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MEMBER BRIEFING



**HOSPITALS AND HEALTH SYSTEMS;
PAYORS, PLANS, AND MANAGED CARE;
PHYSICIAN ORGANIZATIONS;
and REGULATION, ACCREDITATION, AND
PAYMENT PRACTICE GROUPS;
MEDICARE PART D TASK FORCE**

THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT

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INTRODUCTION

On July 15, 2008, the Medicare Improvements for Patients and Providers Act, Pub. L. No. 110-275 (MIPPA), was enacted following a Congressional override of the President's veto. MIPPA, which makes numerous changes to the Medicare program, prevents a mandated reduction in Medicare payments for physicians and, instead, freezes physician fees at June 2008 levels until January 1, 2009, and provides a 1.1% increase through 2009. The increased payments are mainly offset by reducing payments to the Medicare Advantage (MA) program and the physician assistance quality initiative (PAQI) fund.

MIPPA makes additional changes to Medicare, Medicaid, and other Social Security Act programs, including (a) extending expiring provisions under Medicare; (b) increasing access to mental health services; (c) making changes to low-income programs for beneficiaries; and (d) maintaining access to care in rural areas, including pharmacy access.

This Member Briefing summarizes select provisions of MIPPA.

SUMMARY OF MIPPA PROVISION

TITLE I: MEDICARE

Subtitle A: Beneficiary Improvements

Part I: Prevention, Mental Health, and Marketing

Section 102. Elimination of discriminatory copayment rates for Medicare outpatient psychiatric services. Medicare has historically paid only 50% of the

allowed amount for outpatient mental health services, while paying 80% of the allowed amount for outpatient physical health services. This amendment phases in an increase to Medicare's payment responsibility for outpatient mental health services of 80% by 2014. When the amendment is fully implemented in 2014, Medicare will pay outpatient mental health services at the same level as other Part B services.

Section 103. Sales and marketing restrictions for MA and Part D. MIPPA codifies most of the MA and Medicare Part D sales and marketing restrictions that the Centers for Medicare and Medicaid Services (CMS) proposed in rulemaking published on May 16, 2008.¹ MIPPA also requires CMS to establish certain other marketing and sales limitations, many of which may be prescribed when the May 16 proposed rule is modified and becomes final.

Beginning in plan year 2009, the following marketing activities by Medicare Advantage Organizations (MAOs) and Part D plan sponsors (or agents, brokers, and third parties who represent them) are prohibited:

- Offering cash or monetary rebates (no matter the value);
- Offering gifts or promotional items, except those of nominal value as established by CMS (nominal value is further described below);
- “[A]ny unsolicited means of direct contact of prospective enrollees, including . . . any outbound telemarketing without the prospective enrollee initiating contact” (actions that might qualify as “initiating contact” are not illustrated; additionally, the window of opportunity to follow-up with a prospective enrollee after he or she “initiates contact” is unclear);
- The sale of other non–health-related products (such as annuities and life insurance) during sales or marketing activities or presentations;

¹ CMS, “Medicare Program; Revisions to the Medicare Advantage and Prescription Drug benefit Programs; Proposed Rule,” 73 Fed. Reg. 28555 (May 16, 2008). The comment period for the proposed rule ended July 15, 2008, the same day MIPPA was enacted. CMS has stated publicly that it is in the process of considering MIPPA and comments and finalizing the rule.

- The provision of meals to prospective enrollees during any promotional or sales activity, regardless of the meal's value (a "meal" is not defined); and
- Sales and marketing activities designed for enrollment at educational events and healthcare settings in areas where healthcare is delivered (e.g., physician offices and pharmacies), except in common areas

This provision also requires CMS to establish limitations on sales and marketing activities. The provision states that the limitations must take effect on a date established by CMS, no later than November 15, 2008. MIPPA directs CMS to establish limitations with the respect to at least the following:

- **Scope of marketing appointments.** MAOs and Part D plan sponsors must establish advance agreements with prospective enrollees on the scope of the marketing appointments and document agreements in writing.
- **Co-branding.** CMS must restrict the use of names and logos of co-branded network providers on plan membership and marketing materials, although the manner in which CMS must do so is not set out in the law.
- **Gifts.** CMS must limit MAOs and Part D plan sponsors offering promotional items given to prospective enrollees at promotional activities to those of "nominal value." CMS currently defines "nominal value" as a retail value of not more than \$15.²
- **Agent and broker compensation.** CMS must establish guidelines ensuring that the use of compensation creates incentives for agents and brokers to enroll individuals in a MA plan or Part D plan "that is intended to best meet their health care needs." Although MIPPA

² CMS Medicare Managed Care Manual, Chapter 3, "CMS Medicare Marketing Guidelines for MA, MA-PDs and 1876 Cost Plans", § 11.

does not instruct further, CMS has proposed regulations regarding agent and broker compensation in its May 16 proposed rule.

