

## Chapter 2 - Medicare

### *Legislative History*

This section summarizes major Medicare legislation enacted into law, beginning in 1997. Previous editions of the Green Book review legislation enacted prior to that date. The summary highlights major provisions; it is not a comprehensive list of all Medicare amendments. Included are provisions which had a significant budget impact, changed program benefits, modified beneficiary cost sharing, or involved major program reforms. Provisions involving policy changes are mentioned the first time they are incorporated in legislation, but not necessarily every time a modification is made. The descriptions include either the initial effective date of the provision or, in the case of budget savings provisions, the fiscal years for which cuts were specified.

- Balanced Budget Act (BBA) of 1997 (P.L.105-33)**
- Balanced Budget Refinement Act (BBRA) of 1999 (P. L. 106-113)**
- Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (P.L. 106-554)**
- Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 (P.L. 108-173)**
- Deficit Reduction Act (DRA) of 2005 (P.L. 109-171)**
- Tax Relief and HealthCare Act (TRHCA) of 2006 (P.L. 109-432)**
- Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 (P.L. 110-173)**
- Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (P.L. 110-275)**
- American Recovery and Reinvestment Act (ARRA) of 2009 (P.L. 111-5)**
- Patient Protection and Affordable Care Act (PPACA) of 2010 (P.L. 111-148) as amended by the Health Care and Education Affordability Reconciliation Act (HCERA) of 2010 (P.L. 111-152)**
- Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309)**

BALANCED BUDGET ACT (BBA) OF 1997 (P.L. 105-33)

#### *Hospitals*

Froze payments to PPS hospitals<sup>1</sup> and PPS-exempt hospitals and units for fiscal year 1998 and limited updates for fiscal years 1999-2002. Established a PPS for inpatient rehabilitation hospitals, effective beginning in fiscal year 2001. Rebased capital payment rates and provided for additional reductions over the fiscal year 1997-2002 period. Reduced the indirect medical education payment from 7.7 percent to 5.5 percent by fiscal year 2001 and reformed direct graduate medical education payments (generally effective

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<sup>1</sup> Medicare pays most acute care hospitals under a prospective payment system (PPS). A fixed predetermined amount is paid according to the patient's diagnosis. Payments to PPS hospitals are updated annually using an update factor which is determined in part by the projected increase in the hospital market basket index (MBI) which measures the cost of goods and services purchased by hospitals.

on enactment or October 1, 1997).

#### *Skilled Nursing Facilities*

Provided for a phase in of a PPS that will pay a Federal per-diem rate for covered SNF services (generally effective July 1, 1998).

#### *Home Health*

Provided for the establishment of a PPS for home health services. Provided for a reduction in per-visit cost limits prior to the implementation of the PPS, clarified the definitions of part-time and intermittent care, and provided for a study of the definition of homebound. Provided for the transfer of some home health costs from Part A to Part B (prospective payment effective October 1, 1999, reduction in cost limits effective on enactment, definition clarification effective October 1, 1997, and transfer of costs effective January 1, 1998).

#### *Hospice*

Reduced the hospice payment update for each of fiscal years 1998-2002, and clarified the definition of hospice care (generally effective on enactment).

#### *Physicians*

Provided for use of a single conversion factor; replaced the volume performance standard with the sustainable growth rate; provided for phased-in implementation of resource-based practice expenses; and permitted use of private contracts under specified conditions (generally effective January 1, 1998).

#### *Hospital Outpatient Departments*

Extended reductions in payments for outpatient hospital services paid on the basis of costs through December 1999 and established a PPS for hospital outpatient departments (OPDs) for covered services beginning in 1999 (generally effective on enactment).

#### *Laboratory Services*

Froze payments for laboratory services for fiscal years 1998-2002.

#### *Ambulance Services*

Provided for establishment of a fee schedule in 2000 for payment for ambulance services (generally effective on enactment).

#### *Preventive Services*

Authorized coverage for annual mammograms for all women over 40. Added coverage for screening pelvic exams, prostate cancer screening tests, colorectal cancer screening tests, diabetes self-management training services, and bone mass measurements for certain high-risk persons (generally effective in 1998, except prostate cancer screening effective 2000).

#### *Beneficiary Premiums*

Permanently set the Part B premium at 25 percent of program costs and expanded the

premium assistance beginning in 1998 available under the Specified Low-Income Medicare Beneficiary (SLMB) Program (effective on enactment).

*Supplementary Coverage*

Provided for guaranteed issuance of specified Medigap policies without a preexisting condition exclusion for certain continuously enrolled aged individuals (effective July 1, 1998).

*Competitive Bidding*

Provided for competitive bidding demonstrations for furnishing Part B services (not including physicians services) (effective on enactment).

*Commissions*

Established a 17-member National Advisory Commission on the Future of Medicare (with appointments to be made by December 1, 1997). Established the Medicare Payment Advisory Commission replacing the Prospective Payment Assessment Commission and the Physician Payment Review Commission (with appointments to be made by September 30, 1997).

*Medicare+Choice*

Established a new part C of Medicare called Medicare+Choice (M+C). Built on the existing Medicare Risk Contract Program which enabled beneficiaries to enroll, where available, in health maintenance organizations (HMOs) that contracted with the Medicare Program. Expanded, beginning in 1999, the private plan options that could contract with Medicare to other types of managed care organizations (for example, preferred provider organizations and provider-sponsored organizations), private fee-for-service plans, and, on a limited demonstration basis, high deductible plans (called medical savings account plans) offered in conjunction with medical savings accounts (effective on enactment).

**BALANCED BUDGET REFINEMENT ACT (BBRA) OF 1999 (INCORPORATED IN CONSOLIDATED APPROPRIATIONS ACT OF 1999, P.L.106-113)**

*IPPS Hospitals*

Froze the indirect medical education adjustment at 6.5 percent through fiscal year 2000, reduced the adjustment to 6.25 percent in fiscal year 2001 and to 5.5 percent in fiscal year 2002 and subsequent years. Froze the reduction in the DSH adjustment to 3 percent in fiscal year 2001; changed the reduction to 4 percent in fiscal year 2002. Changed the methodology for Medicare's direct graduate medical education payments to teaching hospitals to incorporate a national average amount calculated using fiscal year 1997 hospital-specific per-resident amounts. Increased the number of years that would count as an initial period for child neurology residency training programs. Provided for the reclassification of certain counties and areas for the purposes of Medicare reimbursement.

