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HEALTH LAW
Update

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Medicare Improvements for Patients and Providers Act of 2008: Congress Giveth and Congress Taketh Away

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The Balanced Budget Act of 1997 (BBA)[1] established a formula for calculating Medicare physician payment updates that requires substantial annual reductions in the reimbursement amounts under the Medicare physician fee schedule. In the decade since the enactment of the BBA, physicians and legislators have repeatedly deferred the annual reimbursement cuts required under the statute by enacting various temporary fixes, the most recent of which was enacted on July 15, 2008 as part of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).[2] MIPPA simultaneously expands and narrows various portions of the Medicare program, providing increases in provider reimbursement and new benefits for Medicare beneficiaries while also reducing spending for Medicare Advantage and other programs. This *Health Law Update* briefly summarizes these changes.

Physician Fee Schedule Payment

The original BBA physician payment formula would have required a 10.6% reduction in Medicare physician reimbursement beginning July 1, 2008. MIPPA provides physicians an eighteen-month reprieve by freezing payment amounts under the Medicare physician fee schedule at the June 2008 level until January 2009 (*i.e.*, providing physicians a 0.5% increase in payment for the last six months of 2008, rather than the scheduled 10.6% cut), and providing a 1.1% fee increase for calendar year 2009. In 2010, however, the original statutory formula will again apply, requiring a 21% reduction in Medicare physician payment rates beginning January 1, 2010, with increasing cuts in each subsequent year, unless Congress enacts a more long-term solution.

In addition to the fee schedule increases described above, MIPPA creates new opportunities for physicians to receive incentive payments relating to e-prescribing and reporting quality data to

[1] *See* Pub. L. 105-33, 111 Stat. 251 (Aug. 5, 1997).
[2] *See* Pub. L. 110-275 (July 15, 2008). MIPPA became law after Congress voted to override President Bush's veto of the legislation.

Medicare. However, MIPPA cuts the physician assistance and quality initiative (PAQI) fund to help pay for the stabilization of the physician fee schedule.

Other Providers

Physicians were not the only beneficiaries of MIPPA. The new law also provides payment increases for federally qualified health centers, renal dialysis providers, and certain rural providers.

Federally Qualified Health Centers. MIPPA increases by $5 per patient visit the dollar amount of the payment limits for federally qualified health centers that would otherwise apply beginning in 2010. The statute also provides that the amount of the payment limit will increase in each subsequent year to account for inflation.

Renal Dialysis Providers. Renal dialysis providers will benefit from a 1% increase in the composite rate for dialysis services in 2009 and an additional 1% increase in 2010. Beginning January 1, 2009, however, Medicare reimbursement for dialysis services will become "site neutral" by eliminating upward adjustments currently available for hospital-based dialysis services intended to account for higher hospital overhead costs. Additionally, Medicare will bundle reimbursement for all of the elements of end-stage renal disease (ESRD) care into a single payment beginning January 1, 2011. The new bundled payment will be phased in over four years (to be fully implemented by 2014) and will provide reimbursement for services currently included in the composite rate for dialysis services, as well as for drugs and laboratory services used to treat ESRD that are currently separately reimbursed (*e.g.*, erythropoiesis stimulating agents). To ensure proper care for Medicare beneficiaries with more complex needs, MIPPA requires that the new bundled payment rate allow for higher payments to facilities treating such patients. MIPPA also requires that Medicare provide payment adjustments for facilities in rural areas or other facilities that require additional resources to provide high-quality ESRD care to their patients.

Rural Providers. MIPPA updates the data used to calculate reimbursement rates for sole community hospitals, permitting facilities to elect to receive payment based on FY2006 data for cost reporting periods beginning on or after January 1, 2009.[3] Regulators anticipate that, in most cases, these updates will result in an increase in payments to these facilities. MIPPA also increases payments for certain clinical diagnostic laboratory services provided by critical access hospitals.

Ambulance Providers. The new law also increases the amount of reimbursement for ground ambulance services, providing a 3% increase for transports originating in rural areas or rural census tracts and a 2% increase for transports originating in other areas.

