New Medicare Law Enacts Changes that Affect Providers, Insurers, Pharmacies, and Beneficiaries.

On July 15, 2008 Congress voted to override President Bush's veto, thus enacting the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The new law implements several changes affecting matters ranging from patient coinsurance rates for mental health services to the reimbursement fees paid to physicians under Medicare. Below is a summary of the wide range of changes made to Medicare by MIPPA.

Coverage for "Preventive Services" Improved and Expanded:

The Secretary of Health and Human Services ("HHS") is now authorized to cover beneficiaries' costs for "additional preventive services." So long as the services are deemed to be reasonable and necessary for the prevention or early detection of an illness or disability, preventative services are now covered by Medicare. In addition, physicians can now measure a beneficiary's body mass index and discuss "end-of-life planning" with the beneficiary in an initial preventive physical examination. End-of-life planning can be either verbal or written information about what the patient wishes to happen if he or she is unable to make health care decisions and whether the physician is willing to follow the patient's wishes. The Act also waives the deductible for the "Welcome to Medicare" initial preventive examination during an individual's first year of Medicare eligibility.

Mental Health Services:

The Act harmonizes patient coinsurance rates for outpatient psychiatric services with the levels for all other outpatient medical care. Prior to MIPPA, outpatient mental health services impose a 50% coinsurance rate, as compared to 20% for most other services. MIPPA phases in a lower coinsurance rates for mental health services to provide a 20% rate by 2014.

New Limits on "Medicare Advantage" and prescription drug plans:

Certain sales and marketing activities by firms offering Medicare Advantage or Plan D prescription drug plans are now prohibited by law. Such prohibited acts include any direct, unsolicited contact with a potential enrollee, such as door-to-door or outbound telemarketing and requires limitations on commissions and gifts, effective for the 2010 plan year. Companies cannot provide meals to prospective enrollees, no matter what the value of the meal. Further, companies may not engage in "cross selling," which means the company cannot sell any non-health related products during any marketing activity or presentation conducted with respect to a Medicare Advantage Plan.

Coverage for "Qualified Individuals" Extended Through 2009:

For individuals and families who would otherwise qualify for Medicare but for the fact that their income is otherwise too high for coverage under state law, Federal law offers coverage to those individuals or families so long as their income is between 120% and 135% of the poverty line. This is known as the "Qualifying Individual" program and was scheduled to expire at the end of June of 2008. The Act extends the program until December 31, 2009.

The Commissioner of Social Security is Required to Provide Aid to Individuals Applying for Low Income Subsidies:

The Act requires the Commissioner of Social Security (the "Commissioner") to eliminate barriers to enrollment by requiring the Commissioner to provide information and applications to individuals applying for either the Low-Income Subsidy program or Medicare Savings Program. Individuals wishing to apply or otherwise identified as potentially eligible under those programs must be assisted with the application process.

States can no longer go after the Estates of Deceased Beneficiaries:

MIPPA removes the requirement that States collect from the estates of deceased former Medicaid beneficiaries the Medicare cost sharing benefits that were paid while the deceased was enrolled in the Medicare Savings Programs.

Pending Cuts in Physician Fees are Blocked:

Former law required a 10.6% cut in physician fees under a "Sustainable Growth Program." One of MiPad's primary goals was to block the scheduled reduction in physician fees. Congress feared that such a drastic cut would lead to an exodus of physicians from the Medicare program. The Act further requires the secretary to submit a plan to Congress for transition to a "value-based" purchasing program for physicians other providers.

New Incentives for Electronic Prescriptions; Future holds Penalties:

The Act provides incentives for physicians to adopt technology that will allow them to prescribe medication to their patients electronically. To qualify for the incentive, the provider must be a "successful electronic prescriber." A successful electronic provider is one who either reports at least 50% of any electronic prescribing quality measures if such a measure is in place *or*, if the Secretary elects, submitted a sufficient number of electronic prescriptions under part D during the applicable period. In 2009 and 2010, providers who qualify for the incentive will receive a 2.0% bonus on top of all the charges allowed for furnished services. That incentive decreases to 1.0% in 2011 and 2012, and 0.5% in 2013. However, beginning in 2011, providers are required to use electronic prescriptions. Failure to "e-prescribe" will result in a 1% cut in payments in 2012, 1.5% in 2013, and 2.0% for 2014 and all subsequent years.

Accreditation Now Required for Certain Imaging Services:

MIPPA requires a supplier of the "technical component of advanced diagnostic imaging services" to be accredited in order to be eligible for payment by Medicare. This includes MRIs, computed tomography and nuclear medicine such as positron emission tomography.

Pharmacists *must* be paid within 14 days of Submitting Electronic Claims:

Prescription drug plans must remit payment to pharmacies submitting "clean claims" within 14 days, if the claim is submitted electronically, and 30 days for claims submitted otherwise. The Act prescribes the procedure prescription drug plans must implement if they determine a claim is not "clean," meaning a claim with no defect, impropriety, or circumstance preventing timely payment). If the prescription drug plan fails to notify the claimant that it has deemed the claim "not clean" within ten days of receipt of electronic claims or within 15 days of

receipt of all other types of claims, the drug plan cannot subsequently deny payment based on any defect of the claim.

Pharmacies contracting with long-term care facilities are given a statutory window for submitting claims to Medicare. The pharmacies must have “no less than 30 days but no more than 90 days” to submit their claim for re-imbursement.

New Drug Coverage:

Beginning January 1, 2012, Medicare Part D drug coverage is expanded to include coverage for barbiturates if the barbiturates are used to treat epilepsy, cancer, or a chronic mental health disorder. This means that popular anti-depressants will now be covered by Medicare Part D prescription drug plans.

Raises the Allowed Asset Levels in the Medicare Savings Program:

Current law limits the asset level allowed in the Medicare Savings Program held by beneficiaries to $4,000 for individuals and $6,000 for couples. These limits have not been changed since 1989. The MIPPA, however, raises these asset levels to $6,000 for individuals and $9,000 for couples in 2008.

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