- **Agent and broker training and testing.** CMS must require MAOs and Part D plan sponsors to provide initial and annual training and testing of their brokers. Again, MIPPA does not instruct further and defers to CMS's discretion.³

While November 15 is the start of the MA and Part D annual enrollment period, MAOs and Part D plan sponsors may begin marketing on October 1. It is therefore reasonable to anticipate that CMS will set October 1, 2008 as the effective date for marketing restrictions. Depending on when the “yet to be determined” sales regulations are promulgated, MOAs and Part D plan sponsors might be hard-pressed to process and implement any agent and broker commission changes and training programs by November 15, 2008.

Section 103 further requires MAOs and Part D plan sponsors to (i) use only state-licensed agents and brokers to sell their MA and Part D plans and (ii) abide by state appointment laws. Sponsors will be required to report all agent and broker terminations to the state, including the reasons for termination. Sponsors will be further required to comply promptly with any state request for information regarding agent and broker performance as part of an investigation by the state into the conduct of an agent or broker.

CMS guidance currently requires sponsors to use state licensed agents and brokers. Although requiring compliance with state appointment laws is new, many sponsors already abide by such laws. The specific mandate to comply with state information requests is also new; however, sponsors were previously “expected” to comply with such requests and generally did so.

Except in the areas of plan licensure and solvency, federal laws governing MA and Part D preempt state law.⁴ Despite increasing states' roles in marketing compliance, MIPPA

³ *Id.*

⁴ § 1856 of the Social Security Act, 42 U.S.C. § 1395w-26; § 1860D-12(g), 42 U.S.C. § 1395w-112(g).

seems to emphasize and, indeed, strengthen federal preemption of MA and Part D marketing. In addition, the May 16 proposed regulations explicitly affirm that state laws requiring compliance with appointment laws for MA and Part D marketing are preempted by federal law. While MIPPA and the proposed regulations instruct observance of certain state laws, the legal foundation for such requirements is clearly a federal one. The difficulty for MAOs and Part D organizations, it seems, will be balancing the authority granted states to investigate alleged marketing abuses, with the understanding that the ultimate authority in regulating such activities remains with CMS. Finally, beginning in plan year 2010, Section 103 requires that the names of each MA and Part D plan include the plan type (e.g., PPO, HMO) using standard terminology developed by CMS.

Section 104. Improvements to the Medigap program. This amendment addresses the time for implementation by the states of the changes to the Medigap program resulting from the addition of Medicare Part D.

Part II: Low-Income Programs

Section 111. Extension of qualifying individual (QI) program. MIPPA extends funding for the QI program, which pays Part B premiums for certain eligible low-income individuals, in addition to extending the term of the QI program through December 31, 2009.

Section 112. Application of full LIS subsidy assets test under Medicare Savings Program. Effective January 1, 2010, MIPPA will increase the amount of resources an individual may have while still being eligible to participate in the Medicare Savings Program (MSP). The limit on such resources will be equal to the amount specified for the Medicare Part D Low-Income Subsidy (LIS) program.

Section 113. Eliminating barriers to enrollment. MIPPA endeavors to make enrollment in the MSP and LIS program more accessible to eligible individuals. The law requires that both applications be made more readily available to potentially eligible individuals, together with information on how an individual may obtain assistance in completing the forms. The Commissioner of the Social Security Administration (SSA) is

also required to provide training to SSA employees who receive these applications in order that they may promote the understanding of, and increase participation in, the MSP and LIS program.

Section 114. Elimination of Medicare Part D enrollment penalties paid by subsidy eligible individuals. Part D eligible individuals who fail to timely enroll in a Part D plan are subject to a late enrollment penalty of up to 1% of the base beneficiary premium for each month they fail to enroll. Although Part D eligible individuals who qualify for a premium subsidy under the Part D program already have some of this penalty waived, beginning in January 2009, MIPPA will eliminate the late enrollment penalty altogether for subsidy-eligible individuals.

