2176 Wisconsin Ave., NW
Washington, D.C. 20007
(202) 364-8283
(202) 244-8324 *fax*

To: **Clients and Friends**

From: **John Gorman and Jean LeMasurier**

Date: **July 17, 2008**

Re: **The Medicare Improvements for Patients and Providers Act of 2008; Amended with Clarification**

On July 15, 2008, the White House vetoed H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008. By afternoon, both the House and the Senate voted to override the veto by margins substantially larger than their earlier veto proof votes to pass the legislation.

In addition to avoiding a 10.6 percent cut in the physician fee schedule, P.L. 110-275 includes a significant number of changes to the Medicare Advantage (MA) and Part D programs. While the Act will fund the physician fee fix primarily with MA cuts, the impact is substantially less than the cuts included in the CHAMP act last year which would have reduced MA rates to fee for service levels.

The Congressional Budget Office (CBO) estimates that federal spending on MA will be reduced by $12.5 billion over five years due to both the phase out of Indirect Medical Education (IME) costs from MA plan payments beginning in 2010 and the requirement that most PFFS plans have a network by 2011. These savings result from a 2.3 million reduction in the growth of MA enrollment (1.8 million from PFFS plans) in 2013 compared to CBO projections. The CBO is estimating that these 2.3 million beneficiaries will enroll in Medicare FFS and thus will also consider a stand-alone PDP.

Additional savings will be realized by the phase out of the Regional PPO Stabilization Fund in 2013. Costs will be incurred by extending the SNP program, Part D prompt payment and coverage expansions, and improvements to the Low Income programs.

Additional changes in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) include:

- Marketing reforms similar to the provisions included in the May 2008 proposed CMS regulations. Marketing changes will apply to the Annual Open Election period this fall for 2009 enrollment.

Copyright © 2008, Gorman Health Group, LLC

- Expansion of the Low Income Assistance programs will allow more beneficiaries to qualify for Part D low income subsidies.
- Phase out of the IME payment from the MA benchmarks.
- Elimination of deeming for most PFFS plans and a requirement that these plans establish a contracted provider network by 2011.
- Extension of the SNP programs for one year with additional eligibility and program requirements.
- Prompt payment of Part D claims.
- Codification and expansion of the Part D protected classes.
- Requirements for E-prescribing by 2011.

Additional details on the changes are included in the summary of the law.

Summary of the Changes included in P.L. 110-275: The Medicare Improvements for Patients and Providers Act of 2008

Marketing Reforms: The MIPPA includes a number of prohibitions and limitations on sales and marketing activities by Medicare Advantage (MA) and Prescription Drug (PDP) Plan Sponsors and their agents, brokers or other third parties that represent them. Effective January 1, 2009, plans and their representatives are *prohibited* from:

- Unsolicited direct contact of prospective enrollees such as door-to-door sales and cold calling (telemarketing).
- Selling non-health related products (cross-selling).
- Providing meals at promotional and sales events.
- Selling or Marketing in healthcare settings and at educational events.

Other marketing requirements include:

- Advance agreement with a prospective enrollee on the scope of products to be discussed during marketing appointments.
- Limitations on the use of the name or logo of a network provider (co-branding).
- Limitation of gifts to prospective enrollees to nominal dollar value.
- Compensation of Brokers and Agents – Plans must comply with guidelines established by the Secretary that provide incentives to enroll individuals in plans that best meet their health care needs.
- Annual training and testing of agents, brokers and other parties
- Inclusion of Plan Type in Plan Name in 2010.
- Plans can only use state licensed agents and brokers and must comply with state appointment laws and state investigations of agent, broker or third party conduct.

Copyright © 2008, Gorman Health Group, LLC

Low Income Programs: The law extends many low income programs and also relaxes the requirements for qualifying for LIS which would make more beneficiaries eligible for Part D Low Income Subsidies (LIS).

- Extends and funds the Qualifying Individual (QI) program through December 2009.
- Beginning January 2010, increases the allowable resources under the Medicare Savings Program (MSP) program to the amount for full subsidy Part D LIS beneficiaries.
- Life insurance policies and in-kind support and maintenance are exempt from LIS eligibility determinations.
- Facilitates and funds outreach efforts including the distribution of LIS and MSP applications and information through SSA, and additional grants for SHIPs, AoA and state agencies on aging.

