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P.L. 110-173: Provisions in the Medicare, Medicaid, and SCHIP Extension Act of 2007

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Summary

On December 29, 2007, the President signed S. 2499, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173). This Act was passed by the House on December 19, 2007, and by a voice vote in the Senate on December 18, 2007. The Act makes changes to the nation's three major health programs, Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP), as well as other federally funded programs.

The most prominent provisions in the Act were to (1) suspend the Medicare physician payment cut scheduled to take effect and (2) provide SCHIP funding through March 2009. P.L. 110-173 mandates a 0.5% increase in the Medicare physician fee schedule for the six-month period from January 1, 2008, through June 30, 2008, and provides FY2008 and FY2009 SCHIP funding allotments through March 31, 2009. The Act also extends a number of expiring provisions and programs. These extensions affect Medicare plans and providers and Medicaid payments and programs. The Act also includes funding for some miscellaneous activities.

The Act's Medicare extensions include incentive payments for certain physicians, and extensions of current law provisions for Medicare Special Needs Plans and cost-based plans. A variety of extensions also affect how long-term care, rural, and acute care hospitals are paid or classified. Other extensions affect Medicare payments for certain services and providers, outpatient physical therapy services, speech language pathology services, certain pathology laboratories, brachytherapy services, and therapeutic radiopharmaceuticals.

The Act also includes Medicaid provisions designed to extend certain payments and programs, such as Medicaid disproportionate hospital share (DSH) allotments for Tennessee and Hawaii, the Transitional Medical Assistance (TMA) program, and the Qualifying Individual (QI) program, among other provisions.

Miscellaneous provisions include using Medicare funds to make grants to State Health Insurance Assistance Programs, Area Agencies on Aging, and Aging and Disability Resource Centers. The Act also establishes the Medicare Payment Advisory Commission (MedPAC) as a congressional agency.

The Act provides a number of offsets to pay for the spending increases, including a reduction in the Medicare Advantage stabilization fund in 2012. The Act also includes provisions affecting Medicare's responsibility as a secondary payer for covered services, Medicare payments for Inpatient Rehabilitation Facilities (IRFs), payments for most Medicare part B drugs, payments for certain diagnostic laboratory tests, and Medicare Long-Term Care Hospitals.

This report provides short descriptions of the provisions contained in P.L. 110-173.

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On December 29, 2007, the President signed S. 2499, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173). This Act was passed by the House on December 19, 2007, and by a voice vote in the Senate on December 18, 2007. The Act makes changes to the nation's three major health programs, Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP), as well as other federally funded programs.

Perhaps the most prominent provisions of the Act were to (1) suspend the Medicare physician payment cut scheduled to take effect and (2) provide SCHIP funding through March 2009. The update formula for Medicare physician payment would have required a reduction in the fee schedule for physician reimbursement of 10.1% as of January 1, 2008, and by roughly 5% annually thereafter. SCHIP needed to be reauthorized because Title XXI of the Social Security Act, as established by the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33), specified national appropriation amounts only from FY1998 to FY2007. The President vetoed two bills prior to P.L. 110-173 (H.R. 976, H.R. 3963) that would have provided federal funding for SCHIP in FY2008 through FY2012. In response to these vetoes, four continuing resolutions (P.L. 110-92, P.L. 110-116, P.L. 110-137, and P.L. 110-149) appropriated $5 billion for federal SCHIP allotments in FY2008 through December 31, 2007.

P.L. 110-173 mandates a 0.5% increase in the Medicare physician fee schedule for the six-month period from January 1, 2008, through June 30, 2008, and provides FY2008 and FY2009 SCHIP allotments through March 31, 2009.[1] It also redistributes any FY2006 funds that are unspent by FY2008 to states that are projected to experience shortfalls. For 2008, the Act provides up to $1.6 billion to shortfall states and additional sums to territories. For the first two quarters of FY2009, up to $275 million is appropriated for the same purpose.

The Act also extends a number of expiring provisions and programs. These extensions affect Medicare plans and providers and Medicaid payments and programs. The Act also includes funding for some miscellaneous activities.

Regarding Medicare Advantage plans, the Act allows Medicare Special Needs Plans to continue to restrict their enrollment to Medicaid-entitled institutionalized beneficiaries and other specified individuals until January 1, 2010. Also, cost-based plans under Medicare may continue to operate in an area with two local or two regional Medicare Advantage plans until January 1, 2009.

Extensions that affect Medicare payments for certain providers and services include, among others, extending the secretarial authority to reclassify certain hospitals to areas with higher wage index values. The Act allows qualified rural hospitals that provide clinical diagnostic laboratory services to continue to be reimbursed under a reasonable cost system rather than a fee schedule. The Act also extends exceptions to annual per beneficiary payment limits on outpatient physical therapy services and speech language pathology services for the next six months. Certain pathology laboratories are allowed to continue billing hospitals directly for their services. The Act extends the Medicare incentive payment program for certain physicians providing services in scarcity areas and Medicare payments for the accommodation of physicians ordered to active duty in the Armed Services. The Act also extends cost reimbursement for brachytherapy services and cost reimbursement to therapeutic radiopharmaceuticals.