Section 117. Judicial review of decisions of the Commissioner of Social Security under the Medicare Part D low-income subsidy program. In some cases the SSA determines whether individuals are eligible for Part D low-income subsidies. Beginning in January 2009, MIPPA grants individuals appealing the SSA's determination the same rights to judicial review as individuals have with respect to appealing Social Security eligibility.

Section 118. Translation of model form. Section 118 directs that the MSP application form be translated into those languages most frequently used by Medicare beneficiaries.

Section 119. Medicare enrollment assistance. MIPPA provides additional funding to State Health Insurance Assistance Programs (SHIPs) and Area Agencies on Aging to provide outreach to eligible Medicare beneficiaries regarding available benefits.

Subtitle B: Provisions Relating to Part A

Section 121. Expansion and extension of the Medicare Rural Hospital Flexibility

(FLEX) Program. This provision extends and expands certain provisions initially enacted by the Balanced Budget Act of 1997, Pub. L. No. 105-33. Pursuant to MIPPA, CMS can award grants to states to increase the delivery of mental health services or other health services deemed necessary to meet the needs of veterans of Operation Iraqi Freedom and Operation Enduring Freedom and other residents of rural areas. CMS must give special consideration to applications submitted by states where veterans make up a high percentage of the state's total population. A state awarded such a grant may use the funds to reimburse providers for services to veterans. For fiscal years 2009 and 2010, \$50 million have been authorized for this program. Additionally, the FLEX grant program will be expanded to provide support for critical access hospitals (CAHs) for quality improvement, quality reporting, performance improvements, and benchmarking. For fiscal years 2009 and 2010, \$55 million has been authorized for this support. Further funding is available for eligible CAHs receiving a grant to transition to a skilled nursing or assisted living facility. To be eligible, a CAH must have an average daily acute census of less than 0.5 and an average daily swing bed census of greater than 10.0. In 2008, \$5 million has been appropriated for this purpose.

Section 122. Rebasing for sole community hospitals. Sole community hospitals (SCHs) may be paid for inpatient hospital services under certain circumstances on the basis of their updated hospital-specific per discharge amount from fiscal year 1982, 1987, or 1996, whichever will result in the largest payment. Pursuant to MIPPA, for cost reporting periods beginning on or after January 1, 2009, an SCH can also use fiscal year 2006 as its base year for determining its hospital-specific payment amount per discharge. This amount will be increased by the annual update starting for discharges on or after January 1, 2009.

Section 123. Demonstration project on community integration models in certain rural counties. Effective October 1, 2009, a three-year demonstration project will be established in up to four states enabling them to develop and test a new model of

healthcare delivery services for improved integration of acute, extended, and other healthcare services.

Section 124. Extension of classification of certain hospitals. The one-time, three-year geographic reclassification for certain hospitals, as established by Section 508 of the Medicare Modernization Act, is extended until September 30, 2009.

Section 125. Revocation of unique deeming authority of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This amendment strikes from the Medicare Act the explicit deeming authority granted to the Joint Commission to accredit hospitals. Under this amendment, hospitals will be accredited by national accrediting organizations approved by the Secretary, which can include the Joint Commission. This amendment will take effect 24 months after the legislation is enacted and, during that stub period, will not affect hospitals currently accredited by the Joint Commission.

Subtitle C: Provisions Relating to Part B

Part I: Physician Services

Section 131. Physician payment, efficiency, and quality improvements. Section 131 of MIPPA postpones a Medicare physician pay cut that would have taken effect on July 1, 2008. Instead, the Medicare Physician Fee Schedule (PFS) conversion factor will remain at 0.5% for the rest of calendar year 2008 and will increase by 1.1% for calendar year 2009.

The Medicare PFS pays a physician the lower of the actual charge for a physician's services or the amount calculated from the product of the relative value of the service, a geographic factor and a conversion factor. Without the new legislation, the conversion factor would have been updated by -10.6% on July 1, 2008, and by an additional -5.0% in 2009. With the new legislation, the conversion factor remains at .5% for the remainder of 2008 and increases to 1.1% in 2009. Absent further legislation, the conversion factor is expected to be updated by as much as -21% on January 1, 2010.

