

## Summary of the Medicare and Medicaid Extenders Act of 2010

### Extensions

**Physician payment update.** Medicare physician payment rates are scheduled to be reduced by 25 percent on January 1, 2011. This provision would reverse that reduction and extend current Medicare payment rates through December 31, 2011.

**Extension of MMA section 508 reclassifications.** Under current law, hospital geographic reclassifications authorized under section 508 of the Medicare Modernization Act expire on September 30, 2010. The bill would extend these reclassifications through FY 2011.

**Extension of Medicare work geographic adjustment floor.** Under current law, the Medicare fee schedule is adjusted geographically for three factors to reflect differences in the cost of resources needed to produce physician services: physician work, practice expense, and medical malpractice insurance. The provision would extend the existing 1.0 floor on the “physician work” index through December 31, 2011.

**Extension of exceptions process for Medicare therapy caps.** Current law places annual per beneficiary payment limits for all outpatient therapy services provided by non-hospital providers. The Secretary was required to implement an exceptions process for cases in which the provision of additional therapy services was determined to be medically necessary. The provision would extend the therapy caps exception process through December 31, 2011.

**Extension of payment for technical component of certain physician pathology services.** The provision would extend the ability of independent laboratories to receive direct payments for the technical component for certain pathology services through December 31, 2011.

**Extension of ambulance add-ons.** The provision would extend the increased Medicare rates for ambulance services, including in super rural areas, through December 31, 2011.

**Extension of physician fee schedule mental health add-on payment.** The provision would extend the five percent increase in payments for certain Medicare mental health services through December 31, 2011.

**Extension of outpatient hold harmless provision.** Under current law, the outpatient hold harmless provision expires on December 31, 2010. This provision extends the outpatient hold harmless provision through December 31, 2011.

**Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas.** Under current law, laboratory services provided by certain rural hospitals receive reasonable cost reimbursement through July 1, 2011. This provision extends this policy until July 1, 2011. .

**Extension of the qualifying individual (QI) program.** This program allows Medicaid to pay the Medicare part B premiums for low-income Medicare beneficiaries with incomes between 120 percent and 135 percent of poverty. QI expires December 31, 2010.

**Extension of Transitional Medical Assistance (TMA).** Transitional Medical Assistance (TMA) allows low-income families to maintain their Medicaid coverage as they transition into employment and increase their earnings. TMA expires December 31, 2010.

**Special Diabetes Programs.** Funds research for type I diabetes and supports diabetes treatment and prevention initiatives for American Indians and Alaska Natives. The Special Diabetes Program (SDP) expires at the end of 2011, but early reauthorization is critical to the continuation of the existing research initiatives. This provision would extend the SDP for two years.

### **Other Provisions**

**Clarification of effective date of part B special enrollment period for disabled TRICARE beneficiaries.** Under current law, disabled Medicare beneficiaries who are also eligible for TRICARE are eligible for a 12-month special enrollment period (SEP) for Medicare Part B in order to ensure that they properly enroll in Medicare Part B and retain their TRICARE eligibility. This provision would clarify the effective date of this SEP to ensure that beneficiaries can use it.

**Repeal of delay of RUG–IV.** Under current law, implementation of Version four of the Resource Utilization Groups (“RUG IV”) for purposes of reimbursing skilled nursing facilities under Medicare is delayed until October 1, 2011. The provision would repeal the delay and allow RUG IV to go into effect on October 1, 2010, consistent with the final SNF payment regulation for FY2011.

**Clarification for affiliated hospitals for distribution of additional residency positions.** The provision would make a technical correction to clarify that residency positions that are being shared between teaching hospitals under an “affiliation agreement” would not be redistributed to other hospitals.

**Continued inclusion of orphan drugs in definition of covered outpatient drugs with respect to children’s hospitals under the drug discount program.** The provision would make a technical correction to ensure the continued inclusion of orphan drugs in the definition of covered outpatient drugs with respect to children’s hospitals under the 340B drug discount program.

**Medicaid and CHIP technical corrections.** The provision would make technical corrections to Medicaid and CHIP relating to exclusion from participation, income eligibility levels for children, measurement of payment error rates, coverage of children of state employees, and payment for electronic health records. Also included are some designation corrections from HR5712 as passed the House of Representatives on July 14, 2010 and several additional corrections made at the request of Senate Legislative Counsel.

**Funding for claims reprocessing.** Extensions of Medicare payment policies for calendar year

2010 were enacted into law on March 23, 2010, requiring the Centers for Medicare & Medicaid Services (CMS) to reprocess Medicare claims back to January 1, 2010. The provision allocates funding for CMS to reprocess these claims.

**Revision to the Medicare Improvement Fund.** The Medicare Improvement Fund makes a limited amount of money available to make improvements to the Medicare program.

**Limitations on aggregate amount recovered on reconciliation of the health insurance tax credit and the advance of that credit.** Under current law, if an individual's income turns out to be higher than the amount that was used to calculate the advanced premium tax credit, the individual must return part or all of the excess payment to the government. The amount repaid by the individual is limited to \$250 for individuals and \$400 for families for those at or below 400 percent of the Federal Poverty Level. This provision increases the existing limits of \$250 and \$400, and replaces the across-the-board structure with a scaled structure that starts with lower limits for those with lower incomes.

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