Many extensions also affect certain Medicaid payments and programs. The Act extends increased payments for Medicaid disproportionate hospital share (DSH) allotments for Tennessee and Hawaii to provide additional assistance to certain hospitals that provide a disproportionate share

[1] For more projections of states' FY2008 SCHIP federal funding and expenditures, see CRS Report RS22739, *FY2008 Federal SCHIP Financing*, by Chris L. Peterson.

of care to low-income patients with special needs. It also continues Medicaid benefits through June 30, 2008, for certain low-income families that would otherwise lose coverage because of changes in their income under the Transitional Medical Assistance (TMA) program. Medicaid's coverage of Medicare part B premiums under the Qualifying Individual (QI) program is extended through June 2008, including an allocation of $200 million for this program. S. 2499 also prohibits the Secretary from taking action to restrict Medicaid coverage of school-based, health-related services, including transportation and administrative activities for the next six months.

Miscellaneous activities include providing additional funds under the State Health Insurance Assistance Programs to assist Medicare-eligible individuals in obtaining information and counseling on enrollment in health insurance. Medicare funds are also used to make grants for Area Agencies on Aging and Aging and Disability Resource Centers for FY2008 and FY2009. The Act also includes provisions that extend the Title V Abstinence Education block grant through June 30, 2008, and amend the Public Health Service Act to provide for research into the prevention of Type I diabetes. Grants for the prevention and treatment of diabetes among American Indians and Alaskan Natives are also provided. In addition, the Medicare Payment Advisory Commission (MedPAC) will become a congressional agency. Finally, additional funds are provided to the Current Population Survey to improve the collection of data on state populations of low-income children

Because the pay-go rule as reestablished by the 110th Congress requires all considered bills to neither have the net effect of increasing the deficit nor reducing the surplus, the Act includes a number of offsets to pay for the aforementioned provisions. These offsets include a reduction in federal payments for the Medicare Advantage stabilization fund in 2012. The Act also strengthened procedures and additional funding for the determination of Medicare's responsibility as a secondary rather than a primary payer for covered services. The market basket update for certain discharges is eliminated, and the compliance requirements for payment are modified for Inpatient Rehabilitation Facilities (IRFs) for FY2008 and FY2009. Another offset requires the Secretary of Health and Human Services (HHS) to use constant volume weighting in the computation of the average sales price (ASP) for the payments for most Medicare part B drugs. Payment rates for certain diagnostic laboratory tests are also changed. Finally, the Act modifies the statutory definition of and requirements for Long-Term Care Hospitals that participate in Medicare and authorizes a study on the establishment of a national long-term care hospital facility and patient criteria, among other purposes.

The Congressional Budget Office (CBO) estimated that S. 2499 would result in a net savings to the federal government of $100 million between FY2008 and FY2012.[2] Included in this calculation is an estimate of a spending increase for certain SCHIP, Medicaid, and miscellaneous provisions that would total approximately $1.8 billion. It also includes an estimate of approximately $1.8 billion in savings as a result of the direct effects of the Medicare provisions (saving approximately $1.6 billion) and the interactions between provisions (saving approximately $200 million).

This report provides short descriptions of the provisions contained in S. 2499. For additional assistance, congressional clients may contact a CRS specialist or analyst. Names of these individuals are included in the **Key Policy Staff** table.

[2] CBO Estimate of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (GOEO7DO3), December 18, 2007. Available at http://www.cbo.gov/ftpdocs/88xx/doc8898/SFC_MMS_ExtensionGOE07D03.pdf. Savings and expenditures for the Medicare, Medicaid, SCHIP and miscellaneous provisions do not add up to the net savings estimated by CBO due to rounding by CBO.

A Brief Description of the Current Programs

The Medicare, Medicaid, and SCHIP programs are briefly described below. More complete and detailed descriptions of the programs are available to congressional clients from CRS upon request.[3]

Medicare

Medicare is the nation's health insurance program for persons aged 65 and over and certain disabled persons. In FY2008, the program will cover an estimated 44.6 million persons (37.3 million aged and 7.3 million disabled) at a total cost of $456.3 billion. Federal costs (after deduction of beneficiary premiums and other offsetting receipts) will total $389.7 billion. In FY2007, federal Medicare spending will represent approximately 13% of the total federal budget and 3% of GDP. Medicare is an entitlement program, which means that it is required to pay for all covered services provided to eligible persons, so long as specific criteria are met.

Medicare consists of four distinct parts: Part A (Hospital Insurance, or HI); Part B (Supplementary Medical Insurance, or SMI); Part C (Medicare Advantage, or MA); and Part D (the new prescription drug benefit added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or MMA, P.L. 108-173). The program is administered by the Centers for Medicare and Medicaid Services (CMS) in the Department of HHS.

Medicaid

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services, as well as long-term care, to more than 63 million people at an estimated cost to the federal and state governments of roughly $317 billion. Each state designs and administers its own version of Medicaid under broad federal rules. State variability in eligibility and covered services, and how those services are reimbursed and delivered, is the rule rather than the exception. In the federal budget, Medicaid is an entitlement program that constitutes a large share of mandatory spending. Federal Medicaid spending is open-ended, with total outlays dependent on the spending levels of state Medicaid programs.

SCHIP

SCHIP is authorized under Title XXI of the Social Security Act. In general, this program allows states to cover targeted low-income children with no health insurance in families with income that is above Medicaid eligibility levels. As of July 2006, the highest upper-income eligibility limit under SCHIP had reached 350% of the federal poverty level (FPL) in one state. States may enroll targeted low-income children in an SCHIP-financed expansion of Medicaid, create a new separate state SCHIP program, or devise a combination of both approaches. States choosing the Medicaid option must provide all mandatory benefits and all optional services covered under the state plan, and must follow the nominal Medicaid cost-sharing rules (with some exceptions). In general, separate state programs must follow certain coverage and benefit options outlined in SCHIP law. While some cost-sharing provisions vary by family income, the total annual aggregate cost-

[3] See, for example, CRS Report RL33712, *Medicare: A Primer*, by Jennifer O'Sullivan; CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz; and CRS Report RL30473, *State Children's Health Insurance Program (SCHIP): A Brief Overview*, by Elicia J. Herz, Chris L. Peterson, and Evelyne P. Baumrucker.

sharing (including premiums, copayments, and other similar charges) for a family may not exceed 5% of total income in a year. Preventive services are exempt from cost-sharing.