[3] A hospital is eligible to be classified as a sole community hospital if it is located more than 35 miles from other like hospitals. Other rural hospitals may also be classified as sole community hospitals if various conditions are met. For additional information about sole community hospitals, *see* CMS Medicare Claims Processing Manual (Pub. 100-4) § 20.6, *available at* http://www.cms.hhs.gov/manuals.

Other provisions designed to facilitate, maintain (*i.e.*, not reduce) or increase provider reimbursement include:

Continuation of Moratorium Permitting Global Billing of Pathology Services by Non-Hospital Providers. In 1999, CMS announced its intent to implement a policy to pay only hospitals for the technical component of physician pathology services furnished to hospital patients. Prior to the announcement of this rule, any independent laboratory could directly bill Medicare for the technical component of physician pathology services furnished to hospital patients, and it was common practice in the industry for hospitals and independent laboratories to enter into such arrangements. In response to industry comment, CMS delayed the implementation of the new policy, and in 2000 Congress enacted a formal moratorium prohibiting the implementation of the rule. This moratorium has been periodically extended, most recently through June 30, 2008. MIPPA continues the extension of the moratorium through December 31, 2009.

Delay and/or Elimination of Competitive Bidding Programs. In 2007, CMS announced its intent to conduct a clinical laboratory competitive bidding demonstration project. The industry immediately responded in protest, expressing concerns about patient access and quality of care that might result from CMS limiting the number of clinical laboratory providers in a geographical area. MIPPA repeals Congress's prior authorization of the clinical laboratory competitive bidding demonstration project; however, in exchange, current reimbursement rates for clinical laboratory services will be reduced by 0.5% for each year from 2009 through 2013. MIPPA also delays until 2011 the implementation of the competitive biding demonstration project for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) announced by CMS in 2007.

Prompt Payment for Pharmacies. Beginning in 2010, Medicare Part D plan sponsors (including Medicare Advantage prescription drug plans) must pay all "clean claims" submitted by pharmacies within 14 calendar days if the claims are submitted electronically, or within 30 calendar days for paper claims.[4] Plan sponsors will be required to pay interest on all clean claims not paid within the prompt pay timelines. The new prompt pay requirement does not apply to claims submitted by mail-order pharmacies or by long-term care pharmacies located in, or contracted with, long-term care facilities.

Regular Update of Prescription Drug Pricing Standard. Beginning January 1, 2009, contracts between pharmacies and Medicare Part D plan sponsors (including Medicare Advantage prescription drug plans) that use the cost of a drug as the standard for calculating pharmacy reimbursement amounts must require the plan sponsor to update the data used to calculate reimbursement at least every seven days, to ensure that the reimbursement calculation accurately reflects the market price of acquiring the drug.

[4] 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. A claim is automatically deemed to be a clean claim unless the Medicare Part D plan sponsor notifies the pharmacy submitting the claim in writing of a defect or impropriety within 10 calendar days of receiving an electronic claim, or within 15 calendar days of receiving a paper claim.

Expanded Coverage for Medicare Beneficiaries

In addition to increasing reimbursement for certain categories of Medicare providers, MIPPA expands Medicare coverage for certain healthcare services, provides additional assistance for low-income beneficiaries and authorizes the implementation of multiple initiatives intended to increase beneficiary access to care.

Additional Coverage for Preventive Services. Medicare currently provides very limited coverage for preventive healthcare services. MIPPA expands the scope of healthcare services covered by the Medicare program to include "additional preventive services," which are defined as services that identify medical conditions or risk factors that the Secretary determines are (1) reasonable and necessary for the prevention or early detection of an illness or disability, (2) recommended with a grade of A or B by the United States Preventive Services Task Force, and (3) appropriate for individuals entitled to Medicare Part A or enrolled in Part B. MIPPA also expands the list of services covered under the initial preventive Medicare physical exam (commonly known as the "Welcome to Medicare" physical) to include measurement of body mass index and end-of-life planning (upon agreement with the beneficiary). The new law waives the deductible for the initial preventive screening exam and extends the eligibility period for this service from the first six months to the first year of Part B enrollment.