*PPS-Exempt Hospitals*

Adjusted the labor-related portion of the 75-percent cap to reflect the wage differences in

the hospital's area relative to the national average. Increased the amount of continuous bonus payments to eligible long-term care and psychiatric providers from 1 percent to 1.5 percent for cost reporting periods beginning on or after October 1, 2000 and before September 30, 2001 and to 2 percent for cost reporting periods beginning on or after October 1, 2001 and before September 30, 2002. Required the Secretary to report on a discharge-based PPS for long-term care hospitals which would be implemented in a budget neutral fashion for cost reporting periods beginning on or after October 1, 2002. Required the Secretary to report on a per-diem-based PPS for psychiatric hospitals which would be implemented in a budget neutral fashion for cost reporting periods beginning on or after October 1, 2002. Required the Secretary to base the PPS for inpatient rehabilitation hospitals on discharges and incorporate functional related groups as the basis for payment adjustments.

#### *Rural Hospitals*

Permitted reclassification of certain urban hospitals as rural hospitals. Updated existing criteria used to designate outlying rural counties as part of metropolitan statistical areas for the purposes of Medicare's hospital IPPS. Changed certain requirements pertaining to Medicare's Critical Access Hospital Program. Extended the Medicare dependent hospital classification through fiscal year 2006. Permitted certain sole community hospitals to receive Medicare payments based on their hospital specific fiscal year 1996 costs. Increased the target amount for sole community hospitals by the full market basket amount for discharges occurring in fiscal year 2001.

#### *Skilled Nursing Facilities (SNFs)*

Increased per-diem payments by 20 percent for 15 resource utilization groups (RUGs) under the PPS from April 1, 2000, until such time as the Secretary of HHS implements refinements to the RUGs. SNFs were permitted to elect to be paid under the full Federal PPS rate for SNFs (rather than go through the transitions period). Provided a temporary 4 percent increase in the Federal per-diem rate for SNF services for FY 2001 and FY 2002. The increase could not be considered in the base amount used to compute subsequent updates to the Federal per-diem rate. Expanded the list of services excluded from SNF PPS to include certain chemotherapy items and administration services, certain radioisotope services, certain prosthetic devices, and ambulance services furnished in conjunction with renal dialysis treatments, beginning in FY 2001. Any increase in total payments resulting from these exclusions are required to be budget neutral. Allowed SNFs with a 60 percent immunocompromised patient population to be paid temporarily a 50/50 blend of their facility-specific and Federal rates beginning with the first cost reporting period beginning after enactment of BBRA and ending on September 30, 2001.

#### *Home Health*

Delayed the 15-percent reduction in home health payments until 12 months after implementation of the PPS and, within 6 months of implementation, required the Secretary to assess the need for any reductions. Increased per-beneficiary limits by 2 percent for agencies whose per-beneficiary limit was below the national median; excluded durable medical equipment (DME) from consolidated billing, and provided agencies an additional \$10 per beneficiary to offset costs for collecting outcome and

assessment information set (OASIS) data.

### *Hospice*

Increased payment rates otherwise in effect under the hospice PPS for fiscal year 2001 by 0.5 percent and for fiscal year 2002 by 0.75 percent, provided that these increases are not to be included in the base on which subsequent increases will be computed.

### *Hospital Outpatient Departments*

Made seven major changes to Medicare payments under the HOPD OPDS: (1) required the Secretary of the U.S. Department of Health and Human Services (DHHS) to provide payments (within specified limits, and on a budget neutral basis) over and above PPS payments for certain high cost ("outlier") patients; (2) as a transition to the PPS, for 2-3 years, on a budget neutral basis, required the Secretary of DHHS to provide "passthrough payments" to hospital OPDs above and beyond PPS payments for costs of certain "current innovative" and "new, high cost" devices, drugs, and biologicals; (3) limited the cost range of items or services that are included in any one PPS category and required the Secretary to review the PPS groups and amounts annually and to update them as necessary; (4) as a transition to the PPS, through 2003, limited the reduction in Medicare payments due to the PPS; (5) provided special payments until 2004 for small, rural hospitals to ensure that they receive no less under the outpatient PPS than they would have received under the prior system and provided the same protection permanently for cancer hospitals; (6) limited beneficiary copayments for outpatient care to no more than the amount of the beneficiary deductible for inpatient care; and (7) required that the pre-PPS payment base used as the budget neutrality benchmark for the PPS include beneficiary coinsurance amounts as paid under the pre-PPS system (i.e., 20 percent of hospital charges).

### *Physicians*

Made technical changes to limit oscillations in the annual update to the conversion factor beginning in 2001 and provided that the sustainable growth rate is calculated on a calendar year basis. Required the Secretary, in determining practice expense relative values, to establish by regulation a process under which the Secretary would accept for use and would use, to the maximum extent practicable and consistent with sound data practices, data collected by outside organizations and entities.

### *Therapy Services*

Suspended for 2 years (2001 and 2002) application of the caps on physical therapy and occupational therapy services.

### *Immunosuppressive Drugs*

Extended the 36-month limit on coverage of immunosuppressive drugs for persons exhausting their coverage in 2000-2004. Set the increase for persons exhausting benefits in 2000 at 8 months, and limited total expenditures to \$150 million over the 5 years.

### *Medicare+Choice*

Contained several provisions designed to facilitate the implementation of M+C. Changed

the phase in of the new risk adjustment payment methodology based on health status to a blend of 10 percent new health status method/90 percent old demographic method in 2000 and 2001, and not more than 20 percent health status in 2002. Provided for payment of a new entry bonus of 5 percent of the monthly M+C payment rate in the first 12 months and 3 percent in the subsequent 12 months to organizations that offer a plan in a payment area without an M+C plan since 1997, or in an area where all organizations announced withdrawal as of January 1, 2000. Reduced the exclusion period from 5 years to 2 years for organizations seeking to reenter the M+C Program after withdrawing. Allowed organizations to vary premiums, benefits, and cost sharing across individuals enrolled in the plan so long as these are uniform within segments comprising one or more M+C payment areas. Provided for submission of adjusted community rates by July 1 instead of May 1. Provided that the aggregate amount of user fees collected would be based on the number of M+C beneficiaries in plans compared to the total number of beneficiaries. Delayed implementation of the Medicare+Choice Competitive Bidding Demonstration Project.

MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT  
AND PROTECTION ACT (BIPA) OF 2000 (INCORPORATED IN THE  
CONSOLIDATED APPROPRIATIONS ACT OF 2001  
PUBLIC LAW 106-554)

*IPPS Hospitals*

Provided the full market basket update to all hospitals for FY2001. Established that all hospitals are eligible to receive Disproportionate Share Hospital (DSH) payments when their DSH percentage (threshold amount) exceeds 15 percent. Decreased the scheduled reduction in IPPS hospitals= DSH payments. Established that the cost of new medical technologies should be recognized with a budget neutral payment adjustment in IPPS by October 1, 2001. Established that starting for FY2001 Medicare Geographic Classification Review Board (MGCRB) decisions, the reclassification of an IPPS hospital for use of a different area=s wage index is effective for 3 fiscal years. Modified teaching hospitals= indirect medical education (IME) percentage adjustment. Established that a teaching hospital=s approved per resident amount for cost reporting periods beginning during FY2002 is not less than 85 percent of the locality adjusted national average per resident amount. Changed a hospital=s payment of the direct costs of approved nursing and allied health payments to incorporate Medicare managed care enrollees.

*IPPS Exempt Hospitals*

Established that total payments for inpatient rehabilitation facility (IRF) services in FY2002 would equal the amounts of payments that would have been made if the IRF prospective payment system (PPS) had not been enacted. Permitted an IRF to make a one-time election during the transition period to be paid based on a fully phased-in IRF-PPS rate. Increased the incentive payments for psychiatric hospitals and distinct part units to 3 percent for cost reporting periods beginning on or after October 1, 2000. Increased the national cap for long-term care hospitals by 2 percent and the target amount by 25 percent for cost reporting periods beginning during FY2001. Required the

Secretary to examine the feasibility and impact of basing payment on the existing (or refined) acute hospital diagnosis resource groups (DRGs) and using the most recently available hospital discharge data when developing the PPS for long-term care hospitals.

#### *Rural Providers*

Modified the critical access hospital (CAH) program: (1) eliminated liability of Medicare beneficiaries for coinsurance, deductible, copayment, or other cost sharing amount with respect to clinical diagnostic laboratory services furnished as an outpatient CAH service; (2) permitted CAHs to elect outpatient payments based on reasonable costs plus an amount based on 115 percent of Medicare's fee schedule for professional services; (3) exempted swing beds in CAHs from the SNF prospective payment system; (4) provided for payment to CAHs for the compensation and related costs for on-call emergency room physicians who are not present on the premises, are not otherwise furnishing services, and are not on-call at any other provider or facility; and (5) specified that ambulance services provided by a CAH (or provided by an entity that is owned or operated by a CAH) are paid on a reasonable cost basis if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of the CAH.

Modified the Medicare dependent hospital (MDH) classification so that an otherwise qualifying small rural hospital may be classified as an MDH if at least 60 percent of its days or discharges during a cost reporting period were attributable to Medicare Part A beneficiaries in at least two of the three most recent audited cost reporting periods. Permitted sole community hospitals to elect payment based on hospital specific, updated FY1996 costs if this target amount resulted in higher Medicare payments. Increased payments to providers of ground ambulance services for trips originating in rural areas that are greater than 17 miles and up to 50 miles. Provided permanent authority to physician assistants who owned rural health clinics which lost their designation as such to bill Medicare directly. Revised Medicare reimbursement for telehealth services. Exempted rural health clinics operated by hospitals with less than 50 beds from the per-visit payment method.

#### *Skilled Nursing Facilities*

Provided higher payments to SNFs by increasing the update to the full market basket for FY 2001 and the market basket minus 0.5 percentage point for FY 2002 and FY 2003. The nursing component of the federal rate was temporarily increased by 16.66 percent beginning April 1, 2000 through October 1, 2002. BIPA also corrected a payment anomaly created by BBRA by temporarily increasing all the rehabilitation RUGs by 6.7 percent (rather than the 20 percent for 3 specific rehabilitation RUGs). BIPA also limited application of the consolidated billing requirement to Part A-covered stays and to therapy services furnished during Part A and Part B-covered stays. Permitted the Secretary to establish a procedure for geographic reclassification for SNFs under PPS. The provision required the Secretary to collect the data necessary to establish a wage index for SNFs prior to establishing a geographic reclassification process. Required reports on different systems for categorizing patients in SNFs in a manner that accounts for the relative resource utilization of different patient types (by the Secretary); on the adequacy of Medicare payments to SNFs (by the GAO); and on nurse staffing ratios and the impact of

the 16.66 percent increase in the nursing component payment rate (by the GAO).

### *Home Health*

Delayed the effective date of the 15 percent reduction on payment limits for home health services an additional year after the implementation of PPS. Also provided the Secretary the authority to adjust for case mix changes that are not the result of real case mix changes. Provided home health agencies with the full market basket update for FY 2001. Provided a temporary 10 percent increase in payment for home health services furnished in a rural area from April 1, 2001 until March 31, 2003. Provided a two-month periodic interim payment after PPS began and subject to repayment with the settlement of the last cost report filed before PPS. Clarified that home health agencies are not prevented from using telehealth services if the services do not substitute for in-person home health services ordered under a plan of care and are not considered a home health visit for eligibility or payment purposes. Prohibited the Secretary from using solely time or distance in determining branch office status and permitted the Secretary to include forms of technology in determining what constitutes supervision for purposes of determining branch office status. Clarified the definition of homebound to permit beneficiaries who require home health services to attend adult day care for therapeutic, psychosocial, or medical treatment and remain eligible for the home health benefit. Also clarifies that any absence for the purpose of attending a religious services is considered infrequent or of short duration.

### *Hospices*

Increased the hospice update by 5.0 percentage points in FY 2001 and required the Secretary to use 1.0043 as the Wichita, Kansas hospice wage index for FY 2000. Clarified that certification of an individual=s terminal illness must be based on the physician=s or the medical director=s clinical judgment regarding the normal course of the individual=s illness. Also required the Secretary to study and report on the appropriateness of the certification process regarding terminal illness and any recommendations for legislation by two years after enactment.

