ReedSmith

MEMORANDUM

TO: HEALTH CARE CLIENTS

DATE: January 24, 2008

RE: The "Medicare, Medicaid, and SCHIP Extension Act of 2007" Enacted into Law

I. INTRODUCTION

President Bush has signed into law S. 2499, the "Medicare, Medicaid, and SCHIP Extension Act of 2007" (the "Act").[1] Most notably, the legislation postpones for six months a 10.1% across-the-board cut in Medicare physician payments that was scheduled to go into effect January 1, 2008. Other policy changes include, among many others:

- Changes in Medicare **long-term care hospital** ("LTCH") policy**,** including a new statutory definition of an LTCH with facility criteria, relief from certain payment policies for three years, a three-year moratorium on the development of new LTCHs and LTCH beds, no payment update for the last quarter of rate year 2008, and new medical necessity reviews by Medicare contractors;
- Revisions to **inpatient rehabilitation facility** ("IRF") qualifications and payment policy, including a permanent freeze in the patient classification criteria compliance threshold at 60% (with comorbid conditions counting toward this threshold) and a payment freeze from April 1, 2008 through September 30, 2009;
- An extension of the **therapy cap exception process** through June 30, 2008;
- A provision to require the Centers for Medicare & Medicaid Services ("CMS") to adjust **Part B drug average sales pric**e ("ASP") calculations to use volume-weighted ASPs based on actual sales volume;
- Elimination of **Medicare Advantage** ("MA") stabilization funding for regional preferred provider organizations in 2012, an extension of authority for specialized MA plans for special needs individuals, and a moratorium on new special needs plans and expanded service areas through December 31, 2009;
- A 6-month delay in CMS rules on Medicaid payment for **school-based and rehabilitation services**; and

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1 Pub. L. No. 110-173 (December 29, 2007). The text of the Act is available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:s2499enr.txt.pdf.

- An extension of the authorization and funding of the **State Children's Health Insurance Program** ("SCHIP") through March 31, 2009.

The following is a summary of the major provisions of the Act. We would be pleased to provide you with additional information upon request.

II. MEDICARE PROVISIONS

A. Physician Fee Schedule Payments

The driving force behind enactment of the Act was a looming 10.1% cut in Medicare physician fee schedule payments that was scheduled to go into effect January 1, 2008 as a result of the statutory "sustainable growth rate" ("SRG") formula. Under the SRG formula, CMS must adjust the Medicare physician fee schedule update depending on how actual expenditures compare to a target for Medicare spending growth. In recent years, this would have resulted in negative updates, but Congress has repeatedly overridden the formula by specifying separate update factors to avoid payment cuts. In the absence of a change to the SGR formula, negative physician payment updates are forecast into the next decade.

The Act temporarily replaces the 10.1% cut with a 0.5% increase, effective for services provided from January 1 through June 30, 2008. During this period, the conversion factor will be $38.0870, compared to the conversion factor of $34.0682 that will apply to services provided from July 1 through December 31, 2008 in the absence of further statutory change. Congressional leaders have committed to additional action on Medicare policy in the first half of this year to prevent the upcoming reimbursement cut.

The Act also extends the Physician Quality Reporting Initiative ("PQRI") under the Tax Relief and Health Care Act of 2006 ("TRHCA") through 2009. Under this program, eligible professionals who voluntarily report on certain quality measures as specified by the Secretary of the Department of Health and Human Services ("Secretary") are eligible for a 1.5% "transitional bonus incentive payment." The Act directs the Secretary to establish "alternative criteria for satisfactorily reporting" on quality. Bonus payments to a professional for 2008 and 2009 are not subject to the cap that applies for 2007. The Act provides $25 million in additional funds for this provision.[2]

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2 For more information about implementation about the PQRI, see http://www.cms.hhs.gov/PQRI/35_2008PQRIInformation.asp.

Also with regard to physician payment policy, the Act:

- Modifies funding levels through 2013 for the Physician Assistance and Quality Initiative fund, which was established by the TRHCA to promote physician payment stability and quality initiatives;
- Extends through June 30, 2008 a program that provides a 5% bonus payment to physicians practicing in a primary or specialist care scarcity area; and
- Extends through June 30, 2008 the floor on the Medicare work geographic adjustment, which has the effect of increasing physician payments in certain rural areas.