In the Balanced Budget Act of 1997, nearly $40 billion was appropriated for SCHIP for FY1998 to FY2007. Appropriations for FY2007 equaled about $5.7 billion.[4] Annual allotments among the states are determined by a formula that is based on a combination of the number of low-income children and low-income uninsured children in the state, and includes a cost factor that represents the average health service industry wages in the state compared with the national average. Like Medicaid, SCHIP is a federal-state matching program. While the Medicaid federal medical assistance percentage (FMAP) ranged from 50% to 75.89% in FY2007, the enhanced SCHIP FMAP ranged from 65% to 83.12% across states.

All states, the District of Columbia, and five territories have SCHIP programs. As of November 2006, 17 use Medicaid expansions, 18 use separate state programs, and 21 use a combination approach. Approximately 6.7 million children were enrolled in SCHIP during FY2006. In addition, 12 states reported enrolling about 700,000 adults in SCHIP through program waivers.

Summary of Provisions in S. 2499

Title I—Medicare

Section 101. Increase in physician payment update; extension of the physician quality reporting system

This provision increases the physician payment update factor, modifies the amounts available in the Physician Assistance and Quality Initiative (PAQI) Fund, and extends the Physician Quality Reporting System.

The current update formula for Medicare physician payment would have required a reduction in the fee schedule for physician reimbursement of 10.1% in 2008 and by roughly 5% annually for at least several years thereafter. This provision averts this reduction and mandates a 0.5% increase in the physician fee schedule for the six-month period from January 1, 2008, through June 30, 2008. The conversion factor for the remaining six months of 2008 and afterwards will be computed as if the modification to the conversion factor for the first six months of 2008 had never applied.

The Tax Relief and Health Care Act of 2006 (TRHCA; P.L. 109-432) authorized $1.35 billion for FY2008 for the PAQI Fund, which is to be available to the Secretary of HHS for physician payment and quality improvement initiatives. This provision modifies the amounts that will be available in the PAQI Fund and the years in which the monies can be spent. However, there are provisions in the Department of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act of 2008 (division G of the Consolidated Appropriations Act of 2008) that also affect the PAQI Fund. The net effect of these two laws is that no funds remain available in the PAQI Fund for the years 2008 through 2012, and $4.96 billion are available in 2013. This provision requires that the amount available for expenditures during 2013 be available only for an adjustment to the update of the conversion factor for that year. The amount of money that would have been available in the PAQI Fund for payment with respect to physicians' services

[4] In addition to the original appropriation level of $5.04 billion this appropriation amount includes supplemental funding up to $650 million. In some years, there were unspent prior year funds that were available for a state's use. As a result, relying on appropriation amounts alone may not accurately reflect total funds available in any given year.

furnished prior to January 1, 2013, is to be deposited into the Federal Supplementary Medical Insurance Trust Fund, and these funds are to be made available for expenditures.

The provision also extends and modifies the existing Physician Quality Reporting System for physicians and other health care professionals under Medicare for FY2008 and FY2009. The CMS Program Management Account is authorized to be appropriated $25 million for FY2008 and FY2009 to carry out the Physician Quality Reporting System.

Section 102. Extension of Medicare incentive payment program for physician scarcity areas

Current law provides a 5% bonus payment for certain physicians providing services in scarcity areas for the period January 1, 2005, through December 31, 2007. The provision extends the add-on payments through June 30, 2008. During the extension period, the Secretary is required to use the primary care scarcity counties and specialty care scarcity counties that the Secretary was using on December 31, 2007.

Section 103. Extension of floor on work geographic adjustment under the Medicare physician fee schedule

Medicare makes payment for physician services under the fee schedule. Three factors enter into the calculation of the fee schedule payment amount: the relative value for the service, a geographic adjustment, and a national dollar conversion factor. The geographic adjustments are indexes that reflect cost differences among areas compared with the national average in a "market basket" of goods.[5] These geographic adjustments are made in 89 distinct payment localities; 34 are statewide and include urban and rural areas. A value of 1.00 represents expenses equal to the average across all areas. A value less than 1.00 represents expenses below the national average. Current law includes a temporary provision under which the value of any work geographic index under the physician fee schedule that is below 1.00 is increased to 1.00 for services furnished on or after January 1, 2004, and before January 1, 2008. The provision extends the floor through June 30, 2008.

Section 104. Extension of treatment of certain physician pathology services under Medicare

The provision extends through June 30, 2008, the temporary provision that allows independent laboratories providing services to hospitals to continue to bill directly for such services. The provision is limited to laboratories that had agreements with hospitals on July 22, 1999, to bill directly for the technical component of pathology services.