Section 131 also changed the Medicare Physician Quality Reporting System. These changes extended the incentive payments available under the system to 2010, allowed audiologists to be eligible for incentive payments beginning in 2009, and increased the maximum incentive payment from 1.5% to 2.0% in 2009 and 2010.

Additionally, Congress directed that the Secretary implement by regulation a Physician Feedback Program no later than January 1, 2009. This new program will collect claims data and provide confidential feedback to physicians and physician groups on resource usage on an episode and/or per capita basis. The feedback program may focus on physician specialties, high-volume and high-value patient conditions, and certain physicians that use a high amount of resources. The program may also focus on certain geographic areas and physicians who treat a minimum number of individuals under the Medicare program. Section 131 also provides that feedback reports provided to physicians will be exempt from public disclosure under the federal Freedom of Information Act.

Section 131 also eliminates approximately \$5 billion available in 2013 for the PAQI fund to offset the increased payments mandated by MIPPA.

Lastly, Congress directed the Secretary to report by May 1, 2010, on a plan to transition from the current Medicare PFS to a Value-Based Purchasing Program. A value-based program could provide incentives for certain types of patient care designed to increase the effectiveness of patient outcomes and concurrently decrease Medicare expenditures for those outcomes.

Section 132. Incentives for electronic prescribing. Section 132 of MIPPA creates new financial incentives to encourage physicians and certain other eligible professionals to order prescriptions electronically. Specifically, Section 132 provides incentive payments for eligible professionals who use a qualified electronic prescribing system in 2009 through 2013. Beginning January 1, 2009, eligible professionals will receive a 2% increase in payments, phasing down to 0.5% in 2013. In addition, Section 132 also provides certain penalty adjustments beginning in 2012. Eligible professionals who have not begun using electronic prescribing by 2012 will be penalized by -1% in 2012, by -1.5% in 2013, and by -2% in 2014.

Section 132 also prohibits the application of the above financial incentives and penalties to eligible professionals who write prescriptions infrequently (according to standards defined by the Secretary) and permits the Secretary to establish a hardship exception for eligible professionals who are unable to use a qualified e-prescribing system.

Section 133. Expanding access to primary care services. This section of MIPPA allows the Secretary to increase the duration of the Medicare Medical Home Demonstration Project beyond the scheduled three years if the Secretary determines that the project will either improve the quality of patient care or reduce Medicare spending. Congress provided up to \$100 million from the Federal Supplementary Medical Insurance Trust Fund to pay for the project.

Section 134. Extension of floor on Medicare work geographic adjustment under the Medicare physician fee schedule. Section 134 of MIPPA extends the floor on the geographic adjustment for work costs for physicians in rural and poorer areas where the local work costs are lower than the national average. Physician payments are adjusted geographically based on geographic practice costs indexes (GPCI) that represent the difference in physician practice costs in different areas of the country. The geographic adjustment consists of (a) a physician work GPCI, (b) a practice expense GPCI, and (c) a malpractice expense GPCI. The indexes are expressed as a ratio of costs for a specific area compared to the national average. Previous modifications to the Medicare PFS established a minimum floor value of 1.00, or the national average, for the physician work GPCI. In other words, the effective physician work GPCI could not fall below the national average for any geographic area. That floor expired on June 30, 2008, but Section 134 extends the 1.00 floor to work performed before January 1, 2010. In addition, Section 134 provides that, after January 1, 2009, the physician work GPCI for work performed in Alaska will be adjusted to a minimum floor of 1.50.

Section 135. Imaging services. Section 135 provides that beginning January 1, 2012, the technical component of “advanced diagnostic imaging services,” that are billed under the Medicare PFS and furnished by a supplier (as opposed to a “provider of services” such as a hospital), are payable only if the supplier is accredited by an organization designated by the Secretary. “Advanced diagnostic imaging services”

include magnetic resonance imaging, computerized tomography, and nuclear medicine diagnostic imaging services. The Secretary may add other types of diagnostic imaging services (excluding X-ray, ultrasound, and fluoroscopy) to the list of “advanced diagnostic imaging services,” in consultation with physician specialty organizations and other stakeholders.