Increased Access to Mental Health Treatment. Medicare currently pays only about 50% of the amount allowed for outpatient mental health services, while paying 80% of the allowed amount for outpatient physical health services, requiring a substantially higher beneficiary co-payment for mental health services than for physical healthcare services. MIPPA reduces the amount of the beneficiary co-payment for mental health services beginning in 2010 by incrementally increasing the percentage of expenses for outpatient mental health services covered by Medicare until 2014, when beneficiary co-payments and Medicare payments for outpatient mental health services must be equivalent to those for physical healthcare services. The new law also expands the Medicare Part D drug benefit to include coverage for benzodiazepines and barbiturates used for mental health treatment.

Therapy Services. Medicare currently limits payment for all outpatient therapy services provided by non-hospital providers ($1,810 per-beneficiary annual cap for all outpatient physical therapy and speech language pathology services, and $1,810 per-beneficiary annual cap for all outpatient occupational therapy services). Where additional therapy services are deemed medically necessary, beneficiaries may apply for an exception that would allow payment in excess of the therapy caps. The current authorization for the exception process was scheduled to expire June 30, 2008, but MIPPA extends the authorization for the exceptions process through 2009. The new law also increases therapy coverage for beneficiaries suffering from chronic obstructive pulmonary disease (COPD) and adds coverage for outpatient speech-language pathology services.

Additional Assistance for Low-Income Beneficiaries. The federal Qualifying Individuals (QI) program, which pays outpatient care premiums for certain low-income elderly or

disabled individuals, was scheduled to expire on June 30, 2008. MIPPA extends authorization and funding for the program through December 2009. The new law also increases the amount of resources low-income individuals may have while still being eligible to participate in the Medicare Savings Program (which provides Medicaid assistance for Medicare Part B premiums) and provides a special enrollment period for low-income seniors to choose a Medicare Part D drug benefit plan or private Medicare plan with drug coverage without being subject to the premium penalty generally applicable to individuals who fail to enroll in the Medicare drug benefit in a timely manner.

Beneficiary Access Initiatives. In an effort to eliminate barriers to Medicare program enrollment and participation, MIPPA (a) requires the Social Security Administration to strengthen outreach programs designed to educate low-income seniors who may be eligible for additional benefits under the Medicare program (*e.g.*, low-income subsidy program, Medicare Savings program, etc.), (b) provides $25 million to state and local programs that assist seniors attempting to access the Medicare program, and (c) requires the Secretary to develop and distribute a simplified Medicaid application form for use by Medicare Savings program applicants and to provide for the translation of the model application form into at least 10 languages other than English by January 1, 2010.

There's No Such Thing as a Free Lunch: Where the Money Comes From

The reimbursement increases and expanded services described above are largely funded by focused cuts to Medicare Part C, commonly known as Medicare Advantage (MA).

Phase-Out of Indirect Medical Education (IME) Payments to MA Plans. Medicare currently compensates teaching hospitals for the graduate medical education costs incurred when treating Medicare beneficiaries by providing such hospitals with indirect medical education (IME) payments. Under the Medicare fee-for-service program, IME is paid directly to the teaching hospital; however, under Medicare Part C, IME may also be paid to an MA organization as part of the overall MA plan payment rate. Since Medicare reimburses hospitals directly for IME costs (including costs incurred while treating MA patients), MIPPA eliminates this redundancy (and potential for double payment) by phasing out IME payments to MA organizations beginning in 2010.

Reduced Funding for Medicare Advantage Regional Stabilization Fund. To encourage the development of MA regional preferred provider organizations (PPOs), Congress established the Regional Stabilization Fund to provide bonus payments to MA organizations maintaining or sponsoring new regional PPOs in previously underserved regions. MIPPA reduces the amount of Congress's scheduled 2013 contribution to the Regional Stabilization Fund from $1.8 billion to $1 billion.