The law also eliminates the Late Enrollment Penalty for LIS beneficiaries and codifies a beneficiary's right to federal court review for denial of the LIS.

Medicare Advantage Changes: Several changes were made to the MA program to finance the physician payment fix, as well as to make other program changes:

- **Phase-out of Indirect Medical Education (IME) Payments** — Medicare Advantage payments will be reduced by phasing out IME costs beginning in 2010. The IME adjustment will lower the MA benchmarks by an amount that reflects IME costs in an area, with a maximum reduction of 0.60 percentage points each year until the IME costs are totally phased out. The impact will vary by county, based on the number of teaching hospitals and beds. Most counties have IME costs under one percent of the MA benchmark before budget neutrality, however a number of counties have IME costs over five percent.

- **Elimination of "Deeming" for PFFS Plans** — Beginning with 2011, individual PFFS plans operating in a "network area" will have to have a contracted provider network that meets CMS access standards. Network areas are those areas with enrollees in at least two "network based plans," including coordinated care plans, network-based MSA plans and section 1876 cost contracts. Also in 2011, all employer group PFFS plans must have a network that meets access requirements. PFFS plans that are allowed to continue to deem providers will be given new flexibility to vary provider payments.

- **Quality Improvement Programs** – Beginning in 2010, Regional PPOs, PFFS and MSA plans will be required to have the same quality improvement program required for local PPO plans (i.e. data collection will only apply to network providers). In 2010, PFFS and MSA plans will only be required to collect administrative claims data.

Copyright © 2008, Gorman Health Group, LLC

SNP Changes: The law extends authority for enrollment in current MA SNP plans and prohibits the approval of new disproportionate share SNPs through December 31, 2010. While other new SNPs may be approved for 2010, the authority expires December 31, 2010.

- **Institutional SNP** – As of January 2010, requires new enrollees who live in the community to be assessed by an entity other than the SNP using a State assessment tool.

- **Dual SNP** – As of January 2010, the plan must provide each prospective enrollee with a standardized written statement comparing benefits and cost-sharing protections that would be covered under the Medicaid program and the SNP. In addition, the SNP has a contract with the Medicaid agency to provide or arrange Medicaid benefits, which may include long term care services. If the Dual SNP does not have a contract with the state Medicaid agency by January 2010, it can continue to operate during the year, but may not be approved for a service area expansion.

- **Dual SNP Cost Sharing** – As of January 2010, a MA plan may not impose cost-sharing for a full dual eligible (DE) or Qualified Medicare Beneficiary (QMB that exceeds the amount that would have been permitted under Medicaid.

- **Chronic Care SNPs** – As of 2010, the eligibility definition is amended to require one or more co-morbid and medically complex chronic conditions that are substantially disabling or life threatening, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems across domains of care. The Secretary must convene a panel of clinical advisors to determine the conditions that meet the definition of severe and disabling chronic conditions.

- **All SNPs –** SNPs must have in place an evidenced-based model of care with appropriate networks of providers and specialists. The SNP must also conduct an initial and annual assessment of each individual's physical, psychosocial, and functional needs, develop an appropriate treatment plan and use an interdisciplinary team to manage care. The Secretary's audits must review plan compliance with these requirements.

- **Quality Reporting –** All SNPs shall collect, analyze and report data based on claims data at the plan level that permits the measurement of health outcomes and other indices of quality related to the new SNP requirements. The Secretary shall specify an effective date no later than January 2010.

- **Regional Stabilization Fund** - The fund is reduced to $1 in 2014.

- **1876 Cost Plans** – The deadline for cost plans to convert to MA plans is extended through December 31, 2009. Modifies the two plan requirement that determines if there is a prohibition on the requirement for conversion.

Copyright © 2008, Gorman Health Group, LLC

- **Studies** - MedPAC will conduct a study on how comparable measures of performance and patient experience can be reported by 2011 for MA and FFS. MedPAC will also study MA and FFS costs and recommend alternate MA payment methods. HHS will evaluate data collection and quality reporting (including HEDIS) on disparities in health care services on the basis of race, ethnicity and gender, report to Congress, and implement improved approaches for FFS, MA and Part D within two years.