Section 135 directs the Secretary to designate advanced diagnostic imaging services accreditation organizations no later than January 1, 2010. Such organizations must use specified criteria to evaluate a supplier for the purpose of accreditation. These criteria must include standards for evaluating: the qualifications of non-physician personnel who furnish the technical component of the imaging services; the qualifications of medical directors and supervising physicians; the equipment used in performing the imaging services; the supplier’s procedures for ensuring the safety of persons who furnish the imaging services; and the supplier’s quality assurance and quality control program. Suppliers accredited by an accrediting organization that is placed on the Secretary’s list of approved accreditation organizations, but later removed from the list, will not require a new accreditation until their accreditation by the removed organization expires. In addition, suppliers accredited prior to January 1, 2010 by an organization on the Secretary’s list of designated accreditation organizations as of January 1, 2010, will be considered accredited for the remaining period of their accreditation.

In addition, Section 135 directs the Secretary to conduct a two-year demonstration project to collect data regarding physician compliance with clinical appropriateness criteria when furnishing advanced diagnostic imaging services to Medicare beneficiaries. The Secretary is authorized to focus the demonstration project on imaging services that account for a large amount of expenditures under the Medicare program, have recently experienced a high rate of growth, or for which appropriateness criteria exist.

In fashioning the demonstration project, the Secretary is directed to:

- Select physician participants who can submit data for the project in an electronic format and who represent a wide range of geographic and demographic characteristics and practice settings;

- Reimburse physicians for their reasonable administrative costs incurred in participating in the demonstration project and provide reasonable incentives to encourage participation;
- Select clinical appropriateness criteria in consultation with medical specialty societies and other stakeholders, and use only criteria that are developed or endorsed by a medical specialty society and developed in adherence to appropriateness principles developed by a consensus organization; and
- Use various models for collecting data, including a model that uses information collected at the time the imaging service is furnished and a model that requires transmittal of information at the time of referral and provides automated decision-support feedback to the referring physician. (The Secretary is prohibited from using prior authorization as a model for data collection.)

Section 136. Extension of treatment of certain physician pathology services under Medicare. In the November 2, 1999, final Medicare PFS rule, CMS stated that it would implement a policy to pay only hospitals for the technical component of physician pathology services furnished to hospital patients. Previously, any independent laboratory could bill Medicare for the technical component of physician pathology services furnished to hospital patients. After several requests to allow independent laboratories and hospitals adequate time to negotiate these arrangements, CMS delayed the implementation of this rule. Subsequent legislation formalized a moratorium on the implementation of the rule. The most recent extension of the moratorium expired on June 30, 2008. Section 136 of MIPPA established a new extension of the moratorium retroactive to July 1, 2008. The moratorium will continue for claims with dates of service prior to January 1, 2010.

Section 137. Accommodation of physicians ordered to active duty in the armed services. Section 137 of MIPPA extends indefinitely an exception to the 60-day limitation on locum tenens billing arrangements for physicians ordered to active duty in the armed services. As a general rule, payments for Medicare covered services to

anyone other than the patient or the physician who performs the service are prohibited. One long-standing exception to this rule permits a patient's regular physician to submit bills for work performed by a substitute or locum tenens physician for a limited, continuous period of 60-days while the regular physician is unavailable to perform the services. Previous revisions to Medicare had created an exception to the 60-day limitation on locum tenens billing for physicians called to active duty in the armed forces. The exception expired on July 1, 2008. Section 137 of MIPPA eliminated the expiration date, thus permitting physicians called to active duty to continue to use locum tenens billing for periods longer than 60 days.

Section 138. Adjustment for Medicare mental health services. Section 138 alleviates some of the recent cuts in payments for psychotherapy and other psychological services that were due, in part, to budget neutrality provisions. This section increases the Medicare PFS amount for mental health "specified services" by 5% for services furnished between July 1, 2008, and December 31, 2009. The specified services consist of Health Care Common Procedure Coding System procedure codes for psychiatric therapeutic procedures furnished in office or other outpatient facility settings or in inpatient hospital, partial hospital, or residential care facility settings. The specified services are limited to services that fall into categories that are subcategories of (a) insight oriented, behavior modifying, or supportive psychotherapy services, or (b) interactive psychotherapy services. Importantly, this increase is exempt from the budget neutrality provisions. This section also provides that the Secretary may implement this provision by program instruction or otherwise.