Section 105. Extension of exceptions process for Medicare therapy caps

The Balanced Budget Act of 1997 established annual per beneficiary payment limits for all outpatient therapy services provided by non-hospital providers. The limits applied to services provided by independent therapists, as well as to those provided by comprehensive outpatient rehabilitation facilities (CORFs) and other rehabilitation agencies. The limits did not apply to

[5] The law specifies that the practice expense and malpractice indices reflect the full relative differences. However, the work index must reflect only one-quarter of the difference. Using only one-quarter of the difference generally means that rural and small urban areas receive higher payments and large urban areas lower payments than if the full difference were used.

outpatient therapy services provided by hospitals. The Deficit Reduction Act of 2005 required the Secretary to implement an exceptions process for 2006 for cases in which the provision of additional therapy services was determined to be medically necessary. The exceptions process was slated to end December 31, 2007. The provision extends the exceptions process through the first six months of 2008.

Section 106. Extension of payment rule for brachytherapy; extension to therapeutic radiopharmaceuticals

MMA required Medicare's outpatient prospective payment system to make separate payments for specified brachytherapy sources. As mandated by the TRHCA, until January 1, 2008, this separate payment will be made using hospitals' charges adjusted to their costs. The provision extends cost reimbursement for brachytherapy services until July 1, 2008. Therapeutic radiopharmaceuticals will be paid using this methodology for services provided on or after January 1, 2008, and before July 1, 2008.

Section 107. Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas

Generally, hospitals that provide clinical diagnostic laboratory services under Part B are reimbursed using a fee schedule. Hospitals with under 50 beds in qualified rural areas (certain rural areas with low population densities) receive 100% of reasonable cost reimbursement for the clinical diagnostic laboratories covered under Part B that are provided as outpatient hospital services. This provision extends reasonable cost reimbursement for clinical laboratory services provided by qualified rural hospitals through June 30, 2008.

Section 108. Extension of authority of specialized Medicare Advantage plans for special needs individuals to restrict enrollment

Special Needs Plans (SNPs) are Medicare Advantage (MA) plans that exclusively serve special needs beneficiaries. Special needs beneficiaries are defined as eligible enrollees who are institutionalized, are entitled to Medicaid, or would benefit from enrollment in a SNP (as determined by the Secretary of HHS). This provision allows SNPs to restrict enrollment to one or more class of special needs beneficiaries until January 1, 2010. The provision also restricts the Secretary from designating other MA plans as SNPs and imposes a moratorium on new SNP plans until January 1, 2010.

Section 109. Extension of deadline for application of limitation on extension or renewal of Medicare reasonable cost contract plans

Cost-based Medicare plans are those managed care plans that are reimbursed by Medicare for the actual cost of furnishing covered services to Medicare beneficiaries. After January 1, 2008, any cost-based plan operating within the service area of either two local or two regional MA plans would not have its contract with Medicare renewed. This provision extends for one year—from January 1, 2008, to January 1, 2009—the length of time a cost-based plan can continue operating in an area with two local or two regional MA plans.

Section 110. Adjustment to the Medicare Advantage stabilization fund

The Secretary is required to establish an MA Regional Plan stabilization fund to provide incentives for plan entry and plan retention in MA regions. Funding for the stabilization fund was to be $1.6 billion in 2012 and $1.79 billion in 2013, with additional funds available in an amount equal to 12.5% of the average per capita monthly savings from regional plans. This provision eliminates the $1.6 billion in funds available for the stabilization fund in 2012.

Section 111. Medicare secondary payor

Generally, Medicare is the "primary payer"—that is, it pays health claims first, and if a beneficiary has other insurance, that insurance may fill in all or some of Medicare's gaps. However, in some situations, the Medicare Secondary Payer (MSP) rules prohibit Medicare from making payments for any item or service when payment has been made or can reasonably be expected to be made by a third-party payer. The law authorizes several methods to identify cases when an insurer other than Medicare is the primary payer and to facilitate recoveries when incorrect Medicare payments have been made.[6]

This provision requires an insurer or third-party administrator for a group health plan (and in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary) to (1) secure from the plan sponsor and participants information required by the Secretary for the purpose of identifying situations where the group health plan is or has been a primary plan to Medicare, and (2) submit information specified by the Secretary. If an insurer or third-party administrator for a group health plan fails to comply, then a $1,000 per day civil monetary penalty will be imposed for each individual for which information should have been submitted.

The provision requires the Secretary to share information on Medicare Part A entitlement and Part B enrollment with entities, plan administrators, and fiduciaries. The Secretary may share this information with other entities and may share information as necessary for the proper coordination of benefits.

An applicable plan (defined as laws, plans, or other arrangements, including the fiduciary or administrator for liability insurance, no fault insurance, and worker's compensation law or plans) is required to determine whether a claimant is entitled to benefits under Medicare on any basis, and if so, to submit required information to the Secretary, including (1) the claimant's identity and (2) other information specified by the Secretary to enable an appropriate determination concerning coordination of benefits and any applicable recovery claims. Failure to comply will result in a $1,000 per day civil monetary penalty for each claimant. The Secretary can share this information as necessary for proper coordination of benefits.

For purposes of using this new information to ensure appropriate Medicare payments, the Secretary will transfer, in appropriate parts, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund $35 million to the CMS Program Management Account for fiscal years 2008, 2009, and 2010.

Section 112. Payment for part B drugs

MMA revised the way Part B pays for covered drugs. Payments for most Part B drugs are based on an average sales price (ASP) payment methodology; the Secretary has the authority to reduce

[6] For more information, see CRS Report RL33587, *Medicare Secondary Payer—Coordination of Benefits*, by Hinda Chaikind.

the ASP payment amount if the widely available market price is significantly below the ASP. Alternatively, beginning in 2006, drugs can be provided through the competitive acquisition program (CAP). Each year, each physician is given the opportunity either to receive payment using the ASP methodology or to obtain drugs and biologicals through the CAP.

