# Medicare Improvements for Patients and Providers Act of 2008

## Section-by-Section Summary

## BENEFICIARY IMPROVEMENTS

### *Prevention, Marketing and Quality Improvement*

**Sec. 101. Improvements to coverage of preventive services.**
Authorizes the Secretary to cover new preventive services under the Medicare NCD process that are recommended by the U.S. Preventive Services Task Force. Makes improvements to the "Welcome to Medicare Visit," including waiving the deductible and extending coverage from 6 months to 1 year.

**Sec. 102. Elimination of discriminatory copayment rates for Medicare outpatient mental health services.**
Reduces Medicare beneficiaries' coinsurance for mental health services to the same level applied to other outpatient medical care. Phases in these decreases over a six year period.

**Sec. 103. Prohibitions and limitations on certain sales and marketing activities under Medicare Advantage and prescription drug plans.**
Prohibits certain sales activities of Medicare Advantage (MA) plans and Part D drug plans, including door-to-door sales, cold calling, free meals, and cross selling of non health-related products, effective for the 2010 plan year; requires the Secretary to limit co-branding, gifts and commissions; and requires plans to abide by state appointment laws affecting agents and brokers.

**Sec. 104. Improvements to the Medigap program.**
Directs the Secretary to implement NAIC Model Regulation #651 to eliminate certain Medigap plans made redundant by Medicare Part D; modernize benefits under current Medigap plans; and adds two new plans with new cost-sharing structures. Clarifies current law that supplemental policies for Medicare Advantage and PFFS plans sold to Medicare beneficiaries must meet the standards for Medigap.

### *Low-Income Programs*

**Sec. 111. Extension of qualifying individual (QI) program.**
Extends the QI program through December 31, 2009 and ensures funding needed to serve current populations in states.

**Sec. 112. Application of full LIS subsidy assets test under Medicare Savings Program.**
Increases the amount of allowable resources for applicants to the Medicare Savings Program to the amount specified for full subsidy low-income beneficiaries under Part D beginning January 1, 2010.

**Sec. 113. Eliminating barriers to enrollment.**
Directs the Commissioner of Social Security to provide applications for MSP and LIS to individuals applying for Medicare benefits, to provide assistance in completing such applications, and to coordinate with States.

**Sec. 114. Elimination of Medicare Part D late enrollment penalties paid by subsidy-eligible individuals.**
Codifies current guidance allowing for a special enrollment period for LIS subsidy-eligible individuals to select a Part D plan or Medicare Advantage plan that covers prescription drugs. This provision takes effect in 2009.

**Sec. 115. Eliminating application of estate recovery.**
Removes the requirement that States collect from the estates of deceased Medicaid beneficiaries the Medicare cost sharing benefits that were paid while the deceased was enrolled in the Medicare Savings Programs.

**Sec. 116. Exemptions from income and resources for determination of eligibility for low-income subsidy.**
Exempts value of life insurance policy and in kind support and maintenance (e.g., assistance provided by a family member or church) from low-income subsidy determinations.

**Sec. 117. Judicial review of decisions of the Commissioner of Social Security under the Medicare Part D low-income subsidy program.**
Codifies a beneficiary's right to federal court review of a denial for the low-income subsidy.

**Sec. 118. Translation of model form.**
Requires the Secretary to translate the application form for the Medicare Savings Program into languages most frequently used by Medicare beneficiaries.

**Sec. 119. Medicare enrollment assistance.**
Provides $25 million to State Health Insurance Assistance Programs (SHIPs) and Area Agencies on Aging to help enroll low-income seniors in assistance programs and all seniors navigate the Medicare program. Funds allocated to Area Agencies on Aging and Aging Disability Resource Centers from the Medicare, Medicaid, and SCHIP Extension Act of 2007 shall only be used for outreach to beneficiaries who may qualify for low income assistance under Part D and funds for Area Agencies on Aging also includes Native American Aging Programs.

## MEDICARE PART A PROVISIONS

**Sec. 121. Expansion and extension of the Medicare rural hospital "FLEX" program.**
Extends the FLEX program through September 30, 2010 and expands the program to provide grants to increase access to mental health services for veterans in crisis and residents of rural areas. Also, provides assistance for small rural hospitals transitioning to nursing home status.