Part II: Other Payment and Coverage Improvements

Section 147. Extension and expansion of the Medicare hold harmless provision under the prospective payment system for hospital outpatient department (HOPD) services for certain hospitals. MIPPA extends, until December 31, 2009, a hold harmless provision that ensures that small rural hospitals and sole community hospitals, both with under 100 beds, will receive 85% of their adjusted costs in excess of hospital outpatient prospective payment system payments.

Section 148. Clarification of payment for clinical laboratory tests furnished by CAHs. Effective for clinical laboratory tests furnished by CAHs critical access hospitals on or after July 1, 2009, MIPPA will allow such hospitals to receive 101% of their reasonable costs for such tests, regardless of whether the individual to whom such services are furnished is physically present in the CAH, or offsite in a skilled nursing facility or clinic operated by the hospital, at the time the specimen is collected.

Subtitle D: Provisions Relating to Part C

Section 161. Phase-out of indirect medical education (IME). Medicare currently compensates teaching hospitals for the graduate medical education costs teaching hospitals incur when treating Medicare beneficiaries. This additional compensation includes indirect medical education (IME) payments, which are intended to compensate for higher costs that teaching hospitals, as compared to non-teaching hospitals, generally incur for offering a wider array of healthcare services and servicing patients with poorer health. Under Medicare fee-for-service (FFS), IME is paid directly to hospitals. Under MA, IME is paid to MAOs as part of the overall MA plan payment rate. Beginning in 2010, MA county rates will be reduced by an amount determined by multiplying the Secretary's estimate of the standardized IME costs in the area for the year by the phase-in percentage set by MIPPA. This reduction will continue each year until the ratio reaches 100%.

The most often cited justification for eliminating IME costs from payments to MAOs is that Medicare essentially pays twice for medical education costs incurred by hospitals—once by reimbursing teaching hospitals directly and a second time in MA plan payments.⁵ Absent from the analysis, however, is whether MAOs typically pass these IME payments on to the teaching hospitals through higher reimbursements in their network contracts. Instead, it has been suggested that without evidence to the contrary,

⁵ Congressional Budget Office Testimony, The Medicare Advantage Program: Enrollment Trends and Budgetary Effects, April 11, 2007.

teaching hospitals don't receive IME payments from MAOs through network contracts.⁶ Whether MAOs that do, in fact, reimburse teaching hospitals for IME will adjust reimbursements to compensate for this reduction remains to be seen.

Section 162. Revisions to requirements for Medicare Advantage private fee-for-service plans. Beginning in plan year 2011, most private fee-for-service (PFFS) plans must meet provider access standards by developing contracted provider networks. PFFS plans are currently permitted to meet these access standards without provider contracts through the establishment of uniform provider payment rates that equal or exceed reimbursement rates for identical services under Medicare FFS (up to a maximum of 115% of Medicare FFS rates).⁷ A non-contracted provider who participates in Medicare is “deemed” to have accepted the PFFS plan’s term and conditions (including payment rate) if that provider knows or has reason to know that the beneficiary is enrolled in a PFFS plan and elects to service the patient.⁸

These new access standards will apply to all individual market PFFS plans except those in geographic areas that CMS determines have fewer than two “network-based” MA plans. “Network-based plans” are coordinated care plans, network-based Medicare savings account (MSA) plans, and cost plans. Not included in the network-based plan designation, however, are non-network regional PPOs (regional PPOs in areas where it has been unable to meet access standards through written contracts). PFFS plans offered under employer group waiver authority must meet access standards applicable to network-based MA Plans solely through written contracts.

MIPPA also provides clarification regarding PFFS plan provider payments rates. It provides that the existing stipulation that a PFFS plan must not vary provider rates based on utilization shall not be interpreted as preventing a PFFS plan from varying

⁶ See American Bar Association. “The American Medical Association is Setting the Record Straight on the Medicare Advantage Provisions in H.R. 6331;” *available at* www.ama-assn.org/ama1/pub/upload/mm/399/ma_myths.pdf.

⁷ Social Security Act § 1852(k)(2), 42 U.S.C § 1395w-22(k)(2).

⁸ Social Security Act § 1852(j)(6), 42 U.S.C. Sec. 1395w-22(j)(6).

provider payment rates based on provider specialty, location, use of specified preventative or screening services, or other factors not related to utilization.

Section 164. Revisions relating to specialized MA plans for special needs

individuals. MIPPA continues the authority for the establishment of new MA special needs plans (SNPs) through 2010 but extends the existing moratorium on designation of new disproportionate-share SNPs through 2010.