In addition, MIPPA imposes new compliance requirements on the marketing and contracting activities of MA plans.

Private Fee-For-Service Plans. Historically, MA coordinated care plans were required to form networks in order to guarantee access, while private fee-for-service plans (PFFS) serving MA enrollees were allowed to manage access via payment rates to physicians and/or contracting with an appropriate number of providers. MIPPA institutes parity between these two types of plans by requiring any PFFS plans that contract with providers to satisfy the same access requirements as the coordinated care plans beginning in 2010. By 2011, most PFFS plans will be required to develop networks and meet access requirements similar to all other types of MA plans. MIPPA also addresses quality issues regarding PFFS plans by requiring PFFS plans to have a quality improvement program similar to other MA plans by 2010.

Marketing. While MA marketing has been the source of increasing guidelines and restrictions, MIPPA expands the list of absolutely prohibited activities beginning in 2009. These forbidden actions include meals, cash, gifts or monetary rebates, marketing in health care settings or at educational events, unsolicited means of direct contact, and cross-selling. The Act also requires that marketing appointments with potential beneficiaries be limited in scope in advance of the meeting and that all agents, brokers and other third parties be trained annually and complete annual testing regarding MA marketing rules. One additional notable change is that all MA plans will be required to have the plan type included in the plan name by 2010.

Keeping Watch: Quality Initiatives

Although the physician payment fix may have grabbed the headlines, MIPPA also includes several provisions designed to increase the quality of care provided to Medicare beneficiaries.

Imaging Accreditation. Although major cuts to imaging were avoided, quality control measures and review of imaging services, including those provided in physician offices, were included in the new law. Beginning in 2012, advanced diagnostic imaging services must be accredited by a national, CMS-approved organization in order for the supplier to be eligible to receive reimbursement for the technical component of the service. Advanced diagnostic imaging includes diagnostic MRI, CT and nuclear medicine (including PET), although CMS may later add other modalities to this requirement. In addition, MIPPA directs HHS to perform a demonstration project to evaluate the quality and quantity of advanced imaging services provided to Medicare beneficiaries, specifically collecting data regarding physician compliance with clinical appropriateness criteria when furnishing advanced diagnostic imaging services to Medicare beneficiaries.

Elimination of Exclusive "Deeming" Authority of The Joint Commission. In order to receive Medicare payments, Medicare providers and suppliers must meet certain health and safety requirements specified in the statute. A provider can be deemed to satisfy these requirements if it has been accredited by an approved national accreditation body. Under current law, hospitals seeking to take advantage of "deemed" status must be accredited by The Joint Commission. MIPPA revokes the exclusive accreditation authority previously granted to The Joint Commission and authorizes the Secretary to

deem a hospital to satisfy the specified health and safety requirements if the hospital is accredited by any national accrediting organization approved by the Secretary (including, but not limited to, The Joint Commission). This provision will take effect July 1, 2010 and will not affect those hospitals currently being accredited or under accreditation by The Joint Commission.

New Quality Reporting Incentives for ESRD. Beginning January 1, 2012, renal dialysis providers that fail to satisfy certain quality requirements specified by the Secretary will be subject to a reduction in reimbursement of up to 2%. The requirements will include measures relating to anemia management, dialysis adequacy and patient satisfaction (to the extent feasible).

MedPAC Study. MIPPA instructs the Medicare Payment Advisory Commission (MedPAC) to conduct a study on how measures of quality of care performance and patient experience can be collected in order to compare the Medicare Advantage program to the Medicare fee-for-service program.

What MIPPA Doesn't Do

While MIPPA makes many adjustments to the current Medicare system, some of the most notable elements of the Act are those that are missing: provisions anticipated or feared by the industry but that did not appear in the Act.

Ban on Physician Ownership of Hospitals. Over the past several months, various bills have included provisions limiting or even forbidding physician ownership of health care facilities, most commonly ownership of hospitals.[5] Many predicted that a ban on physician ownership of hospitals would be included in any legislation addressing Medicare, yet MIPPA contains no such provision. However, providers and their counsel should not relax, since Congress continues to focus on this issue, and many in the industry expect some form of restriction to be enacted before the end of the year.