B. Payment for Part B Drugs

The Act revises the volume weighting used in the calculation of average sales price ("ASP") for multiple source and single source drugs. By way of background, manufacturers submit ASPs by national drug codes or NDCs, which are 11-digit identifiers that indicate the manufacturer, the product dosage form, and the package size of a drug. More than one NDC may crosswalk to a billing and payment or HCPCS code, which is the measure upon which CMS bases payment for separately-payable Part B drugs and biologicals. To translate payment from multiple NDCs to a single HCPCS code, the ASP calculation methodology requires CMS to apply a volume weighting calculation so that the ASP for a drug with a high volume of sales will have greater influence on the reimbursement amount for a HCPCS code than the ASP for a drug with a lower volume of sales.

The change in the volume weighting calculation in the Act results from issues identified by the Department of Health and Human Services, Office of Inspector General ("OIG"), in its report entitled, "Calculation of Volume-Weighted ASP for Medicare Part B Prescription Drugs" (February 2006). The OIG found that following the implementation of the ASP methodology, CMS exercised its discretion to change the unit of ASP submission from the lowest identifiable quantity of the drug (e.g., 1 milliliter, 1 tablet) to the amount of the drug represented by the NDC (e.g., 50 milliliters, 100 tablets). Accordingly, this resulted in there not being a standard unit across NDCs to use in calculating a volume-weighted ASP for the HCPCS code and resulted in some volume-weighted ASPs being calculated incorrectly. The OIG found that this could result in current and future reimbursement amounts being inaccurate.

Section 112 of the Act addresses this issue by revising the volume weighting calculation that CMS must apply beginning April 1, 2008. Under the new formula, volume-weighted ASP is determined by taking the sum of products for each NDC of ASPs and the units sold and dividing this amount by the sum of products for each NDC of units sold and number of billing units. Billing unit is defined as the "identifiable quantity associated with a billing and payment code, as established the Secretary of HHS."

The Act also includes a new "Special Rule" applicable to the ASP calculation methodology for inhalation drugs or biologicals furnished through durable medical equipment (e.g., albuterol). Under the Special Rule, beginning April 1, 2008, where there are therapeutically equivalent single source inhalation drugs or biologicals of this nature that are within the same HCPCS code or multiple source drugs within the same HCPCS code, the payment amount will be the lower of the payment amount that would apply to the drug taken alone or the payment amount that would result from volume weighting of the other products in the same HCPCS code.

C. Therapy Cap Exceptions Process

The Balanced Budget Act of 1997 ("BBA") established two types of annual per-beneficiary limitations on outpatient therapy services: (1) a $1,500 cap for all outpatient physical therapy ("PT") services and speech language pathology ("SLP") services; and (2) a $1,500 cap for all outpatient occupational therapy ("OT") services, with both of these amounts indexed for inflation. Although enforcement of the caps has been suspended periodically, the caps are currently in place. In 2008, the cap amount is $1,810 for PT and SLP services combined, and a separate $1,810 cap for OT services.

The Deficit Reduction Act of 2005 ("DRA") required CMS to implement an exceptions process for therapy expenses incurred in 2006. Under this process, a Medicare enrollee (or person acting on behalf of the enrollee) could request an exception from the therapy caps. The individual could obtain an exception if the provision of services was determined medically necessary; CMS established an automatic process to facilitate exceptions. The TRHCA extended the therapy cap exceptions process for an additional year, through 2007. The Act further extends the exceptions process through June 30, 2008.

D. Laboratory Services

The Act extends through June 30, 2008 a provision allowing direct billing for the technical component of certain physician pathology services by independent laboratories, rather than hospitals. In addition, the Act extends Medicare reasonable cost payments for clinical laboratory tests furnished in certain small rural hospitals through June 30, 2008.

The Act also addresses payment for a particular diabetes test (HbA1c). Specifically, any diagnostic laboratory test for HbA1c that is labeled for home use will be paid at the same rate as a glycated hemoglobin test (HCPCS code 83036 and succeeding codes), effective April 1, 2008.