Beginning in 2010, dual-eligible SNPs (MA plans designed for beneficiaries enrolled in Medicare and Medicaid) may continue to operate but are prohibited from expanding service areas unless the plan has a contract with the state Medicaid agency to provide or arrange for the provision of Medicaid benefits. State Medicaid agencies, however, are not required to enter into such contracts with MAOs. As a result, MAOs wanting to expand dual-eligible SNPs into new service areas will be forced to negotiate with states possessing a significant amount of bargaining power. Dual-eligible SNPs must also provide each prospective enrollee, prior to enrollment, a written statement using standard content and format developed by CMS, describing benefits and cost sharing under the Medicaid program, as well as which such benefits and cost sharing are covered under the plan. Finally, for full benefit dual eligibles and qualified Medicare beneficiaries (QMBs) who are enrolled in dual-eligible SNPs, the plan may not impose cost sharing that exceeds the amount permitted under the Medicaid program. CMS will provide staff and resources in order to address state questions regarding coordination of state and federal benefits under a dual-eligible SNP.

For all SNPs, 100% of beneficiaries enrolling in 2010 and beyond must meet the plan's special needs eligibility criteria. The development and implementation of care management requirements designed specifically for their populations, care management, quality reporting requirements, and modification to the standard defining a severe or disabling chronic condition, are other SNP modifications established by MIPPA.

Section 166. Adjustment to MA stabilization fund. MIPPA exhausts stabilization funding intended to promote and retain MA regional preferred provider organizations (Regional PPOs). Regional PPOs are MA plans authorized by the Medicare Prescription

Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. 108-173, to provide healthcare coverage in geographic regions defined by CMS, including both urban and rural areas, as opposed to counties picked by the MAO.⁹ Regional PPOs have greater flexibility than local PPOs in meeting provider access standards and in establishing cost sharing requirements for in-network and out-of-network providers, but must offer a combined deductible and out-of-pocket maximum.

To encourage development of Regional PPOs, the MMA established a blended payment benchmark mechanism as financial incentive for these types of plans.¹⁰ In addition to these financial incentives, the Regional Stabilization Fund (the Stabilization Fund) was established to provide, at the Secretary's discretion, bonus payments to MAOs sponsoring Regional PPOs new to or remaining within previously underserved regions.

MIPPA reduces the scheduled 2013 Stabilization Fund contribution of \$1.8 billion to \$1 billion. However, the Stabilization Fund will continue to receive one half of the government's 25% share of any rebates from regional MA plans bidding below the regional MA benchmarks.¹¹ Future monies accumulated in the Stabilization Fund would be, at least theoretically, available for bonus distribution as established by the MMA. The likelihood that such monies would ever be distributed as bonus payments, however, seems remote.

Sections 168-9. Medicare Payment Advisory Commission (MedPAC) study and report on quality measures/MedPAC study and report on MA payments. MIPPA instructs the MedPAC to conduct a study on how measures of quality of care performance and patient experience can be collected in order to compare MA to Medicare FFS. A report containing the results of the study along with recommendations must then be submitted to Congress by March 31, 2010.

⁹ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, § 221, *amending* § 1851(a), *creating* § 1858 of the Social Security Act (42 U.S.C. §§ 1395w-21(a), 1395w-27a)).

¹⁰ Social Security Act § 1858(e), 42 U.S.C. § 1395w27a(e).

¹¹ Social Security Act § 1858(e)(2)(B), 42 U.S.C. § 1395w27a(e)(2)(B).

MedPAC is also charged with conducting a study on MA payments and submitting a report to Congress by March 31, 2010.

Subtitle E: Provisions Relating to Part D

Part I: Improving Pharmacy Access

Section 171. Prompt payment by prescription drug plans and MA-PD plans under Part-D. Beginning in 2010, MIPPA will require Part D plan sponsors (including MA-PD sponsors) to pay “clean claims” submitted by pharmacies electronically within 14 calendar days of receipt and clean claims submitted by pharmacies on paper within 30 calendar days of receipt. MIPPA exempts from the prompt pay requirements claims submitted to Part D plan sponsors by mail-order pharmacies and by long-term care pharmacies located in, or contracted with, long-term care facilities.