**Sec. 122. Rebasing for sole community hospitals.**
Provides a new base year for sole community hospitals.

**Sec. 123. Demonstration project on community health integration models.**
Establishes a demonstration project to allow states to test new ways to better coordinate hospital, nursing home, home health and other critical health care services in rural areas.

**Sec. 124. Extension of the reclassification of certain hospitals.**
Extends the provisions of the Medicare Modernization Act of 2003 relating to wage index reclassifications for certain hospitals through September 30, 2009.

**Sec. 125. Revocation of unique deeming authority of the Joint Commission.**
Revokes the unique authority of the Joint Commission to deem hospitals in compliance with the Medicare Conditions of Participation.

## MEDICARE PART B PROVISIONS

### *Physicians' Services*

**Sec. 131. Physician payment, efficiency, quality incentives.**
Blocks pending cuts scheduled under the sustainable growth rate (SGR) formula through December 31, 2009; provides a 1.1% update for 2009; extends the physician quality reporting initiative (PQRI) through December 31, 2010 while increasing the PQRI bonus to 2.0% for 2009 and 2010. Makes improvements to the PQRI, including a requirement for the endorsement of measures by a consensus-based, standard setting entity and permits group practices to report, using a sampling methodology, on measures targeting high-cost, chronic conditions. Requires the Secretary to provide confidential feedback to providers regarding their resource use and to submit a plan to Congress regarding transition to a value-based purchasing program for physicians.

**Sec. 132. Incentives for electronic prescribing.**
Provides positive incentives for practitioners who use a qualified e-prescribing systems in 2009 through 2013. Requires practitioners to use qualified e-prescribing system in 2011 and beyond. Enforcement of the mandate achieved through a reduction in payments of up to 2% to providers who fail to e-prescribe. Prohibits application of financial incentives and penalties to those who write prescriptions infrequently, and permits the Secretary to establish a hardship exception to providers who are unable to use a qualified e-prescribing system.

**Sec. 133. Expanding access to primary care services.**
Increases funding and expands authority for the Medical Home Demonstration Project established in TRHCA 2006. Authorizes the Secretary to expand the duration and scope of the demonstration if certain quality and/or savings targets are achieved, and waives application of administrative obstacles to launching the demonstration. Reapplies budget neutrality adjustment for recent RVU changes to the conversion factor, rather than work RVUs, effective January 1, 2009.

**Sec. 134. Extension of floor on Medicare work GPCI.**
Extends the 1.0 floor on the work geographic practice cost index (GPCI) through December 31, 2009.

**Sec. 135. Imaging provisions.**
Requires accreditation of providers of the technical component for advanced diagnostic imaging services by an entity identified by the Secretary prior to January 1, 2012. Establishes, by January 1, 2010, a two-year, voluntary demonstration program to test the use of appropriateness criteria for advanced diagnostic imaging services. Includes a GAO study regarding assumptions about utilization and interest rates in setting payments for imaging studies removed.

**Sec. 136. Extension of treatment of certain physician pathology services.**
Extends for 18 months the provision that allows independent laboratories providing services to hospitals that utilized independent laboratories prior to the November 1999 final physician fee schedule rule to continue to bill Medicare directly for the physician pathology services they provide to hospitals.

**Sec. 137. Accommodation of physicians ordered to active duty in the armed services.**
Allows physicians in the armed services to engage in substitute billing arrangements for longer than 60 days when they are ordered to active duty.

**Sec. 138. Adjustment for Medicare mental health services.**
Restores a portion of cuts recently applied to psychotherapy and related services.

**Sec. 139. Improvements for Medicare anesthesia teaching programs.**
Reverses the CMS payment rule for teaching anesthesiologists so that they will now receive 100% of payment. Ensures equitable treatment of certified registered nurse anesthetists.

***Other Payment and Coverage Improvements***

**Sec. 141. Extension of exceptions process for therapy caps.**
Extends the exceptions process for therapy limits through December 31, 2009.

**Sec. 142. Extension of payment rule for brachytherapy and therapeutic radiopharmaceuticals.**
Extends the "charge to cost" payment methodology for certain brachytherapy and radioimmunotherapy services through December 31, 2009.