### *Hospital Outpatient Departments*

Limited the amount of a beneficiary=s copayment for a procedure in a hospital outpatient department (OPD) to the hospital inpatient deductible applicable in that year, effective April 1, 2001. Reduced the effective copayment rate for outpatient services to a maximum rate of 57 percent and then gradually reduced the effective coinsurance rate in 5 percentage point intervals from 2002 through 2006 until the maximum rate is 40 percent in 2006, starting in April 2001. Increased the 2001 update to the full rate of increase in the market basket index. Increased the 2001 outpatient PPS payment rates. Authorized the Secretary to adjust the conversion factor in later years to eliminate the effect of coding or classification changes. Modified the procedures and standards by which certain medical devices are categorized and determined eligible for pass-through payments under the PPS. Permitted all qualifying hospitals to be eligible for transitional payments under OPDS. Established that existing provider-based status designations continue for 2 years beginning October 1, 2000. Established that children=s hospitals would not receive lower Medicare payments under the outpatient PPS system than they

would have received under the prior payment system.

#### *Ambulatory Surgical Centers*

Delayed implementation of proposed regulatory changes to the ambulatory payment classification system, which are based on 1994 cost data, until January 1, 2002.

Established that these changes would be phased in over 4 years. Required that the revised payment system, based on 1999 (or later) cost data, be implemented January 1, 2003. Established that the phase-in of the revised system and 1994 data ends when the system with 1999 or later data is implemented.

#### *Laboratory Services*

Permitted certain independent laboratories to continue to bill Medicare directly for the technical component of pathology services provided to hospital inpatients and hospital outpatients under a grandfather arrangement for a 2-year period (2001-2002).

#### *Preventive Services*

Made the following changes to coverage of preventive services: 1) modified existing law to provide Medicare coverage for biennial screening Pap smears and pelvic exams; 2) added Medicare coverage for annual glaucoma screenings for persons determined to be at high risk for glaucoma, individuals with a family history of glaucoma, and individuals with diabetes; 3) authorized coverage for screening colonoscopies for all individuals, not just those at high risk; 4) specified that screening mammographies are paid under the physician fee schedule; and 5) authorized coverage for medical nutrition therapy services for beneficiaries who have diabetes or renal disease.

#### *Immunosuppressive Drugs*

Eliminated the time limitations of the coverage of immunosuppressive drugs for beneficiaries who have received a transplant paid for by Medicare.

#### *Ambulance Services*

Provided for the full inflation update in 2001. Increased payments (from July 1, 2001 - December 31, 2003) for ground ambulance trips originating in rural areas that are greater than 17 miles and up to 50 miles.

#### *Therapy Services*

Extended the moratorium on physical therapy and occupational therapy caps for an additional year through 2002.

#### *Dialysis Services*

Increased the composite rate payment for renal dialysis by 2.4 percent for 2001. The Secretary was required to collect data and develop an end-stage renal disease (ESRD) market basket whereby the Secretary could estimate, before the beginning of each year, the percentage increase in costs for the mix of labor and non-labor goods and services included in the composite rate. The Secretary was required to report to Congress on the index together with recommendations on the appropriateness of an annual or periodic update.

### *Durable Medical Equipment and Prosthetics and Orthotics*

Provided full CPI-U update for DME and PO for 2001, but maintained for 2002 the 0 percent update for DME and 1 percent update for PO. Provided coverage for certain prosthetics and custom-fabricated orthotics. Provided coverage for replacement of certain artificial limbs and replacement parts for such limbs.

### *Persons with Amyotrophic Lateral Sclerosis*

Waived the 24-month waiting period for Medicare coverage (otherwise applicable for disabled persons) for persons with amyotrophic lateral sclerosis (ALS).

### *Medicare Coverage Process*

Clarified when and under what circumstances Medicare coverage policy could be challenged. An aggrieved party could file a complaint concerning a national coverage decision which would be reviewed by the Department Appeals Board (DAB) of HHS. An aggrieved party could also file a complaint concerning a local coverage determination. In this case, the determination would first be reviewed by an administrative law judge. If unsatisfied, complainants could subsequently seek review of such local policy by the DAB. In both cases, a DAB decision would constitute final HHS action and be subject to judicial review. An affected party would be permitted to submit a request to the Secretary to issue a national coverage or non-coverage determination.

### *Medicare+Choice*

Established multiple floor rates, based on population and location. Applied a 3 percent minimum update in 2001 and returned to the current law minimum update of 2 percent thereafter. Increased the M+C payment rates for enrollees with ESRD to reflect the demonstration rate of social health maintenance organizations' ESRD capitation demonstrations. Extended the current risk adjustment methodology until 2003 and beginning in 2004, begin to phase in a new risk adjustment methodology based on data from inpatient hospitals and ambulatory settings. Permitted M+C plans to offer reduced Medicare Part B premiums to their enrollees as part of providing any required additional benefits or reduced cost-sharing. Extended the application of the new entry bonus for M+C plans to include areas for which notification had been provided, as of October 3, 2000, that no plans were available January 1, 2001. Required payment adjustments to M+C plans if a legislative change resulted in significant increased costs. Precluded the Secretary from implementing, other than at the beginning of a calendar year, regulations that impose new, significant regulatory requirements on M+C organizations. Required the Secretary to make decisions, within 10 days, approving or modifying marketing material used by M+C organizations, provided that the organization used model language specified by the Secretary. Allowed an M+C organization offering a plan in an area with more than one local coverage policy to use the local coverage policy for the part of the area that was most beneficial to M+C enrollees (as identified by the Secretary) for all M+C enrollees enrolled in the plan. Expanded the M+C quality assurance programs for M+C plans to include a separate focus on racial and ethnic minorities. Allowed the Secretary to waive or modify requirements that hinder the design of, offering of, or enrollment in certain M+C plans, such as M+C plans under contract between M+C

organizations and employers, labor organizations, or trustees of a fund established by employers and/or labor organizations. Extended the period for Medigap enrollment for certain M+C enrollees affected by termination of coverage. Allowed individuals who enroll in an M+C plan after the 10th day of the month to receive coverage beginning on the first day of the next calendar month. Permitted ESRD beneficiaries to enroll in another M+C plan if they lost coverage when their plan terminated its contract or reduced its service area. Required an M+C plan to cover post-hospitalization skilled nursing care through an enrollee's "home skilled nursing facility" in certain situations. Mandated review of Adjusted Community Rate (ACR) submissions by the HCFA Chief Actuary.