Imaging. One area of significant growth in Medicare spending and therefore a cause of concern to regulators is imaging. Provisions restricting the feasibility of physician office-based imaging are present in the proposed 2009 Physician Fee Schedule.[6] But MIPPA did not introduce any preauthorization requirements as some anticipated, nor did MIPPA introduce additional payment cuts to the imaging sector.

Provider Cuts. While MIPPA was passed to stave off a 10.6% across the board reduction to physician reimbursement, some projected that either wide-spread or targeted cuts would be instituted as an attempt to address the expansion of Medicare spending. However MIPPA did not make cuts to the market basket or CPI levels. Instead cuts were carved out of the MA program and the PAQI fund to pay for the stabilization of physician fees in 2008 and allow for an increase of 1.1% in 2009. MIPPA did not solve the long

[5] Examples of this include the Mental Health Parity Act and the War Appropriations Bill.
[6] See *Health Law Update* entitled "Still on the Radar Screen: CMS Proposes Further Restrictions for Physician Groups Providing Diagnostic Imaging," dated August 28, 2008, available at http://www.bassberry.com.

term problem, however. In 2010, the statutory reduction will again apply, requiring an estimated 21% reduction in physician fees, unless Congress enacts further legislation.

Conclusion

If you have any questions about these the matters discussed in this *Health Law Update*, please do not hesitate to contact any of the attorneys in our Healthcare Industry Practice Group listed below.

Bass, Berry & Sims Healthcare Attorneys

H. Stanford Adams, Jr.
(615) 742-7775
sadams@bassberry.com

Kevin L. Alonso
(615) 742-7913
kalonso@bassberry.com

H. Lee Barfield, II
(615) 742-6202
lbarfield@bassberry.com

Philip F. Berg
(615) 742-7908
pberg@bassberry.com

Mary Beth Fortugno
(615) 742-7739
mfortugno@bassberry.com

Valere B. Fulwider
(615) 742-7742
vfulwider@bassberry.com

Nesrin E. Garan
(615) 742-7903
ngaran@bassberry.com

Pooneh Ghiassi
(615) 742-7782
pghiassi@bassberry.com

Anna Grizzle
(615) 742-7732
agrizzle@bassberry.com

Elisa E. Harris
(615) 742-6553
eharris@bassberry.com

Angela Humphreys
(615) 742-7852
ahumphreys@bassberry.com

Clevonne M. Jacobs
(615) 742-7769
vjacobs@bassberry.com

J. James Jenkins, Jr.
(615) 742-6236
jjenkins@bassberry.com

Seth A. Killingbeck
(615) 742-7707
skillingbeck@bassberry.com

David King
(615) 742-7890
dking@bassberry.com

Leslie Maclellan
(615) 742-7818
lmaclellan@bassberry.com

Claire F. Miley
(615) 742-7847
cmiley@bassberry.com

T. Scott Noonan, Co-Chair
(615) 742-6273
snoonan@bassberry.com

Brenda N. Phillips
(615) 742-6237
bnphillips@bassberry.com

Shannon Pinkston
(615) 742-7727
spinkston@bassberry.com

Cynthia Y. Reisz
(615) 742-6283
creisz@bassberry.com

Brian D. Roark
(615) 742-7753
broark@bassberry.com

Scott B. Shanker
(901) 543-5932
sshanker@bassberry.com

Catherine J.B. Sloan
(615) 742-7789
csloan@bassberry.com

Danielle M. Sloane
(615) 742-7763
dsloane@bassberry.com

Krista L. Thornton
(615) 742-7734
kthornton@bassberry.com

Leigh Walton, Co-Chair
(615) 742-6201
lwalton@bassberry.com

Elizabeth S. Warren
(615) 742-7719
ewarren@bassberry.com

Douglas M. Wolford
(615) 742-7917
dwolford@bassberry.com

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