**Sec. 143. Speech-language pathology services.**
Permits speech language pathologists to bill Medicare directly for their services beginning January 1, 2009.

**Sec. 144. Coverage improvements for patients with chronic obstructive pulmonary disease and other conditions.**
Includes coverage of intensive cardiac rehabilitation programs to the Medicare program and repeals the transfer of ownership of oxygen equipment.

**Sec. 145. Clinical laboratory tests.**
Repeals the competitive bidding demonstration project for clinical laboratory services. Reduces the payment update for clinical lab services by 0.5% in each of the next 5 years.

**Sec. 146. Improved access to ambulance services.**
Reinstates the add-on payment for ground ambulance services at 3% for rural services and 2% for urban services. Provides an 18-month hold harmless for air ambulance regions recently reclassified from rural to urban and clarifies the medical review standard for air ambulance services.

**Sec. 147. Extension and expansion of the Medicare hold harmless provision under the prospective payment system for HOPD services for certain hospitals.**
Extends until December 31, 2009, provisions that ensure small rural hospitals receive payments for outpatient services that are at least 85% of what they received before the Hospital Outpatient Prospective Payment System took effect. This provision would also extend this protection to sole community hospitals under 100 beds.

**Sec. 148. Clarification of payment for clinical laboratory tests furnished by critical access hospitals.**
Allows Critical Access Hospitals serving rural areas to receive 101% of reasonable costs for clinical lab services provided to Medicare beneficiaries regardless of whether the lab specimen was taken in the hospital or off-site at another facility operated by the Critical Access Hospital.

**Sec. 149. Adding certain entities as originating sites for payment of telehealth services.**
Adds hospital-based renal dialysis facilities, skilled nursing facilities, and community mental health centers to the list of sites where Medicare beneficiaries can receive telehealth services.

**Sec. 150. MedPAC study and report on improving chronic care demonstration programs.**
Requires the Medicare Payment Advisory Commission to examine the possibility of using a standing network of providers to test innovative approaches to care coordination and other chronic care delivered to the Medicare patient population. Requires that MedPAC consider the results of the Medicare Coordinated Care Demonstration and Medicare Health Support pilot in developing the report on new approaches to chronic care demonstrations.

**Sec. 151. Increase of FQHC payment limits.**
Increases the existing per visit cap on Medicare payments to community health clinics.

**Sec. 152. Kidney disease education and awareness provisions.**
Requires the Secretary to establish pilot projects to increase awareness, screening, and surveillance systems addressing the prevalence of chronic kidney disease (CKD). These programs will serve as a model for decreasing the incidence of CKD and preventing its tragic complications, including kidney failure and other severe illnesses. Also requires coverage of kidney disease education services furnished by qualified providers that will help beneficiaries manage comorbidities, prevent additional renal complications, and understand all of their options for renal replacement therapy, including home dialysis.

**Sec. 153. Renal dialysis provisions.**
Provides a 1.0% update to the composite rate for renal dialysis services for each of 2009 and 2010. Creates a site-neutral composite rate for dialysis services.

Requires the Secretary to establish, by January 1, 2011, a fully bundled payment system for the treatment of end-stage renal disease (ESRD) and establishes a permanent market-based update to providers of renal dialysis services. Specifies the scope of items and services to be included in the bundled payment, including drugs, biologs and laboratory tests that are currently paid for separately. Requires use of case mix adjustors to payments as well as add-ons for low-volume providers. Allows adjustments based on a geographic index and for pediatric and rural providers. Establishes a four-year phase-in of the new system.

Establishes a quality incentive payment program for ESRD providers, effective January 1, 2011. Requires providers of ESRD services to meet quality metrics endorsed by a consensus-based, standard-setting body by demonstrating improvement or high levels of achievement.

**Sec. 154. Delay in and reform of Medicare DMEPOS competitive acquisition program.**
Imposes an 18-month delay to Round 1 of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Acquisition Program (CAP), with a corresponding 18-24 month delay of Round 2 and subsequent applications of the program. Also modifies and improves the CAP to ensure a fair bidding process and to protect beneficiaries. Pays for this delay with a reduction in the payment rates for items included in the CAP.