Under the ASP methodology, Medicare's payment for Part B equals 106% of the applicable price for a multiple source drug or single source drug, subject to the beneficiary deductible and coinsurance. Applicable prices are derived from data reported by manufacturers under the Medicaid program. The applicable price for multiple source drugs is the volume-weighted average of the ASPs calculated by National Drug Code (NDC) for each calendar quarter. The applicable price for single source drugs is the lesser of the volume-weighted ASP or the wholesale acquisition cost.

MMA included language specifying how to calculate a volume-weighted ASP based on information reported by manufacturers. The reporting unit was the lowest identifiable quantity of the drug (e.g., one milliliter, one tablet). However, the MMA allowed the Secretary, beginning in 2004, to use a different reporting unit. The Secretary used his discretion and changed to the amount of the drug represented by the NDC. The amount of the drug represented by one NDC may differ from the amount represented by another NDC.

In February 2006, the Office of the Inspector General (OIG) of the Department of HHS issued a report (OEI-03-05-00310) which stated that the method used by CMS was incorrect because it did not use billing units consistently throughout the equation. It stated that although CMS used billing units to standardize ASPs across NDCs for each Healthcare Common Procedure Coding System (HCPCS) code, it did not similarly standardize sales volume across NDCs. The HCPCS, established by the American Medical Association, is the set of health care procedure codes used by Medicare, Medicaid, and other insurers to process insurance claims.

The provision requires the Secretary to use constant volume weighting in the computation of the ASP, using the formula recommended by the February 2006 Inspector General's report; this requirement applies with respect to payment for multiple source and single source drugs and biologicals furnished on or after April 1, 2008. For all drug products included within the same multiple source billing and payment code, the provision defines the numerator of the volume-weighted average of the average sales price as the sum of the products (for each NDC assigned to such drug products) of (1) the manufacturer's average sales price, as determined by the Secretary without dividing such price by the total number of billing units for the NDC for the billing and payment code, and (2) the total number of units sold. The numerator is then divided by the denominator, which is defined as the sum of the products (for each NDC assigned to such drug products) of (1) the total number of units sold and (2) the total number of billing units for the NDC for the billing and payment code. The provision defines the "billing unit" as the identifiable quantity associated with a billing and payment code, as established by the Secretary. Beginning on April 1, 2008, for each multiple source drug or biological and for each single source drug or biological that is treated as a multiple source drug because it is pharmaceutically equivalent or bioequivalent to another drug, the payment amount will be the lowest price option available to the Secretary.

Section 113. Payment rate for certain diagnostic laboratory tests

Glycosylated hemoglobin (HbA1c) is used to monitor how well blood glucose levels are controlled in diabetes patients. The current Medicare payment rate for HbA1c is tied to two HCPCS codes: 83036 and 83037. HCPCS code 83037 was developed in 2006 to cover the testing for HbA1c by a device approved by the Food and Drug Administration (FDA) for home use;

83036 is the default code, used for the majority of glycosylated hemoglobin tests, and not limited to specific methodology. This provision changes the Medicare payment rate for HCPCS code 83037 to the rate established for 83036, for HbA1c tests that are furnished on or after April 1, 2008.

Section 114. Long-term care hospitals

A long-term care hospital (LTCH) is an acute care general hospital that has a Medicare inpatient average length of stay greater than 25 days. Since 2002, LTCHs have been paid under their own prospective payment system (LTCH-PPS). Provisions establishing this PPS are contained in Section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA; P.L. 106-113) and Section 307 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA; P.L. 106-554). These LTCH-PPS provisions have not been incorporated into the Social Security Act (SSA). Each year, the LTCH base rate (per discharge payment amount) is updated.

Presently, LTCHs are not explicitly permitted in statute to be units of other facilities. CMS established a new LTCH policy for cost reporting periods beginning on or after July 1, 2007, for determining whether a freestanding LTCH was acting as a unit of independent host hospitals. The regulation had originally been applied only to those LTCHs established as hospitals-within-hospitals (HwHs) or satellite hospitals. The policy (referred to as the "25% rule") limits the proportion of patients who can be admitted from a co-located or host hospital during a cost reporting period and be paid under the LTCH-PPS. After the threshold is reached, the LTCH is paid the lesser of the LTCH PPS rate or the acute hospital PPS rate. The HwH threshold for most admissions from its host hospital for rate year (RY) 2008 is 25%. The expansion of the policy to freestanding LTCHs will occur on a phased-in basis over a three-year transition period.

There are some exceptions to the 25% rule. Generally, for rural HwHs, the applicable percentage is 50%. Urban single HwHs or those located in metropolitan statistical areas (MSAs) with dominant hospitals—those with one-fourth or more of acute care cases for the MSA—also have a threshold of 50%.

A short-stay outlier under the LTCH-PPS is a discharge for stays that are considerably shorter than the average length of stay for a long-term care DRG (five-sixths of the geometric average length of stay for each DRG). These short-stay outliers have an adjustment made to their payment that allows Medicare to pay less than cases that receive a full episode of care. Recent policy changes added a new class of short-stay outliers.

Under CMS policy, the Secretary reviews the payment system and may make a one-time prospective adjustment to the long-term care hospital prospective payment system rates on or before July 1, 2008, so that the effect of any significant difference between actual payments and estimated payments for the first year of the long-term care hospital prospective payment system is not perpetuated in the prospective payment rates for future years.