## MEDICARE PRESCRIPTION DRUG IMPROVEMENT AND MODERNIZATION ACT (MMA) OF 2003 (P.L. 108-173)

### *Outpatient Prescription Drug Benefit (Part D)*

Established a new optional Medicare prescription drug benefit program (Medicare Part D) effective January 1, 2006. Created within the Federal Supplementary Medical Insurance Trust Fund the Medicare Prescription Drug Account for payments for low-income subsidy payments, subsidy payments, payments to qualified retiree prescription drug plans, and administrative expenses. Required States to make payments to the Account for dual eligibles as provided for under Medicaid.

Directed the Secretary to ensure that each part D eligible individual has available a choice of enrollment in at least two qualifying plans in the area in which the individual resides, at least one of which is a prescription drug plan. Provided that in such case in which such plans are not available the part D eligible individual should be given the opportunity to enroll in a fallback prescription drug plan.

Divided qualified prescription drug coverage into either a standard coverage benefit package or an alternative prescription drug coverage with at least actuarially equivalent benefits. Outlined the standard coverage package, which included, for 2006, a \$250 deductible, 25% cost-sharing for drug costs between \$250 and the initial coverage limit of \$2,250, then no coverage; except that the beneficiary shall have access to negotiated prices, until incurring out-of-pocket costs for covered drugs in a year equal \$3,600, with the beneficiary thereafter to pay 5% of the cost of a prescription, or a copayment of \$2 for a generic drug and \$5 for any other drug, whichever is greater. Included as negotiated prices all discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations. Increases these amounts in future years by the annual percentage increase in average per capita aggregate expenditures for covered drugs for the year ending the previous July. Includes among the out-of-pocket costs counting toward the annual \$3,600 limit any costs paid by the part D eligible individual (or by another person such as a family member) under the Medicaid program or under a State pharmaceutical assistance program for which the individual (or other person) is not reimbursed. Provided for premium and cost-sharing subsidies for low-income subsidy-eligible individuals.

Established organizational requirements for prescription drug plan (PDP) sponsors, such as licenses, and required that they enter into a contract with the Secretary to be eligible to receive payments. Provided: (1) for the establishment of risk corridors for each PDP that determines the amount of risk that the PDP shall be exposed to for drug spending, and the resultant adjustment in payment attributable to this risk; and (2) that a PDP sponsor and Medicare Advantage (MA, formerly Medicare+Choice) organization that offers a plan that provides supplemental prescription drug benefits shall be at full financial risk for the provision of such supplemental benefits.

Required PDP sponsors to submit to the Secretary bid and other described information with respect to each drug plan it offers for review by the Secretary for the purpose of conducting negotiations concerning the terms and conditions of the proposed bid submitted and other terms in order for the Secretary to approve or disapprove the plan. In order to promote competition under new Medicare Part D and in carrying out such part, the Secretary may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors and may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs. Authorized the Secretary to make grants to physicians for the purpose of assisting them to implement electronic prescription drug programs that comply with appropriate standards.

Provided that until the permanent prescription drug benefit program became effective, the Secretary was to establish a program to endorse prescription drug discount card programs in order to provide access to prescription drug discounts through prescription drug card sponsors for discount card eligible individuals. Prohibited, effective January 1, 2006, the selling, issuance, or renewal of Medigap Rx policies for part D enrollees, but permitted the renewal of a Medigap Rx policy that was issued before January 1, 2006. Guaranteed issuance of a substitute Medigap policy for persons, enrolling in part D during the initial part D enrollment period, who at the time of such enrollment were enrolled in and terminated enrollment in a Medigap policy H, I, or J or a pre-standard policy that included drug coverage.

#### *Medicare Advantage*

Replaced the Medicare+Choice program with the Medicare Advantage (MA) program. Revised the payment system, requiring all plans to be paid at a rate at least as high as the rate for traditional Medicare fee-for-service plans. Increased minimum percentage increase to national growth rate. Directed the Secretary to establish regional plans to encourage private plans to serve Medicare beneficiaries in 10 to 50 regions, including in rural areas, within the 50 States and the District of Columbia beginning not later than January 1, 2005. Included risk corridors for plans during the first two years of the program in 2006 and 2007; a stabilization fund to encourage plan entry and limit plan withdrawals; a blended benchmark that would allow plan bids to influence the benchmark amount; and network adequacy stabilization payments to assist plans in forming adequate networks, particularly in rural areas. Allowed specialized MA plans for individuals with special needs.

Provided that beginning in 2006, each MA organization is to submit to the Secretary for

each MA plan for the service area in which it intends to be offered in the following year the monthly aggregate bid amount for the provision of all items and services under the plan for the type of plan and year involved. Required this monthly bid amount to be compared against respective benchmark amounts for MA local and MA regional plans, with plans that submit bids below the benchmark to be paid their bids, plus 75% of the difference between the benchmark (and the bid to be returned to beneficiaries in the form of additional benefits or reduced premiums). Provided that for plans that bid above the benchmark the government will pay the benchmark amount, and the beneficiary will pay the difference between the benchmark and the bid amount as a premium.

Established that the MA program is a Federal program operated under Federal rules. Provided that State laws do not apply except state licensing laws or State laws relating to plan solvency. Made the Medicare Medical Savings Account (MSA) demonstration program a permanent program option and eliminated the capacity limit and the deadline for enrollment. Allowed a reasonable cost reimbursement contract to operate indefinitely unless two other plans of the same type enter the cost contract's service area. Directed the Secretary to establish a program for the application of comparative cost adjustment in CCA areas, to begin January 1, 2010, and last six years, and to test whether direct competition between private plans and the original Medicare fee-for-service program would enhance competition in Medicare.

#### *Inpatient Hospital Services*

Generally, Medicare payments to hospitals were increased. Acute-care hospitals paid under the inpatient prospective payment system (IPPS) that submit data on specified quality indicators were to receive a full update from 2005 through 2007; those hospitals that did not submit such data were to receive an update minus 0.4 percentage points for the year in question. Teaching hospitals received an increase in their indirect medical education payments from 2004 through 2006. A one-time, geographic reclassification process to increase hospitals' wage index values for three years was established. Low volume hospitals with fewer than 800 discharges that are 25 road miles away from a similar hospital could qualify for up to a 25% increase in its Medicare payments. Redistributed unused resident positions in both direct and indirect graduate medical education. Certain teaching hospitals with high per resident payments would not receive a payment increase from FY2004 through FY2013. For 18 months from the date of enactment, physicians were not to refer Medicare patients to specialty hospitals in which they had an investment interest. This provision did not apply to hospitals that were in operation or under development before November 18, 2003.