E. Medicare Hospital Provisions

1. Long-Term Care Hospitals

Section 114 of the Act begins to implement the recommendations of the Medicare Payment Advisory Commission ("MedPAC") for new facility and patient criteria to better define LTCHs and the types of patients LTCHs treat. This part of the Act also provides a combination of regulatory relief from certain unfavorable LTCH payment policies along with a moratorium on new LTCHs and LTCH beds, all for a period of three years. During the first half of this period, the Secretary is to study national facility and patient criteria for LTCHs and report to Congress on its recommendations for legislation or administrative actions to implement such criteria. The following is a more detailed summary of how the Act will impact LTCHs.

a. Definition of a Long-Term Care Hospital With New Facility Criteria

Previously, Medicare defined an LTCH as a hospital with an average inpatient length of stay of greater than 25 days. The Act preserves that definition in a new definitional section of the statute, but adds that an LTCH is a hospital primarily engaged in providing inpatient services to Medicare beneficiaries with medically complex conditions that require a long hospital stay and LTCH programs of care. Also included in this definition of an LTCH are new facility criteria. LTCHs must have a patient review process that screens patients for appropriateness of admission and validates that the patient meets LTCH admission criteria within 48 hours. LTCHs will have to evaluate regularly their patients for continuation of care and the availability of discharge options. Furthermore, LTCH are to have active physician involvement with patient care that includes a physician available on-site daily and additional consulting physicians on call. Finally, LTCHs must have an interdisciplinary team of health care professionals including physicians "to prepare and carry out an individualized treatment plan for each patient."

b. Report on Facility and Patient Criteria

The Act requires the Secretary to conduct a study on the establishment of national LTCH facility and patient criteria for the purpose of determining medical necessity, appropriateness of admissions and continued stay at, and discharge from, LTCHs. The Secretary must submit a report on the results of this study to Congress within 18 months, which is to include appropriate recommendations on legislation or administrative actions. Both the study and the report are required to consider recommendations on LTCH-specific facility and patient criteria contained in a June 2004 report to Congress by MedPAC, and the agency's ongoing work to evaluate and determine the feasibility of such recommendations

(presumably, a reference to the work currently being performed for CMS under contract with RTI International).

c. Regulatory Relief from Certain Payment Policies for Three Years

i. Relief from 25% Rule for Freestanding and Grandfathered LTCHs

For a three year period, the Act precludes the Secretary from applying the 25% Rule (which establishes a threshold for adjusting LTCH reimbursement based upon the percentage of discharges referred from another hospital), or any similar provision, under 42 C.F.R. § 412.536 to freestanding LTCHs and so-called grandfathered LTCHs (identified by Section 4417 (a) of the Balanced Budget Act of 1997) and under 42 C.F.R. § 412.534 for grandfathered LTCHs.

On May 1, 2007, CMS published its annual payment rate update for the 2008 LTCH-PPS rate year. The final rule expanded the existing Medicare hospital-within-hospital ("HIH") admissions threshold to Medicare patients admitted from any individual hospital. Previously, the admissions threshold was applicable only to Medicare admissions from hospitals co-located with a LTCH or satellite of an LTCH. Under the final rule, freestanding LTCHs and grandfathered LTCH HIHs became subject to the Medicare admission thresholds, as well as HIHs and satellites that admit Medicare patients from non-co-located hospitals, for cost reporting periods beginning on or after July 1, 2007. The Act prevents CMS from applying the 25% Rule for three years to freestanding LTCHs and grandfathered LTCHs for cost reporting periods beginning on or after the date of enactment of the Act.

ii. Relief from 25% Rule for LTCH HIHs and Satellite Facilities

The Act modifies the effect of the 25% Rule for LTCHs that are co-located with other hospitals, including satellite facilities, for a three-year period beginning with cost reporting periods starting on or after the date of enactment of the Act. For hospitals-within-hospitals and satellites located in urban areas subject to the transition period, the applicable percentage threshold is set at 50% and not phased-in to the 25% level. For hospitals-within-hospitals and satellite facilities located in rural areas and those which receive referrals from MSA dominant hospitals or urban single hospitals (as defined by current regulation) the percentage threshold is set at 75%.

iii. Relief from Very Short Stay Outlier Policy

For three years, the Act prevents CMS from applying the so-called very short stay outlier policy that was added to the LTCH-PPS at 42 C.F.R. § 412.529(c)(3)(i) by the May 11, 2007 final rule, or any similar provision. For a significant number of LTCH patients, this policy pays the equivalent of the

short-term care hospital rate solely on the basis of the patient's length of stay, regardless of the clinical considerations for admission to the LTCH or the averaging of patient lengths of stay that LTCHs perform to satisfy the current certification criteria.

