Payments for Certain Clinical Diagnostic Laboratory Tests Furnished to Hospital Patients in Certain Rural Areas

Generally, Medicare pays for clinical diagnostic laboratory services based on fee schedules. However, for hospitals with fewer than 50 beds in qualified low-density population areas, Medicare pays on the basis of reasonable costs. This special payment provision was set to expire July 1, 2011. MMEA has extended the provision an additional year through July 1, 2012.

Extension of the Qualifying Individual (QI) Program and Transitional Medical Assistance (TMA)

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 120.0 percent and 135.0 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. Both the QI and TMA programs have now been extended through December 31, 2011.

Special Diabetes Programs

Two diabetes programs, the Special Diabetes Program (SDP) and the Special Diabetes Program for Indians (SDPI), were reauthorized to continue through the end of 2013. These diabetes programs, originally instituted under the Balanced Budget Act of 1997, have been legislatively reauthorized several times over more than a decade. The programs make funds available for type 1 diabetes research and for diabetes treatment and prevention initiatives targeted to American Indian and Alaska Native populations.

Repeal of Delay of RUG–IV

An updated methodology for determining Medicare payment rates to Skilled Nursing Facilities (SNFs) will be implemented immediately and apply retroactively to October 1, 2010. Under the health reform law, a moratorium was imposed on implementing the updated methodology, Resource Utilization Group–Version Four (RUG-IV), until October 1, 2011. MMEA repeals that provision, reverses the moratorium, and ends the delay in implementing RUG-IV.

Medicare covers nursing home services for beneficiaries who require skilled nursing care and/or rehabilitation services following a hospitalization of at least three consecutive days. For each eligible day a Medicare beneficiary is in an SNF, Medicare pays the SNF a daily payment, subject to adjustment for certain factors such as wage index in the particular geographic area. The payment covers all services provided by the SNF for the beneficiary that day, including room and board, nursing, therapy and drugs, as well as an estimate of capital-related costs to deliver those services. The SNF retains any profits and absorbs any losses.

RUG-IV uses updated staff time measurement data derived from the recently completed Staff Time and Resource Intensity Verification (STRIVE) project. According to CMS, RUG-IV is needed to recalibrate the case-mix system after changes in FY 2006 caused payments to SNFs to exceed budget neutrality estimates.

In August 2009, CMS announced its intent to begin using the RUG-IV case-mix classification methodology as of October 1, 2010. Before the RUG-IV methodology could take effect as scheduled on October 1, 2010, the health reform law was enacted, delaying the change one year. MMEA repeals the delay provision, allowing SNF rates determined by RUG-IV to be applied as of October 1, 2010, the date originally announced by CMS.

Children's Hospitals and 340B Drug Discounts on Orphan Drugs

A technical correction effectuated by MMEA ensures that discounts on "orphan drugs" remain available to children's hospitals under the 340B drug discount program. The 340B program enables certain providers, including children's hospitals, to purchase outpatient pharmaceuticals at discounted rates.

The health reform law expanded the 340B discount program by making it easier for certain rural hospitals, including critical access hospitals (CAHs), to qualify. However, the reform law also provided that drugs designated as "orphan" are exempt from the 340B program when purchased by newly added hospitals. Even though Congress added children's hospitals to the 340B drug discount program in 2005, the reform law included children's hospitals on its expanded list of 340B covered entities because a technical drafting error in the original 2005 statute left some ambiguity as to the true eligibility of these entities. When Congress sought to correct the original drafting error, it technically, but inadvertently labeled children's hospitals as a newly added facility type. As such, many read the orphan drug exclusion as also applying to children's hospitals, thereby rendering them ineligible to purchase drugs with orphan designations at 340B prices.

MMEA corrects the technical error in the health reform law and clarifies that children's hospitals shall continue to receive the benefit of discounts on orphan drugs through the 340B program.

Clarification for Affiliated Hospitals on Distribution of Additional Residency Positions

Since 1998, Medicare has capped the number of full-time equivalent (FTE) residents for which a hospital may receive Medicare reimbursements. The actual FTE resident count for many hospitals is significantly more than the Medicare cap, while some hospitals are under the cap. The health reform law established a new residency redistribution program that would reassess the caps, increasing the caps for some hospital programs while reducing the cap for others. Subject to statutory parameters, the redistribution of residency slots is made by CMS after taking into account the residency slots used at hospitals in the past three cost-reporting years. MMEA clarifies the health reform law redistribution provision to specify that hospitals that are members of the same "affiliated group" and sharing residency positions would not have those shared positions redistributed to other hospitals.

If you have questions regarding the Medicare and Medicaid Extension Act or the above-referenced programs, please contact your regular McDermott lawyer or:

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