

Office of External Affairs

MEDICARE FACT SHEET

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PAYMENT PROVISIONS IN THE TRADITIONAL MEDICARE PROGRAM THAT MAY BE DELAYED BY THE DEFICIT REDUCTION ACT

Earlier this month, the Congress considered the Deficit Reduction Act of 2005. Versions of this bill and of a subsequent conference report were passed by both chambers. However, because of technical “points of order” against three specific minor provisions in the act, the final version passed by the two chambers differed slightly. We expect this bill to be taken up again soon after the full Congress reconvenes. At such time, CMS will be ready to make all appropriate payment changes in the least burdensome manner possible. In the meantime, a number of changes that the bill intended to be effective on January 1, 2006, will not go into effect.

- As required under current law, claims for **physicians’ services** on or after January 1 will be paid with the -4.4 percent reduction from 2005 levels. The bill would have kept physician payment rates from being reduced, and would have provided significant offsetting savings to limit any impact on beneficiary costs.
- The base composite rate paid to **end-stage renal disease facilities** will not increase from 2005. The bill would have implemented a 1.6 percent increase.
- **Hold harmless payments for outpatient services of small rural hospitals** will expire under current law on December 31. The bill would have helped prevent payment reductions for about 230 small rural hospitals.
- The 5 percent **add-on payment for home health services to rural beneficiaries** expired on April 1, 2005. The bill re-established these payments effective January 1 to support access to home health services in rural areas.
- **Caps on payments for outpatient therapy services** are scheduled to go into effect January 1, without the exceptions process outlined in the conference report for the DRA. Current law calls for two separate caps: \$1740 per beneficiary per year for physical therapy and speech therapy, and the same amount for occupational therapy. The bill would have provided an exception process under which additional services could be approved when they are medically justified, but this provision will not be implemented.

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- **Rental arrangements for durable medical equipment and oxygen equipment** will remain unchanged. Under current law, certain “capped rental” items are rented by Medicare for up to 15 months before they become the property of the beneficiary; the bill would have changed the period to 13 months. Oxygen equipment is now rented indefinitely; the bill would have capped the rental period after 36 months, at which time the equipment would become property of the beneficiary.
- **Skilled nursing facilities** will continue to be fully reimbursed for **bad debt** resulting from failure of Medicare beneficiaries to pay copayments. The bill would have reduced Medicare’s payment to 70 percent of the bad debt.
- **Services** payable by Medicare **at Federally qualified health centers** (FQHCs) will remain unchanged. The bill would have added self-management training and medical nutrition therapy for diabetics to the list of FQHCs Medicare services.
- The minimum number of days Medicare requires after submission of a non-electronic claim before it makes payment will remain unchanged. The bill would have changed this threshold from 27 to 29 days.
- **Home health agencies** will receive payments reflecting a 2.8 percent increase on January 1, rather than the zero percent increase as recommended by MedPAC and specified in the bill.
- **Specialty hospitals.** Last summer, CMS temporarily suspended enrollment of new specialty hospitals while the agency reviewed its procedures for enrollment. At present, CMS plans to continue the suspension until February 15, 2006, after this review is completed. The bill calls for continuation of this suspension for up to six months pending development of a Report to Congress containing a strategic plan for addressing specialty hospitals.

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