Provided that hospitals in Puerto Rico would receive Medicare payments based on a 50-50 split between Federal and local amounts before April 1, 2004. From April 1, 2004 through September 30, 2004, payment would be based on a 62.5 percent Federal amount and a 37.5 percent local amount, and starting October 1, 2004, payment would be based on a 75 percent Federal amount and a 25 percent local amount.

#### *Rural Hospitals*

Rural hospitals (and hospitals in small urban areas) received an permanent 1.6% increase

to Medicare's base rate or per discharge payment; the limit on rural and small urban hospitals that qualify for disproportionate share hospital (DSH) payments increased from 5.25% to 12%; hospitals in low wage areas (those with wage index values below 1) received additional payments through a decrease from 71% to 62% in the labor-related portion of the base payment rate; certain small rural hospitals with less than 50 beds (those in newly established scarcity areas) received cost reimbursement for outpatient clinical laboratory tests; rural hospitals with less than 100 beds were protected from payment declines associated with the hospital outpatient prospective payment system (OPPS) for an additional two years; these OPPS hold harmless provisions were extended to sole community hospitals for services from 2004 through 2006. Amended the Balanced Budget Act of 1997 to extend the telemedicine demonstration project by 4 years and to increase total funding for the project. Directed the Secretary to establish a demonstration program to test the feasibility and advisability of the establishment of rural community hospitals to furnish covered inpatient hospital services to Medicare beneficiaries.

#### *Critical Access Hospital (CAH)*

Changed reimbursement to inpatient, outpatient, and covered skilled nursing facility services provided by a critical access hospital (CAH) to 101 percent of reasonable costs of services furnished to Medicare beneficiaries. Allowed a CAH to operate up to 25 beds while deleting the requirement that only 15 of the 25 beds be used for acute care at any time. Permitted a CAH to establish a distinct part psychiatric or rehabilitation unit that met the applicable requirements that would otherwise apply to the distinct part if the distinct part were established by a "subsection (d) hospital." Limited the total number of beds that may be established for a distinct part unit to no more than ten. Allowed certain mileage standards to be waived in the case of a facility that was designated as a CAH before January 1, 2006 and was certified by the State as being a necessary provider of health care services.

#### *Home Health*

Increased home health agency payments by the full market basket percentage for the last quarter of 2003 and for the first quarter of 2004. Provided that the update for the remainder of 2004 and for 2005 and 2006 is to be the home health market basket percentage increase minus 0.8 percentage points. Provided that with respect to episodes and visits on or after April 1, 2004, and before April 1, 2005, in the case of home health services furnished in a rural area, the Secretary is required to increase the payment amount otherwise made for such services by five percent. Prevented such temporary additional payment increases from being used in calculating future home health payment amounts.

#### *Ambulatory Surgical Centers*

Provided that in FY 2004, starting April 1, 2004, the ambulatory surgery center (ASC) update would be the Consumer Price Index for all urban consumers (U.S. city average) as estimated as of March 31, 2003, minus 3.0 percentage points. Provided that in beginning in fiscal year 2005 to the end of calendar year 2009, the ASC update would be zero percent. Provided that subject to recommendations by GAO, the Secretary is to

implement a revised payment system for payment of surgical services furnished in ASCs. Required the new system to be implemented so that it is first effective on or after January 1, 2006, and not later than January 1, 2008.

#### *Physician Services*

Made changes with respect to payment for physicians' services to: (1) provide that the update to the conversion factor for 2004 and 2005 would be not be less than 1.5 percent; (2) modify the formula for calculating the sustainable growth rate to provide that the gross domestic product factor would be based on the annual average change over the preceding 10 years (a 10-year rolling average); (3) provide that in calendar years 2004 and 2005, for physician's services provided in Alaska, the Secretary is required to increase geographic practice cost indices to a level of 1.67 for each of the work, practice expense, and malpractice cost indices that would otherwise be less than 1.67; and (4) allow podiatrists, dentists, and optometrists to enter into private contracts with Medicare beneficiaries.

Required the Secretary, beginning in 2004, to make adjustments in practice expense relative value units for certain drug administration services when establishing the physician fee schedule; (2) required the Secretary to use the survey data submitted to the Secretary as of January 1, 2003, by a certain physician specialty organization; and (3) required the Secretary, beginning in 2005, to use supplemental survey data to adjust practice expense relative value units for certain drug administration services in the physician fee schedule. Exempted the adjustments in practice expense relative value units for certain drug administration services from the budget neutrality requirements in 2004. Required a transitional adjustment or additional payment for services furnished from January 1, 2004, through December 31, 2005, to be made for drug administration services. Amended BIPA to provide that direct payment for the technical component of pathology services provided to Medicare beneficiaries who are inpatients or outpatients of acute care hospitals will be made for services furnished during 2005 and 2006.

Rural physicians in newly established scarcity areas receive a 5% increase in Medicare payments in 2005, 2006, and 2007; physicians in certain low-cost areas with geographic adjustment factors below 1 receive payment increases so as to increase this factor to 1, starting in 2004 through 2006.

#### *Part B Drugs*

Established the use of an average sales price methodology for payment for drugs and biologicals (except for pneumococcal, influenza, and hepatitis B vaccines and those associated with certain renal dialysis services) that are furnished on or after January 1, 2005. Created an exception to this methodology in the case of a physician who elects to participate in the newly established competition acquisition program.

Directed the Secretary to establish and implement a competitive acquisition program to acquire and pay for competitively biddable drugs and biologicals through the establishment of competitive acquisition areas for the award of contracts. Gives each physician the opportunity annually to elect to obtain drugs and biologicals under the

program, rather than the program above using average sales methodology. Directed the Secretary to begin to phase-in the program beginning in 2006.

#### *Durable Medical Equipment*

Replaced the prior demonstration projects for competitive acquisition of items and services with a permanent program requiring the Secretary to establish and implement programs under which competitive acquisition areas are established throughout the United States for the furnishing of competitively priced items and services (including durable medical equipment and medical supplies) for which payment is made under Medicare Part B. Required payment under Medicare Part B for competitively priced items and services to be based on bids and requires Medicare payment to be equal to 80 percent of the payment amount determined, with beneficiaries paying the remaining 20 percent (after meeting the Part B deductible). Also, directed the Secretary to conduct a demonstration project on the application of competitive acquisition to clinical diagnostic laboratory tests.