## MEDICARE PART C PROVISIONS

**Sec. 161. Phase-out of indirect medical education (IME).**
Phases out an adjustment to Medicare Advantage payment rates for indirect medical education by a maximum of .6 percentage points per year. Continues payment to teaching facilities directly for indirect medical education – which is meant to defray higher patient care cost of teaching hospitals compared to non-teaching hospitals.

**Sec. 162. Revisions to requirements for Medicare Advantage private fee-for-service plans.** Changes requirements for private fee-for-service (PFFS) plans in counties where there are two or more non-PFFS plans (either an HMO or PPO). In these counties, PFFS plans could no longer "deem" providers into the plan. Instead, beginning in 2011, they would have to form provider networks.

**Sec. 163. Quality improvement program revisions.**
Requires regional preferred provider organizations and PFFS plans to have the same quality improvement programs as local preferred provider organizations, effective January 1, 2010.

**Sec. 164. Revisions relating to specialized Medicare Advantage plans for special needs individuals.**
Extends the authority of specialized Medicare Advantage plans to target enrollment to certain populations through December 31, 2010 and revises definitions, care management requirements and quality reporting standards for all specialized plans. Maintains a moratorium on new specialized MA plans through December 31, 2010.

**Sec. 165. Limitation on out-of-pocket costs for dual eligibles and qualified Medicare beneficiaries enrolled in a specialized Medicare Advantage plan.**
Limits cost sharing for dual eligible beneficiaries enrolled in specialized Medicare Advantage plans to what they would otherwise pay under Medicaid.

**Sec. 166. Adjustment to the Medicare Advantage Stabilization Fund**
Removes $1.8 billion from the stabilization fund for regional preferred provider organizations in 2012.

**Sec. 167. Access to Medicare reasonable cost contract plans.**
Extends authority to operate section 1876 cost contracts through December 31, 2010. Modifies requirements for the application of the prohibition on cost contract plans.

**Secs. 168-169. MedPAC studies.**
Directs MedPAC to study how comparable measures of performance and patient experience can be collected and reported in the MA and FFS programs. Also directs MedPAC to study alternative payment formulas for MA plans.

## MEDICARE PART D PROVISIONS

### *Improving Pharmacy Access*

**Sec. 171. Prompt payment by prescription drug plans and MA-PD plans under Part D.**
Requires prescription drug plans to pay pharmacies within 14 days for clean claims submitted electronically, and 30 days for clean claims submitted otherwise; imposes a monetary penalty on prescription drug plans that fail to pay on time.

**Sec. 172. Submission of claims by pharmacies located in or contracting with long-term care facilities.**
Requires long term care pharmacies to have no less than 30 days and no more than 90 days to submit claims to a Medicare prescription drug plan.

**Sec. 173. Regular update of prescription drug pricing standard required.**
Requires Medicare prescription drug plans to update the drug pricing standards used for pharmacy reimbursement at least a weekly, with an initial update on January 1 each year.

***Other Provisions Related to Part D***

**Sec. 175. Inclusion of barbiturates and benzodiazepines as covered Part D drugs.**
Permits Medicare prescription drug plans to cover barbiturates (for certain conditions) and benzodiazepines beginning January 1, 2012.

**Sec. 176. Formulary requirements with respect to certain categories or classes of drugs.**
Codifies the Secretary's current guidance relating to coverage of the "protected classes" of drugs under Part D, and authorizes modifications to the protected classes through rulemaking.

## OTHER PROVISIONS

**Sec. 181. Use of Medicare Part D data.**
Clarifies the use of Part D data collected under 1860D-12 for research and other purposes. Requires the Secretary to release Part D claims data to Congressional support agencies to the extent that the agencies have authority to request the data in their respective authorizing statutes.

**Sec. 182. Revision of definition of medically accepted indication for Part D drugs.**
Clarifies process and use of compendia for Medicare Parts B and D.

**Sec. 183. Contract with a consensus-based entity regarding performance measurement.**
Provides funding for a consensus-based entity to prioritize, endorse, and maintain valid quality performance measures.

**Sec. 184. Cost-sharing for clinical trials.**
Authorizes the Secretary to develop alternative methods of payment for Medicare services provided to beneficiaries who participate in clinical trials conducted by an agency of HHS to the extent such methods are needed to mask the participants of the trial from the study treatments. This will enable Medicare beneficiaries to participate in randomized controlled trials.