iv. Stay of One-Time Budget Neutrality Adjustment

The Act also precludes the Secretary from implementing an optional one-time prospective adjustment to the LTCH standard amount provided for by 42 C.F.R. § 412.523(d)(3), or any similar provision, for a period of three years. This rule was designed to give CMS the ability, on or before July 1, 2008, to make a one-time adjustment to the LTCH-PPS standard amount to correct any "significant difference between actual payments and estimated payments for the first year" of the LTCH-PPS.

d. Partial Year Freeze on LTCH Rates

Under the Act, the Medicare payment update for the last quarter of LTCH-PPS rate year 2008 (from April 1, 2008 to June 30, 2008) is held at the same base rate as applied to LTCH discharges during rate year 2007.

e. Moratorium on New LTCHs, Satellites and Beds

For three years following the date the Act was signed into law (December 29, 2007), the Secretary must impose a moratorium on the establishment and classification of new LTCHs, LTCH satellite facilities, and LTCH beds in existing LTCH or satellite facilities. The moratorium on new facilities does not apply to LTCHs that, before the date of enactment, (a) began the qualifying period for payment under the LTCH-PPS, (b) have a written agreement with an unrelated party for the construction, renovation, lease, or demolition for a LTCH and have expended the lesser of 10% of the estimated cost of the project or $2,500,000, or (c) have obtained an approved certificate of need. The moratorium on new beds does not apply to an increase in beds in an existing hospital or satellite facility if the LTCH is located in a state where there is only one other LTCH and the LTCH requests an increase following the closure or decrease in the number of beds of the other LTCH.

f. Expanded Review of Medical Necessity

The Act requires the Secretary to significantly expand medical necessity review for patients admitted to LTCHs. One or more fiscal intermediaries or Medicare administrative contractors will review the medical necessity of admissions and continued stays of Medicare Part A patients at LTCHs. These annual medical necessity reviews must include a representative sample of admissions that results in a 95% confidence interval and guarantees that at least 75% of overpayments received by LTCHs for

medically unnecessary admissions and continued stays are recovered and not counted toward an LTCH's Medicare average length of stay. The Secretary shall establish an error rate that could require additional medical necessity reviews. This provision is effective for LTCH discharges on or after October 1, 2007 and ceases to apply to discharges occurring after October 1, 2010, unless the intensified reviews are extended by the Secretary. The Secretary may use up to 40% of the recouped overpayments to compensate the fiscal intermediaries and Medicare administrative contractors for the costs of conducting medical necessity reviews. In addition, Congress authorized an additional $35 million for CMS to implement the LTCH provisions of the Act.

2. Payment for Inpatient Rehabilitation Facility Services

Providing a good measure of payment stability to IRFs, the Act grants permanent relief from the IRF 75% Rule at the current level – 60% – which became effective for cost reporting periods beginning on or after July 1, 2006. To qualify as an IRF and be excluded from the inpatient hospital prospective payment system ("IPPS") a hospital must comply with seven requirements outlined in the regulations at 42 C.F.R. § 412.23(b). One of these requirements, otherwise known as the 75% Rule, obligates an IRF to document that, during its most recent twelve-month time period (as defined by CMS or the Intermediary), it served an inpatient population of whom at least a certain percent required intensive rehabilitation services for the treatment of one or more enumerated conditions listed in section 412.23(b)(2) (the "CMS-13"). An IRF that fails to meet the 75% Rule may lose its exemption from the IPPS and be reimbursed under the IPPS as an acute care hospital.

In 2002, CMS became aware that its various contractors were using inconsistent methods to assess compliance with the 75% Rule and that the percentage of IRFs in compliance with the 75% Rule might be low. In response, in June 2002, CMS suspended enforcement of the 75% Rule and, on September 9, 2003, proposed modifications to the regulatory standards for certification as an IRF.