Provided that for durable medical equipment, prosthetic devices, prosthetics and orthotics, the update would be 0 points in 2004 through 2008, and that after 2008 for those items not included in competitive bidding the update would be the consumer price index. Reduced the payment amounts for certain items in 2005 including, oxygen and oxygen equipment, standard wheelchairs, nebulizers, diabetic lancets and testing strips, hospital beds and air mattresses. Limited payments for custom molded shoes with inserts or extra-depth shoes with inserts for an individual with severe diabetic foot disease by the amount that would be paid if they were considered to be a prosthetic or orthotic device. Allowed the Secretary to establish lower payment limits than these amounts if shoes and inserts of an appropriate quality are readily available at lower amounts.

Directed the Secretary to establish and implement quality standards for suppliers of items and services of durable medical equipment, prosthetics and orthotics, and certain other items and services. Required the Secretary to establish standards for clinical conditions for payment for items of durable medical equipment.

#### *Ambulance Services*

Revised payments for ambulance services during phase in of payment rates under the fee schedule. For each level of ground service furnished in a year, the portion of the payment amount that is based on the fee schedule is to be the greater of the amount determined under such national fee schedule or a blended rate of the national fee schedule and the regional fee schedule for the region involved, whichever resulted in a larger payment. Increased by two percent the payments for ground ambulance services originating in a rural area or a rural census tract for services furnished on or after July 1, 2004, and before January 1, 2007. Provided that the fee schedule for ambulances in other areas would increase by one percent.

#### *Preventive Services*

The Act contains a number of provisions that expand coverage beginning January 1, 2005, including the following: (1) an initial preventive physical examination; (2)

cardiovascular screening blood tests; and (3) diabetes screening tests.

#### *Dialysis Services*

Increased the composite rate for renal dialysis by 1.6 percent for 2005. Required the Secretary to establish a basic case-mix adjusted prospective payment system for dialysis services to begin for services furnished on January 1, 2005. Required the system to adjust for a limited number of patient characteristics. Provided that payments for separately billed drugs and biologicals (other than erythropoietin) would be 95 percent of the Average Wholesale Price (AWP) for 2004, the acquisition costs in 2005, and, beginning in 2006, for such drugs and biologicals (including erythropoietin), such acquisition cost or the average sales price payment methodology for the drug or biological as the Secretary may specify. Required drugs and biologicals (including erythropoietin) which were separately billed on the day before the enactment of this Act to continue to be separately billed on and after such date.

#### *Therapy Services*

Provided for an additional two-year moratorium on therapy caps for 2004 and 2005.

#### *Laboratory Tests*

Provided that there would be no updates to the clinical diagnostic laboratory test fee schedule for 2004 through 2008.

#### *Medicare Funding Warning*

Required the Medicare Board of Trustees annual report to include information on: (1) projections of growth of general revenue Medicare spending as a percentage of the total Medicare outlays for the fiscal year and each of the succeeding six fiscal years. Provided that an affirmative determination of excess general revenue funding (defined as general revenue funding exceeding 45 percent of Medicare outlays) for two consecutive annual reports would be treated as a funding warning for Medicare. Amended federal money and finance law to provide in the event that a Medicare funding warning is made, the President is required to submit to Congress, within the 15-day period beginning on the date of the budget submission to Congress for the succeeding year, proposed legislation to respond to such warning. Provided that if during the year in which the warning is made, legislation is enacted which eliminates excess general revenue Medicare funding for the 7-fiscal-year period, then the President is not required to make a legislative proposal. Set out the procedures for House and Senate consideration of the President's legislative proposal.

#### *Part B Premiums*

Increased the monthly Part B premiums for higher-income enrollees beginning in 2007. Beneficiaries whose modified adjusted gross income exceed \$80,000 and couples filing joint returns whose modified adjusted gross income exceeds \$160,000 will be subject to higher premium amounts. The increase is to be calculated on a sliding scale basis and phased-in over a five-year period. The highest category on the sliding scale is for beneficiaries whose modified adjusted gross income is more than \$200,000 (\$400,000 for a couple filing jointly).

### *Part B Deductibles*

The Medicare Part B deductible remained \$100 through 2004, increased to \$110 for 2005, and in subsequent years the deductible is to be increased by the same percentage as the Part B premium increase.

### *Medicare as Secondary Payer*

Allowed the Secretary to make a conditional Medicare payment if a primary plan has not made or cannot reasonably be expected to make prompt payment. Required the payment to be contingent on reimbursement by the primary plan to the appropriate Medicare trust fund. Required a primary plan as well as an entity that receives payment from a primary plan to reimburse the Medicare Trust Funds for any payment made by the Secretary if the primary plan was obligated to make payment. Made other changes with regard to Medicare as a secondary payer to address the Secretary's authority to recover payment from any and all responsible entities and to bring action, including the collection of double damages, to recover payment under the Medicare secondary payer provisions.

### *Program Integrity*

Required the Secretary to conduct a demonstration project to demonstrate the use of recovery audit contractors (RACs) under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the Medicare program for services for which payment is made under Medicare part A or part B. Required a report to Congress on the demonstration program.

Directed the Secretary to establish a pilot program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees.

### *Coverage Determinations Process*

Required the Secretary to make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. Allows for public comment in national coverage determinations. Directed the Secretary to develop a plan to evaluate new local coverage determinations to determine which should be adopted nationally and to what extent greater consistency can be achieved among local coverage determinations.

### *Regulatory Reform*

Required the Secretary, in consultation with the Director of the Office of Management and Budget, to establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation. Prohibited the timeframe established from being longer than three years except under exceptional circumstances. Provided that if the Secretary publishes a final regulation that includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule, such provision would be treated as a proposed regulation and would not take effect until there is the further opportunity for public comment and a publication of the provision again as a final

regulation.