This provision establishes section 1861(ccc) in the SSA that would define an LTCH as an institution that (1) is primarily engaged in providing inpatient services by or under the supervision of a physician to Medicare beneficiaries whose medically complex conditions require a long hospital stay and programs of care provided by a LTCH; (2) has a Medicare inpatient average length of stay greater than 25 days; (3) satisfies Medicare's hospital definition; and (4) meets certain facility criteria, including a patient review process with patient validation within 48 hours of admission. Also, the institution will have active physician involvement with patients, an organized medical staff, on-site physician availability on a daily basis, and consulting physicians

on call and accessible. The institution is required to have interdisciplinary teams, including physicians, to prepare and treat patients using individualized patient treatment plans.

The Secretary is required to conduct a study on the establishment of national long-term care hospital facility and patient criteria. Not later than 18 months from enactment, the Secretary will submit a report to Congress including recommendations for legislation and administrative actions.

During a three-year moratorium period beginning with the enactment of this provision, the Secretary will not apply the 25% rule or a similar policy to freestanding LTCHs or certain LTCH HwHs (referred to as "grandfathered LTCHs") that have been considered to be freestanding. The admission threshold for HwHs or satellite facilities in rural areas or LTCHs that are co-located with an urban single or MSA dominant hospital will increase from 50% to 75%. For other HwHs or satellite facilities, the admission threshold from a co-located hospital will be set at 50%. The Secretary is not able to apply the new short-stay outlier policy during a three-year moratorium period that begins on the date of enactment. The Secretary is not able to make the one-time prospective adjustment to LTCH prospective payments during a three-year moratorium period that begins on the date of enactment.

The Secretary will impose a temporary moratorium on the certification of new LTCHs, satellite facilities, long-term care hospital, and satellite facility beds for a three-year period beginning at the enactment date. The moratorium does not apply to an LTCH hospital, satellite facility, or additional beds that are under development as of the enactment date. The moratorium does not apply to an existing LTCH bed increase request where there is closure of an LTCH or a significant decrease in the number of LTCHS beds in a state where there is only one other LTCH. There is no administrative or judicial review of a Secretary's decision on these exceptions.

This provision establishes 1886(m) of the SSA entitled "Prospective Payment for Long Term Care Hospitals," which would provide specific references to the sections of BBRA and BIPA that contain the LTCH-PPS provisions.

The base rate for LTCH's rate year (RY) 2008 (from July 1, 2007, through June 30, 2008) is the same as that used for discharges in RY2007 (from July 1, 2006, through June 30, 2007). The provision does not apply to discharges starting July 1, 2007, and before April 1, 2008.

Starting for discharges on October 1, 2007, the Secretary will contract with fiscal intermediaries or Medicare administrative contractors to review the medical necessity of LTCH admissions and continued stays. These reviews will be conducted annually and will provide a statistically valid sample (at a 95% confidence interval) and guarantee that at least 75% of the overpayments are identified and recovered. The Secretary will establish an error rate that would require further review. These medical necessity reviews will stop for discharges after October 1, 2010, unless otherwise determined by the Secretary. To carry out these activities, $35 million will be appropriated from the Treasury into the Program Management Account of CMS in FY2008 and FY2009. The costs of the medical necessity reviews will be funded from the aggregate overpayments recouped from the LTCHs; such amounts will not exceed 40% of such recovered overpayments.

Section 115. Payment for inpatient rehabilitation facility (IRF) services

Starting January 1, 2002, payments to inpatient rehabilitation facilities (IRFs) are made under a discharge-based prospective payment system where one payment covers capital and operating costs. Each year, the per discharge payment amount is increased by an update factor based on the increase in the market basket index. The provision establishes the IRF update factor at 0% in FY2008 and FY2009, starting for discharges on April 1, 2008. Starting for cost reporting periods

on or after July 1, 2007, the IRF compliance threshold (which determines whether a facility is an IRF or an acute care hospital) is established as no greater than the 60% compliance rate that became effective for cost reporting periods beginning July 1, 2006; comorbidities are included as qualifying conditions. No later than 18 months from enactment, the Secretary will consult with certain parties and submit a report to the committees with jurisdiction over Medicare. The study will analyze access to medically necessary rehabilitation services and alternatives to the IRF compliance thresholds.

Section 116. Extension of accommodation of physicians ordered to active duty in the Armed Services

Medicare payment may be made to a physician for services furnished by a second physician to patients of the first physician provided certain conditions are met. In general, the services cannot be provided by the second physician for more than 60 days. P.L. 110-54 (enacted August 3, 2007) permitted, for services provided prior to January 1, 2008, reciprocal billing over a longer period in cases where the first physician was called or ordered to active duty as a member of a reserve component of the Armed Forces. The provision extends this accommodation through June 30, 2008.