Notwithstanding concerns stated by the industry and Congress in late 2003 and early 2004 about the adverse impact that CMS's proposed changes and renewed enforcement efforts might have on access to IRF services, and notwithstanding Congressional requests that CMS delay implementation of or changes to the 75% Rule for additional study of clinically appropriate certification criteria, CMS adopted four major changes to the 75% Rule in its May 7, 2004 final rule. First, CMS temporarily lowered the 75% compliance threshold, as follows: (i) 50% for cost reporting periods beginning on or after July 1, 2004 and before July 1, 2005; (ii) 60% for cost reporting periods beginning on or after July 1, 2005 and before July 1, 2006; (iii) 65% for cost reporting periods beginning on or after July 1, 2006 and before July 1, 2007; and (iv) 75% for cost reporting periods beginning on or after July 1, 2007.

Second, CMS modified and expanded from 10 to 13 the medical conditions used to determine whether a hospital qualifies as an IRF. Third, the agency finalized the conditions under which comorbidities can be used to verify compliance with the 75% Rule. Fourth, CMS changed the timeframe used to determine compliance with the 75% Rule from "the most recent 12-month cost reporting period" to "the most recent, consecutive, and appropriate 12-month period," with the result that a determination of non-compliance with the applicable compliance threshold will affect the facility's certification for its cost reporting period that begins immediately after the 12-month review period.

Congress temporarily suspended CMS enforcement of the 75% Rule under the Consolidated Appropriations Act, 2005, enacted on December 8, 2004. The GAO issued a study on April 22, 2005 recommending that CMS, based on further research, refine the 75% Rule to describe more thoroughly the subgroups of patients within the qualifying conditions that are appropriate for care in an inpatient rehabilitation facility. The Secretary issued a formal response to the GAO study on June 24, 2005 in which it concluded that the revised inpatient rehabilitation facility certification standards, including the 75% Rule, were not inconsistent with the recommendations in the GAO report. In light of this determination, the Secretary announced that CMS would immediately begin enforcement of the revised certification standards.

Subsequently, under the DRA, enacted on February 8, 2006, Congress extended the phase-in period for the 75% Rule by maintaining the compliance threshold at 60% (rather than increasing it to 65%) during the 12-month period beginning on July 1, 2006. The compliance threshold then was set to increase to 65% for cost reporting periods beginning on or after July 1, 2007 and again to 75% for cost reporting periods beginning on or after July 1, 2008. CMS stated in its August 2007 final rule that for cost reporting periods beginning on or after July 1, 2008 comorbidities would not be used to determine whether an IRF meets the 75% Rule.

Effective for cost reporting periods beginning on or after July 1, 2007, the Act imposes a permanent freeze in the 75% Rule patient classification criteria compliance threshold at 60% and patients with comorbidities now count toward this threshold. The Act also includes a payment freeze on IRF-PPS rates from April 1, 2008 through September 30, 2009. In consultation with providers, trade organizations, and MedPAC, the Act also requires the Secretary within 18 months to prepare an analysis of the compliance threshold for the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate. Among other things, the analysis must include the potential effect of the 75% rule on access to care, alternatives to the 75% rule policy for certifying inpatient rehabilitation hospitals, and the appropriate setting of care for conditions commonly admitted to IRFs that are not one of the 13 specified conditions.

3. Hospital Wage Index Reclassifications

The Act includes a series of provisions modifying the rules for hospital wage index reclassifications. In particular, the Act extends until September 30, 2008 provisions that have allowed certain hospitals that were otherwise unable to qualify for administrative wage index reclassification to qualify for a higher wage index. The reclassification of a hospital under this section would not impact the group reclassification of otherwise eligible hospitals in the area. The Act also modifies how the Secretary should apply the wage index to hospitals reclassified under the TRHCA extension and requires payment to hospitals of any additional associated reimbursement within 90 days of the applicable cost report settlement.

4. Brachytherapy and Radiopharmaceuticals

The Act extends current policy basing Medicare payment for brachytherapy devices/sources in the hospital outpatient setting on hospital charges reduced to cost through July 1, 2008. It also enables continuation of the hospital charges reduced to costs methodology for therapeutic radiopharmaceuticals under the hospital outpatient prospective payment system for the first six months of 2008.