- **Medigap** – Clarifies current law that supplemental policies for MA and PFFS must meet the standards for Medigap.

Part D Changes - Changes include improved pharmacy access and broader coverage.

- **Prompt Payment to Pharmacies**– Effective in 2010, MA-PD and PDP plan sponsors are required to pay clean claims from all pharmacies (other than mail order and LTC pharmacies) within 14 days after transmission if submitted electronically or 30 days if submitted otherwise (starting on the fifth day after the postmark or transmission date). If claims are not paid timely, PDPs will pay interest to the pharmacy.

  A claim is considered "clean" if the PDP does not notify the pharmacy of deficiencies within 10 days for electronic claims or resubmitted claims and 15 days for other claims.

  PDP plan sponsors must pay clean claims electronically if requested by a pharmacy. Pharmacies retain the right of action and PDPs cannot retaliate.

  Claims from LTC pharmacies (pharmacies located in or contracting with LTC facilities) must be submitted not less than 30 days (or more than 90 days) to Part D plan sponsors.

- **Updating Drug Pricing** – If a MA-PD or PDP pays pharmacies based on the cost of a drug, the plans must provide updates at least weekly beginning with an initial update January 1 of each year.

- **Coverage of Barbiturates and Benzodiazepines** – Effective in 2013, plans cover barbiturates if used to treat epilepsy, cancer, or a chronic mental health disorder and benzodiazepines.

- **Formulary Protected Classes** - The bill codifies current policy on protected classes of drugs under Part D and provides that the Secretary, beginning in 2010, shall identify categories and classes of drugs that: (1) if restricted would have a major or life threatening clinical effect and (2) if individuals need access to multiple drugs in a category or class due to unique chemical actions and pharmacological effects, such as cancer drugs. PDP sponsors will be required to cover all drugs in the category or class that the Secretary identifies through

Copyright © 2008, Gorman Health Group, LLC

rulemaking as a protected class unless there are exceptions based on scientific evidence and medical standards of practice.

- **Access to Part D Data** – The law clarifies that part D data may be used for research and to improve public health and for Congressional oversight, consistent with final regulations published on May 28, 2008.

- **Revision of Definition of Medically Accepted Indications for Drugs** – Effective in 2009, the bill expands the list of compendia that can be used to determine Part D oncology coverage. Effective in 2010, requires all compendia used for Part D to have a publicly transparent process for evaluating therapies and conflicts of interest.

Electronic Prescribing –The law provides incentive payments for practitioners to use qualified e-prescribing systems (e.g. 2 percent in 2009 and 2010; 1 percent in 2011 and 2012; and 0.5 percent in 2013). Practitioners would be required to use qualified e-prescribing systems in 2011. Payments to practitioners who fail to e-prescribe will be reduced by 1 percent in 2012; 1.5 percent in 2013 and 2 percent thereafter. The Secretary is authorized to establish a hardship exception.

Other Provisions – Select FFS changes that also will impact the MA and PDP programs under this legislation include:

- Increases to the physician fee schedule of 0.5 percent for the remainder of 2008 and 1.1 percent for 2009.
- Increases to the PQRI bonus for 2009 and 2010 to two percent.
- Reduction of the coinsurance for outpatient psychiatric services to 20 percent over six years.
- An extension of the period for an initial preventive physical examination under Medicare to 12 months without a deductible.
- Requirement that providers of advanced diagnostic imaging services be accredited beginning in 2012.
- Increase of five percent in the fee schedule for mental health services between July 1, 2008 and December 31, 2009.
- Decrease of 0.5 percent in the clinical laboratory fee schedule for 2009 to 2013.
- For 2009, a decrease of 9.5 percent for items and services selected for the postponed DMEPOS competitive bidding program.
- Increases to the payment for specified rural providers, ambulance services and FQHCs.
- Authorization of coverage for new preventive services and chronic kidney disease education services.

A full text version of H.R. 1633 can be accessed at:

http://www.gormanhealthgroup.com/download/HR6331.pdf

Copyright © 2008, Gorman Health Group, LLC