Section 117. Treatment of certain hospitals

Under IPPS, a hospital (or group of hospitals) can increase its Medicare payments though administrative reclassification (by the Medicare Geographic Classification Review Board or MGCRB) to a different area with a higher wage index value. These reclassifications are budget-neutral. Other hospitals have been reclassified by legislation. Section 508 of MMA provided $900 million for a one-time, three-year geographic reclassification of certain hospitals that were otherwise unable to qualify for administrative reclassification to areas with higher wage index values. These reclassifications were extended from March 31, 2006, to September 30, 2007, by TRHCA. This extension was exempt from any budget neutrality requirements. Under this legislation, Section 508 reclassifications are extended until September 30, 2008. Hospitals that were reclassified through the Secretary's authority to make exceptions and adjustments during the FY2005 rulemaking process will have their reclassification extended until September 30, 2008. A hospital that has been reclassified under Section 508 (as extended) will not prevent the group reclassification of otherwise eligible hospitals during FY2008. Those Section 508 reclassifications, which were extended until September 30, 2007, where the applicable wage index was lower during the six-month extension (from April 1 2007 until September 30, 2007) than the wage index applied to the hospital from October 1, 2006, through March 31, 2007, will have the higher wage index used for the entire FY2007 period. Any additional Medicare payments will be paid to the hospitals within 90 days after settlement of the applicable cost report.

Section 118. Additional Funding for State Health Insurance Assistance Programs, Area Agencies on Aging, and Aging and Disability Resource Centers

State Health Insurance Assistance Programs (SHIPs) provide information, counseling, and assistance to Medicare-eligible individuals on obtaining adequate and appropriate health insurance. State Area Agencies on Aging and State Aging and Disability Resource Centers also conduct health insurance outreach to Medicare-eligible individuals, in addition to administering elder rights programs, providing legal services to the elderly, and coordinating information about

long-term care services. This provision requires the Secretary to transfer $15,000,000 from the Medicare Part A and B Trust Funds to the CMS program management account to provide grants to state SHIP programs for FY2008. The provision also requires the Secretary to transfer $5,000,000 from the CMS program management account to provide grants to Area Agencies on Aging and Aging and Disability Resource Centers for FY2008 and FY2009.

Title II—Medicaid and SCHIP

Section 201. Extending SCHIP funding through March 31, 2009

SCHIP allotments

Title XXI of the Social Security Act specifies national appropriation amounts from FY1998 to FY2007 for SCHIP. Continuing Resolutions (P.L. 110-92, P.L. 110-116, P.L. 110-137) have provided through December 21, 2007, the same level of SCHIP appropriations for FY2008 as was appropriated initially for FY2007 ($5.0 billion for the states and territories, plus an additional $40 million for the territories). The national appropriation available to states is allotted using a formula based on the estimated number of low-income children and low-income *uninsured* children in each state, adjusted slightly by a geographic cost factor. Allotments are available for three years, after which any unspent funds are redistributed to other states.

Under S. 2499, $5.04 billion is appropriated in FY2008 and in FY2009 for SCHIP allotments, as in FY2007. The formula for allotting the funds among the states and territories is unchanged. The FY2009 allotments are available only through March 31, 2009 (or the date of enactment of legislation to reauthorize SCHIP, whichever comes first).

Redistribution

Allotments unspent after three years are redistributed to other states. Under the Continuing Resolutions, FY2005 allotments unspent at the end of FY2007 were to be redistributed to states projected to exhaust all of their SCHIP funds in FY2008. The redistributed FY2005 funds would be provided, until exhausted, to states in the order in which their shortfalls occur. This methodology for redistribution was to be in effect until December 21, 2007, unless legislation was enacted beforehand to reauthorize SCHIP.

Under S. 2499, the methodology specified in the Continuing Resolutions for redistributing unspent FY2005 federal SCHIP funds is made permanent. In addition, under S. 2499, FY2006 allotments unspent at the end of FY2008 will be redistributed to states projected to exhaust all of their SCHIP funds in FY2009 before March 31, 2009. The redistributed FY2006 funds will be provided, until exhausted, to states in the order in which those shortfalls occur.

Additional appropriations for states' shortfalls of federal SCHIP funds

In early FY2006, several states were projected to exhaust their federal SCHIP funds during the year, with a shortfall projected at $283 million. Congress appropriated $283 million in the Deficit Reduction Act of 2005 (P.L. 109-171) for the purpose of eliminating states' shortfalls in FY2006, with 1.05% of the appropriation provided to the territories. To eliminate shortfalls of some states' federal SCHIP funds in FY2007, Congress appropriated such sums as necessary, not to exceed $650 million, in the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (P.L. 110-28). The territories received no portion of this appropriation.

Under S. 2499, such sums as necessary, not to exceed $1.6 billion, are appropriated in FY2008: (1) to eliminate states' shortfalls of federal SCHIP funds and (2) to provide 1.05% of states' projected shortfall amounts to the territories. These funds are available only for FY2008, and unspent funds are not available for redistribution. If the $1.6 billion appropriation is insufficient to cover states' shortfalls and the associated payments to the territories, then the payments to the states and territories would be reduced proportionally. Based on states' latest projections, the total FY2008 shortfalls are projected at less than $1.2 billion.

Under S. 2499, such sums as necessary, not to exceed $275 million, are appropriated in FY2009: (1) to eliminate states' shortfalls of federal SCHIP funds in the first two quarters of FY2009 and (2) to provide 1.05% of states' projected shortfall amounts to the territories. These funds are available only for the first two quarters of FY2009, and unspent funds are not available for redistribution. If the $275 million appropriation is insufficient to cover states' shortfalls and the associated payments to the territories, then the payments to the states and territories would be reduced proportionally. Based on states' latest projections, the total FY2009 shortfalls through March 31, 2009, are projected at approximately $200 million.

