



**Office of External Affairs**

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# FACT SHEET

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## **PAYMENT PROVISIONS IN THE ORIGINAL MEDICARE PROGRAM IMMEDIATELY AFFECTED BY THE DEFICIT REDUCTION ACT**

On February 8, President Bush signed the Deficit Reduction Act of 2005 (DRA) into law. A number of the DRA's provisions are effective on January 1, 2006. This fact sheet summarizes these provisions and describes what the Medicare program will do to implement these changes retroactively.

- The DRA will prevent payments for **physicians' services** delivered on or after January 1 from being reduced by a negative update of 4.4 percent. Medicare claims-processing contractors are preparing to begin paying all 2006 claims at the higher rates **within two business days** following the President's signing of the bill into law.
  - January claims that have already been paid will be reprocessed. Given the volume of claims involved, the reprocessing is expected to be completed by July 1, 2006. Physicians and other practitioners paid under Medicare's physician fee schedule may expect several aggregated (versus claim-by-claim) payments during that time.
  - The higher payment rates may affect a physician's decision to participate or not participate in Medicare. Upon enactment, CMS will announce a second 45-day **participation enrollment** period to allow physicians to change their participation decision, if they so desire.
- The bill provides for an increase in the base composite rate paid to **end-stage renal disease facilities** for 2006. The new rates will be effective for services furnished on or after January 1, 2006. Contractors are preparing to begin processing claims at the correct rate within two business days following the President's signing of the bill into law. Claims requiring reprocessing will be completed by July 1, 2006.
- **Hold harmless payments for outpatient services of certain small rural hospitals**, which expired on December 31, will be reinstated effective January 1 by the DRA. This change will help prevent payment reductions for about 230 small rural hospitals. CMS is in the process of developing a way to reinstate any payments that were reduced.

- The DRA reestablishes a 5 percent **add-on payment** for **home health services to rural beneficiaries** to support access to home health services in rural areas. This provision had expired on April 1, 2005. Contractors are preparing to begin making payments at the higher levels within two business days after the bill is signed into law. Claims requiring reprocessing will be completed by July 1, 2006.
- **Caps on payments for outpatient therapy services** went into effect January 1. The DRA requires CMS to create an **exceptions process** that permits payment for services in excess of the caps to be approved when they are medically justified. Two separate caps are in place: \$1,740 per beneficiary per year for physical therapy and speech-language pathology, and the same amount for occupational therapy. CMS is still developing the detailed specifications for the exceptions process. In the first phase of implementation, on approval of a request, CMS would allow payment of any claims denied due to application of the caps for services provided in the period between January 1, 2006 and our implementation of the therapy caps exceptions process.
- The DRA makes some changes to **Medicare payments for rental arrangements for durable medical equipment**. Prior to the DRA, “capped rental” items are rented by Medicare for up to 15 months; after 15 months, the supplier continues to furnish the equipment to the beneficiary as long as the beneficiary needs it but the supplier retains title to the equipment. Beginning with items newly rented on or after January 1, 2006, DRA changes the rental period to 13 months. After the end of the rental period, title to the equipment transfers to the beneficiary. Medicare will continue to pay for reasonable and necessary service and maintenance after the end of the rental period. CMS will issue instructions to its contractors to implement these changes later this year.
- The DRA also makes some changes to **Medicare payments for oxygen equipment**. Prior to the DRA, oxygen equipment was rented indefinitely. The bill caps the rental period at 36 months, after which time the beneficiary will own the equipment. After the beneficiary owns the equipment, the DRA requires Medicare to pay for reasonable and necessary service and maintenance. The DRA also requires Medicare to continue to pay for gaseous and liquid oxygen contents for beneficiaries using stationary or portable oxygen tanks and cylinders after the beneficiary using that equipment owns it. The DRA provides for a new 36 month rental cap period beginning January 1, 2006 for all oxygen equipment. Thus, a new 36 month rental cap period would apply both for beneficiaries starting to use the equipment as well as for beneficiaries who have been using it for several years. CMS will issue instructions to its contractors to implement these changes later this year.
- The DRA reduces to 70 percent Medicare’s payments to **reimburse skilled nursing facilities** for **bad debt** resulting from failure of Medicare beneficiaries (other than those beneficiaries dually eligible for Medicare and Medicaid) to pay coinsurance. This provision will be implemented through revised cost report instructions. CMS expects to release these instructions through several program transmittals starting in mid-February.
- The DRA adds **diabetes self-management training and medical nutrition therapy** for beneficiaries with **diabetes or renal disease** to the list of services Medicare pays for when delivered

at **federally qualified health centers** (FQHCs). CMS will amend the Medicare manuals to recognize qualified practitioners of these services as core FQHC practitioners. The bill expands the definition of FQHCs to Health Care for the Homeless grantees.

- The DRA changes from 27 to 29 the minimum number of days after the receipt of a non-electronic (paper) claim before Medicare will pay the claim. Medicare's carriers and intermediaries will implement this extended period as soon as possible.
- **Home health agencies** will receive payments reflecting rates unchanged from 2005 for services delivered on or after January 1, consistent with the level recommended by MedPAC. Since a 2.8 percent increase called for under current law has already gone into effect, CMS will recoup payments for claims already paid at the higher rate. As most home health services are paid on the basis of a 60-day episode, only a small fraction of claims will be affected. Contractors are preparing to begin paying claims at the correct rate within two business days after the bill is signed into law. Claims requiring reprocessing will be completed by July 1, 2006.
- **Specialty hospitals.** Last summer, CMS temporarily suspended enrollment of new specialty hospitals while the agency reviewed its procedures for enrollment. The DRA continues that suspension until the earlier of six months after enactment or CMS's release of a final report on specialty hospitals required by the DRA. The DRA directs CMS to develop a strategic and implementing plan addressing the proportionality of investment return; whether the investment is a bona fide investment; and whether the Secretary should require annual disclosure of investment information. In addition, the DRA requires the Secretary to consider the provision by specialty hospitals of care to: (a) Medicaid patients; (b) patients receiving medical assistance under a State demonstration project approved under title XI of the Act; and (c) patients receiving charity care. The DRA also requires the strategic and implementing plan to address the issue of appropriate enforcement. The DRA requires an interim report within 3 months and a final report within 6 months.

The bill contains a number of other provisions that do not have immediate effective dates. CMS will be developing and announcing plans for implementing these provisions shortly.

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