F. Medicare Advantage Provisions

1. Medicare Advantage Special Needs Plans

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA") allowed for a coordinated care type of Medicare Advantage plan which focused on and targeted for enrollment individuals with "special needs." As defined by the statute, special needs individuals may include individuals who (1) are institutionalized, (2) are dually eligible; and/or (3) have a severe or disabling chronic conditions. Medicare Advantage Special Needs Plans ("SNPs") are permitted to limit enrollment to individuals in categories targeted by the plan, with the goal of providing a specialized model of care that would focus on disease management and allow for early clinical intervention. As of the end of 2007, there were 772 SNP plans in place, with 244 enrolling individuals with chronic or disabling conditions, 439 enrolling dual eligible individuals and 89 enrolling institutionalized individuals. The plans' authority to limit enrollment to these targeted individuals was scheduled to end as of January 1, 2009.

The Act extends the period of time for such targeted enrollment to January 1, 2010. However, the Act also limits the establishment of new plans and expansion of enrollment. Specifically, the Act places a moratorium on designating any new SNP plans as of January 1, 2008. It further provides that

existing SNPs may only enroll new members in service areas in which their plan was offered as of January 1, 2008.

2. Medicare Reasonable Cost Contract Plans

Medicare cost contract plans are reimbursed based on the reasonable cost of providing services. Organizations seeking to enter into a cost, rather than risk, contract with CMS may be allowed to do so if the organization is found to be unable to bear the risk of potential losses under a risk-sharing contract or if the eligible organization elects or has an insufficient number of members to be eligible to enter into a risk-sharing contract.

Prior to the enactment of the Act, no reasonable cost reimbursement contract could be extended or renewed after January 1, 2008 if there were two or more Medicare Advantage regional or local plans offered that met certain minimum enrollment requirements for the service area. The Act extends this time frame to January 1, 2009, thereby giving Medicare cost contract holders another year in which their contracts may be renewed or extended.

3. Medicare Advantage Stabilization Fund

The Medicare Advantage Stabilization Fund was designed to provide incentives to have an MA plan offered in each region and to retain plans in certain MA regions that had market penetration at less than the national average. The Fund, which was established by the MMA in 2003, included authorization to spend $10 billion between 2007 and 20013. This initial sum was reduced by $6.5 billion by the Tax Relief and Health Care Act of 2006, which also prohibited spending the remainder of the funds until 2012, with $1.6 billion to be made available that year and $1.79 billion to be made available in 2013.

The Act eliminates the funds that would have been available in 2012, thereby reducing the amount of the fund to $1.79 billion and extending the time frame within which the funds will be available until 2013.

G. Medicare Secondary Payor

Congress has repeatedly amended the Medicare Secondary Payor ("MSP") provisions to protect the financial integrity of the Medicare program. Section 111 of the Act is Congress' latest modification to the MSP provisions. The MSP provisions seek to ensure that Medicare is only secondarily responsible for the payment of medical expenses to beneficiaries who have other forms of insurance,

including private insurance (i.e., no fault insurance), or who may receive payment for medical expenses from liability insurance, self-insurance, or workers' compensation insurance.

Prior amendments to the MSP provisions prohibited providers (e.g., hospitals, skilled nursing facilities, etc.) from billing Medicare where payment for medical expenses had been made or could reasonably be expected to be made under a workers' compensation law, an automobile, liability insurance, or self-insurance plan or a primary no fault insurance plan. The Act's amendments, however, place an express obligation on group health plans and liability insurers to submit certain data to the Secretary to identify beneficiaries for whom Medicare is the secondary payor.

Specifically, beginning on January 1, 2009, an entity serving as an insurer or third party administrator for a group health plan must (1) secure from the plan sponsor and plan participants information for the purpose of identifying instances where the group health plan is or has been a primary plan under Medicare, and (2) submit such information to the Secretary. Beginning on July 1, 2009, liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans must (1) gather information from persons making insurance claims to determine whether they are eligible for benefits under the Medicare program, and (2) if a claimant is eligible for Medicare, submit certain information to the Secretary. This information includes the identity of the claimant who is eligible for Medicare benefits and other information as determined by the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

Given that the purpose of the Act's MSP amendments is to collect information so that the Secretary can protect Medicare's rights as a secondary payor, it is possible that the Secretary may require a copy of the settlement agreement, judgment, or award, as well as injury information, diagnostic codes, and primary payor information to be submitted. The Act notes that the Secretary will determine the timeframe for the submission of the above-described information. In the case of liability insurance, such information likely will be required to be submitted shortly after the date of the settlement, judgment, or award.