**Sec. 185. Addressing health care disparities.**
Directs the Secretary to study and report to Congress on effective approaches for ongoing data collection, measurement, and evaluation of disparities in health care services and performance by race, ethnicity and gender; requires the Secretary to implement best approaches to measure health care disparities and report to Congress.

**Sec. 186. Demonstration to improve care to previously uninsured.**
Within one year after enactment, the Secretary shall establish a 2-year demonstration in 10 sites to determine the greatest needs and most effective methods of outreach to Medicare beneficiaries who were previously uninsured. 1-year after completion of the demonstration the Secretary shall submit an evaluation of the demonstration and its effect on beneficiaries' access to care, utilization of services, health-care delivery and select outcomes to Congress.

**Sec. 187. OIG report on compliance with and enforcement of national standards on culturally and linguistically appropriate services (CLAS) in Medicare.**
Directs the OIG to report, within two years, on the extent to which Medicare providers follow the rules regarding discrimination against beneficiaries with limited English proficiency and the Culturally and Linguistically Appropriate Services (CLAS) Standards, and requires the Secretary to correct and deficiencies.

**Sec. 188. Medicare improvement funding.**
Establishes a fund which the Secretary may use to make improvements to the Medicare fee-for-service program and deposits excess savings into that fund for the Secretary to use beginning in FY 2014. This section also provides $140 million to CMS for implementation of the provisions in this Act.

**Sec. 189. Inclusion of Medicare providers and suppliers in Federal Payment Levy and Administrative Offset Program.** Requires CMS to participate in the FPLP. One year after the enactment of this Act, 50% of all Medicare Part A and B payments would be processed through the FLPM. Two years after the Act's enactment, 75% of Part A and B payments would be processed through the program. CMS would be required to process all payments through the program beginning September 30, 2011.

## MEDICAID PROVISIONS

**Sec. 201. Extension of Transitional Medical Assistance (TMA) and Abstinence Education Programs.**
Extends the Transitional Medical Assistance program (TMA) and abstinence-only education program through June 30, 2009.

**Sec. 202. Medicaid DSH Extension.**
Extends through December 31, 2009 the disproportionate share hospital funding under section 1923 for Tennessee and Hawaii.

**Sec. 203. Pharmacy Reimbursement under Medicaid.**
Delays establishment of Medicaid payment limits using Average Manufacturer Price for multiple source (generic) drugs through September 30, 2009; delays publication of Average Manufacturer Price data on a public website through September 30, 2009. States may not switch to AMP-based pharmacy reimbursement prior to September 30, 2009.

**Sec. 204. Review of administrative claim determinations.**
Codifies a State's right to request a reconsideration of a disallowance of Federal financial participation or appeal disallowances or unfavorable reconsideration determinations to the Departmental Appeals Board, which issues the final administrative decision.

**Sec. 205. County medicaid health insuring organizations.**
Increases the percentage of enrollees who may enroll in a county Medicaid health insuring organization and expands the list of authorized counties.

## MISCELLANEOUS

**Sec. 301. Extension of TANF supplemental grants.**
Extends TANF supplemental grants at $319 million per year through fiscal year 2009.

**Sec. 302. Federal matching rate for foster care and adoption assistance for D.C.**
Amends Title IV-E of the Social Security Act to fix the District of Columbia's (DC) FMAP reimbursement rate at 70% for purposes of foster care maintenance and adoption assistance payments. This change would entitle DC to receive the same FMAP reimbursement rate for those payments as it currently receives for Medicaid and SCHIP. All states currently have FMAP rates that are consistent across programs as a result state FMAP rates remain unchanged by this provision.

**Sec. 303. Extension of the special diabetes programs.**
Extends the Special Diabetes Grants Programs through September 30, 2011. Provides $150 million a year for type 1 diabetes research and type 2 treatment and prevention programs for Native Americans and Alaska Natives.

**Sec. 304. IOM reports.**
Authorizes IOM studies on best practices in setting clinical decision-making protocols and on methodological standards for conducting systematic reviews of clinical effectiveness research.