Qualifying states

Eleven states (Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin) are considered "qualifying states" for purposes of using SCHIP funds under §2105(g) for some children enrolled in Medicaid. For qualifying states, federal SCHIP funds may be used to pay the difference between SCHIP's enhanced FMAP and the Medicaid FMAP that the state is already receiving for children above 150% of poverty who are enrolled in Medicaid. Qualifying states are limited in the amount they can claim for this purpose to the lesser of (1) 20% of the state's original SCHIP allotment amounts (if available) from FY1998-FY2001 and FY2004-FY2008, with the ability to use the FY2008 allotment linked to the December 21, 2007, termination date in the latest Continuing Resolution, and (2) the state's available balances of those allotments. The statutory definitions for qualifying states capture most states that had expanded their upper-income eligibility levels for children in their Medicaid programs to 185% of poverty prior to the enactment of SCHIP.

Under S. 2499, the ability of qualifying states to use their FY2008 allotments for expenditures under §2105(g) is made permanent; their ability to use FY2009 allotments under §2105(g) is permitted through March 31, 2009.

Section 202. Extension of transitional medical assistance (TMA) and abstinence education program

States are required to continue Medicaid benefits for certain low-income families that would otherwise lose coverage because of changes in their income. This continuation is called transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families that lose medicaid eligibility because of increased child or spousal support collections, as well as those that lose eligibility because of an increase in earned income or hours of employment. Congress expanded work-related TMA under Section 1925 of the Social Security Act in 1988, requiring states to provide TMA to families that lose medicaid for work-related reasons for at least six and up to 12 months. Since 2001, work-related TMA requirements under Section 1925 have been funded by a series of short-term extensions, most recently through December 31, 2007.

P.L. 104-193, the 1996 welfare reform law, provided $250 million in federal funds specifically for an abstinence education program ($50 million per year for each of five years, FY1998 through

FY2002). This program is referred to as the Title V Abstinence Education block grant. Funds must be requested by states when they solicit Title V Maternal and Child Health (MCH) block grant funds and must be used exclusively for teaching abstinence. To receive federal funds, a state must match every $4 in federal funds with $3 in state funds. This means that if maximum federal funding is provided, funding for Title V Abstinence Education must total at least $87.5 million annually. Although the Title V Abstinence Education block grant has not yet been reauthorized, the latest temporary extension continues funding through December 31, 2007. This provision extends both TMA and the Title V Abstinence Education block grant through June 30, 2008.

Section 203. Extension of qualifying individual (QI) program

Certain low-income individuals are eligible to have their Medicare part B premiums paid for by Medicaid under the Medicare Savings Program (MSP). One eligible group is Qualifying Individuals (QIs). These persons have incomes between 120% and 135% of poverty. Federal spending under the QI program is subject to annual limits. The program was slated to terminate December 31, 2007. The provision extends the program through June 2008 and specifies that the amount available for allocation for the six-month period beginning January 1, 2008, is $200 million.

Section 204. Medicaid DSH Extension

When establishing hospital payment rates, state Medicaid programs are required to recognize the situation of hospitals that provide a disproportionate share of care to low-income patients with special needs. Total federal reimbursement for each state's DSH payments, however, are capped at a statewide ceiling, referred to as the state's DSH allotment. Those amounts are specified in statute. As part of TRHCA, allotments for only one year, 2007, for the states of Tennessee and Hawaii were raised. Tennessee's DSH allotment for the year was to be based on a formula, and Hawaii's was set at $10 million. After that, allotments for those states would have reverted to former, lower amounts. S. 2499 extends those special allotment provisions, so that for the portion of FY2008 that ends on June 30, 2008, Tennessee's DSH allotment is set at three-quarters of the 2007 level, and the allotment for Hawaii is equal to $7.5 million.

Section 205. Improving data collection

Because of concerns about inadequate sample sizes in the Current Population Survey (CPS) for making estimates of states' number of low-income children, for purposes of determining states' federal SCHIP allotments, $10 million was appropriated in SCHIP statute annually beginning in FY2000. S. 2499 provides $20 million, instead of $10 million, in SCHIP statute for the CPS in FY2008.

Section 206. Moratorium on certain payment restrictions

Medicaid can cover school-based, health-related services required under the Individuals with Disabilities Education Act (IDEA), including transportation, as well as related administrative activities (e.g., outreach for Medicaid enrollment purposes, medical care coordination/monitoring). Medicaid also covers rehabilitation services for eligible beneficiaries in a wide variety of settings. The Bush Administrative issued proposed rules affecting rehabilitation and school-based services in August and September 2007, respectively.

Relative to policies in place on July 1, 2007, S. 2499 prohibits the Secretary of HHS from taking any action to further restrict Medicaid coverage or payments for rehabilitation services and for

school-based transportation and administrative activities. This moratorium would be in effect until June 30, 2008.

Title III—Miscellaneous

Section 301. Medicare Payment Advisory Commission status

The Medicare Payment Advisory Commission (MedPAC) is an independent federal body established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program. The commission's statutory mandate is (1) to advise Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program and (2) to analyze access to care, quality of care, and other issues affecting Medicare. This provision would establish MedPAC as an agency of Congress.

Section 302. Special Diabetes Programs for Type I Diabetes and Indians

As specified in Section 330B of the Public Health Service Act, the Secretary, directly or through grants, must provide for research into the prevention and cure of Type I diabetes. Appropriations are set at $150 million per year during the period FY2004 through FY2008. As specified in Section 330C of the Public Health Service Act, the Secretary must make grants for providing services for the prevention and treatment of diabetes among American Indians and Alaskan Natives. Appropriations are set at $150 million per year during the period FY2004 through FY2008. For each of these two grant programs, S. 2499 provides $150 million for FY2009.

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