A pharmacy claim will be deemed clean unless the Part D plan sponsor notifies the claimant in writing of a defect or impropriety within 10 calendar days of an electronic claim’s receipt or 15 calendar days of a paper claim’s receipt. Otherwise, a clean claim is a claim with “no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made.”

Part D plan sponsors will be required to pay interest on all pharmacy clean claims not paid within the prompt pay timelines. Interest is to be based on a weighted average of interest on three-month Treasury securities plus 0.1 percentage point. Part D sponsors may not include interest payments as allowable costs for purposes of determining CMS obligations under the “risk corridor” risk sharing arrangement.

Part D plan sponsors will be required to pay claims by electronic fund transfer upon request of the pharmacy. This provision applies to claims submitted by all pharmacies, including mail-order pharmacies and long-term care pharmacies located in, or contracted with, long-term care facilities.

Section 172. Submission of claims by pharmacies located in or contracting with long-term care facilities. By 2010, Part D plan sponsors (including MA-PD sponsors)

must ensure that contracts with pharmacies located in, or contracted with, long-term care facilities allow the pharmacies at least 30 calendar days, but no more than 90 calendar days, to submit claims for reimbursement.

Section 173. Regular update of prescription drug pricing standard. Beginning in 2009, Part D plan sponsors (including MA-PD sponsors) that rely on a prescription drug pricing standard, such as average wholesale price (or AWP), will be required to update the standard every January 1 and at least once every seven calendar days during the year, “to accurately reflect the market price of acquiring the drug.”

Part II: Other Provisions

Section 175. Inclusion of barbiturates and benzodiazepines as covered Part D drugs. Section 175 would revise the Part D statutory definition of covered drug to include barbiturates (if used in the treatment of epilepsy, cancer, or a chronic mental health disorder) and benzodiazepines. Currently, the statute specifically excludes barbiturates and benzodiazepines from the definition of a covered Part D drug. This change is effective for prescriptions dispensed on or after January 1, 2013.

Section 176. Formulary requirements with respect to certain categories or classes of drugs. Currently, the Part D benefit requires that a Part D plan formulary “must include drugs within each therapeutic category and class of covered Part D drugs,” although not all prescription drugs within each category or class must be covered. CMS has interpreted this requirement to mean that a Part D plan formulary must include at least two drugs in each category and class of covered prescription drugs unless an exception applies.

Beginning with plan year 2010, MIPPA would revise the formulary requirements to require Part D plan sponsors to include categories and classes of drugs for which restricted access to drugs in the category or class would have major or life threatening clinical consequences for individuals who have a disease or disorder treated by the drugs in such category or class and there is a significant clinical need for a beneficiary to have access to multiple drugs within a category or class due to unique chemical actions and pharmacological effects of the drugs within the category or class, such as

drugs used in the treatment of cancer. The Secretary will have authority to establish exceptions to this formulary requirement.

Subtitle F: Other Provisions

Section 181. Use of Part D data. MIPPA expands the purposes for which CMS may use Part D data it collects to include implementation of the Part D program and Congressional oversight, monitoring, recommendations, and analysis. Part D data may also be used as the Secretary determines is appropriate for “improving public health through research on the utilization, safety, effectiveness, quality, and efficiency of health care services.”

Section 182. Revision of definition of medically accepted indication for drugs. Currently, a Part D drug is defined as a “drug that may be dispensed only upon a prescription” and listed in the Medicaid drug rebate statute for a “medically accepted indication.” Effective for plan years beginning on or after January 1, 2009, MIPPA would revise this definition to specify that “medically accepted indication” means “in the case of a covered Part D drug used in an anticancer chemotherapeutic regimen.” MIPPA also makes some changes to the conflict of interest requirements with respect to the compendia appropriate for identifying medically accepted indications for drugs.

Section 188. Medicare Improvement Funding. This amendment requires the Secretary to establish the Medicare Improvement Fund, which shall be available to the Secretary to make improvements to the Medicare FFS program.

Section 189. Inclusion of Medicare providers and suppliers in Federal Payment Levy and Administrative Offset Program. This amendment enhances the Secretary’s recovery tools by requiring CMS to process Medicare payments through the Federal Payment Levy Program (FPLP) under § 6331(h) of the Internal Revenue Code of 1986. The phase-in of this requirement requires CMS to process all Medicare payments under the FPLP by September 30, 2011. It also extends the administrative offset provisions of 31 U.S.C. § 3716 to Medicare payments.

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