Under the Act, if a group health insurance plan or liability insurance carrier fails to comply with this new reporting requirement, the entity is subject to a penalty of $1,000 for each day of noncompliance for each individual claimant for which information should have been submitted. As such, there is a significant cost for group health plans and insurers for failing to comply with this new reporting requirement.

H. Other Medicare Provisions

The Act extends until June 30, 2008 a current exception to the 60-day limit on **Medicare reciprocal billing arrangements** between two physicians during periods in which one of the physicians is ordered to active duty as a member of a reserve component of the Armed Forces. The provision was scheduled to expire at the end of 2007.

The Act also expands **beneficiary outreach efforts** by providing $15 million for State Health Insurance Assistance Programs and $5 million for state area agencies on aging and Aging Disability Resource Centers.

III. MEDICAID & SCHIP PROVISIONS

A. Current Medicaid Policy Extensions

The Act extends through June 30, 2008 the following current Medicaid programs:

- The **Transitional Medical Assistance** program for certain low-income families who would otherwise lose coverage because of changes in their income;
- The **abstinence-only education** program;
- The **Qualifying Individual program**, through which Medicaid programs subsidizes Medicare Part B premiums for low-income individuals; and
- Authority for Medicaid **disproportionate share hospita**l funding for Tennessee and Hawaii.

B. Moratorium on School-Based Services and Rehabilitation Services Rules

The Act prohibits the Bush Administration from implementing prior to June 30, 2008, any regulation or other policy that restricts Medicaid coverage of or payment for rehabilitation services or school-based administration or transportation services.

This provision has the effect of temporarily blocking a December 28, 2007 CMS final rule providing that federal Medicaid payments will no longer be available for administrative activities performed by school employees or contractors, or anyone under the control of a public or private educational institution, and for transportation from home to school.[3] Moreover, the Act bars CMS from

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3 72 Fed. Reg. 73635. The text of the rule is available at http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-6220.pdf.

implementing before June 30, 2008 a proposed rule issued last summer that would provide a more narrow definition of covered Medicaid rehabilitative services.[4]

C. State Children's Health Insurance Program Provisions

Congress and the President spent much of 2007 clashing on how best to extend, improve, and finance SCHIP. Formal authorization for the program expired September 30, 2007, although Congress subsequently kept the program running through a series of short-term funding extensions. President Bush vetoed two earlier plans to expand SCHIP funding and eligibility.

The Act extends SCHIP funding through March 31, 2009. The legislation also increases funding to enable states to maintain current enrollment levels through that date, and it clarifies rules regarding redistribution of unused funds.

IV. MISCELLANEOUS PROVISIONS

Finally, the Act:

- Clarifies that **MedPAC** officially is an agency of Congress, rather than an independent body. MedPAC is charged with advising Congress on Medicare payment policy, along with quality, and access to services, and other issues affecting the Medicare program.
- Extends for an additional year, through September 30, 2009, the **Special Diabetes Programs for Type I Diabetes** and the **Special Diabetes Programs for Indians**.
- Provides $10 million in additional funding in FY 2008 to improve Census Bureau data collection regarding **uninsured children**.

V. CONCLUSION

Given that Congress provided only a 6-month reprieve from the scheduled 10.1% cut in Medicare physician fee schedule payments, it will not be long before lawmakers are revisiting Medicare policy. In the months ahead, Congress can be expected to look to Medicare and Medicaid financing proposals considered by the House of Representatives last summer but not considered by the Senate, including broader Medicare provider rate freezes and reductions in inflation updates, increased Medicaid

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4 72 Fed. Reg. 45,201. See http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-3925.pdf.

drug rebate amounts, and other policy changes.[5] Congress also will be receiving Medicare payment reform recommendations from MedPAC in March, which are expected to include reduced updates for many types of providers.

We will continue to monitor and report on future legislative developments impacting the health care industry.

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Please contact our Senior Health Policy Analyst Debra A. McCurdy (703/641-4283, dmccurdy@reedsmith.com) or any other member of the Reed Smith health care group with whom you work if you would like additional information or if you have any questions.

The contents of this Memorandum are for informational purposes only and do not constitute legal advice.

5 For additional information on the House bill, H.R. 3162, see http://waysandmeans.house.gov/legis.asp?formmode=item&number=580.