#### *Contracting Reform*

Allowed the Secretary to contract competitively with any eligible entity to serve as a Medicare contractor. Eliminated the distinction between Medicare Part A contractors (fiscal intermediaries) and Medicare Part B contractors (carriers), and merged separate authorities for fiscal intermediaries and carriers into a single authority for the new contractor. Authorized these new contractors, called Medicare Administrative Contractors, to assume all the functions of the current fiscal intermediaries and carriers including: determining payments; making payments; providing education and outreach to beneficiaries; communicating with providers and suppliers; and additional functions as necessary.

Directed the Secretary to provide through the toll free telephone number 1-800-MEDICARE for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free numbers are transferred (without charge) to appropriate entities for the provision of such information or assistance.

#### *Appeals and Recovery*

Directed the Commissioner of Social Security and the Secretary to develop a transition plan under which the functions of administrative law judges responsible for hearing cases under the Medicare program are transferred from the responsibility of the Commissioner and Social Security Administration to the Secretary and HHS. Authorized additional appropriations to increase the number of administrative law judges, improve education and training opportunities for administrative law judges, and increase the staff of the Departmental Appeals Board.

Revised the Medicare appeals process to: (1) require providers and suppliers to present all evidence for an appeal at the reconsideration level that is conducted by a qualified independent contractor (QIC) unless good cause precluded the introduction of the evidence; (2) provide for the use of beneficiaries' medical records in QIC reconsiderations; (3) require that notice of decisions or determinations, redeterminations, reconsiderations, and appeals be written in a manner calculated to be understood by a beneficiary and include reasons for the decision or determination or redetermination and the process for further appeal; (4) specify the eligibility requirements for QICs and their reviewer employees that relate to medical and legal expertise, independence, and prohibitions linked to decisions being rendered; and (5) reduce the required number of QICs from 12 to four.

#### *Quality Improvement Demonstrations and Programs*

Required the Secretary to provide for the phased-in development, testing, evaluation, and implementation of chronic care improvement programs. Required the programs to be designed to improve clinical quality and beneficiary satisfaction and achieve spending targets with respect to expenditures under Medicare for targeted beneficiaries with one or more threshold conditions.

Required the Secretary to develop a plan to improve quality of care and to reduce the cost of care for chronically ill Medicare beneficiaries within six months after enactment. The plan is to use existing data and identify data gaps, develop research initiatives, and propose intervention demonstration programs to provide better health care for chronically ill Medicare beneficiaries. Required the Secretary to implement the plan no later than two years after enactment.

Directed the Secretary to establish a pay-for-performance demonstration program with physicians to meet the needs of eligible beneficiaries through the adoption and use of health information technology and evidence-based outcomes measures.

Required each MA organization to have an ongoing quality improvement program for improving the quality of care provided to enrollees in each MA plan offered by such organization (other than an MA private fee-for-service plan or an MSA plan) effective for contract years beginning January 1, 2006. Required each MA organization, as part of the quality improvement program, to have a chronic care improvement program.

#### DEFICIT REDUCTION ACT (DRA) OF 2005 (P.L. 109-171)

##### *Hospitals*

Required that hospitals that receive payments under the inpatient prospective payment system (IPPS) that do not submit certain quality measures to the Secretary in FY2007 and each subsequent year would have the applicable market basket percentage reduced by two percentage points. Directed the Secretary to develop a plan to implement a value based purchasing program for Medicare payments for these hospitals beginning with FY2009. Required a hospital to report an individual's secondary diagnosis at admission with the information submitted at the time of discharge in order for payment to be made.

Directed the Secretary to develop a strategic and implementing plan regarding physician investment in specialty hospitals that address issues related to proportionality of investment return, bona fide investments, annual disclosure of investment information, and the provision of Medicaid and charity care by specialty hospitals. Required the Secretary to continue the suspension on enrollment of the new specialty hospitals until a certain time.

Directed the Secretary to establish a qualified gainsharing demonstration program for projects to: (1) test and evaluate relationships between hospitals and physicians to improve the quality and efficiency of care provided to Medicare beneficiaries; and (2) develop improved operational and financial hospital performance with sharing of remuneration as specified in the project.

##### *Inpatient Rehabilitation Hospitals*

Specified criterion used to determine whether a hospital or hospital unit is an inpatient rehabilitation facility for Medicare purposes. Established the compliance threshold at: (1) 60% during the 12-month period beginning on July 1, 2006; (2) 65% during the 12-month period beginning on July 1, 2007; and (3) 75% on July 1, 2008 and subsequently.

### *Rural Hospitals*

Extended the Medicare dependent hospital (MDH) status for qualifying rural hospitals through discharges occurring before October 1, 2011. Required an increase in Medicare payments for covered OPD services in calendar 2006-2008 to non-sole community small rural hospitals with no more than 100 beds, if their OPD payments under the OPDS were less than under the prior reimbursement system.

### *Skilled Nursing Facilities*

Reduced payments to skilled nursing facilities for allowable bad debts attributable to Medicare coinsurance by 30 percent for those individuals who are not dually eligible for Medicare and Medicaid. Directed the Secretary to establish a demonstration program for the purposes of understanding costs and outcomes across different post-acute care sites.

### *Home Health*

Revised requirements for home health payments, eliminating the update for home health payments in 2006. Extended through calendar 2006 the prior 5% additional payment for home health episodes or visits furnished in a rural area. Required a home health agency to submit certain quality data to the Secretary annually, or incur a 2% reduction in the fiscal year market basket update. Required MedPAC to report to Congress on a detailed structure of value based payment adjustments for home health services under the Medicare program.

### *Ambulatory Surgical Centers*

Required that ambulatory care surgery centers (ASC) be paid the Medicare OPD fee schedule amount whenever the ASC facility payment (without application of any geographic price differences) is greater than the Medicare OPD fee schedule amount for the same service.

### *Physicians*

Provided that the update to the single conversion factor for physicians' services for 2006 is 0%. Required the Medicare Payment Advisory Commission (MedPAC) to report to Congress on mechanisms that could be used to replace the sustainable growth rate system.

### *Dialysis Services*

Directed the Secretary to increase the amount of the composite rate component of the basic case-mix adjusted PPS for dialysis services furnished on or after January 1, 2006, by 1.6% above the amount of such component for such services furnished on December 31, 2005.

### *Therapy Services*

Directed the Secretary to implement an exceptions process with respect to physical therapy, speech language pathology, and occupational therapy caps for expenses incurred in 2006. Directed the Secretary to implement clinically appropriate code edits with respect to Medicare Part B payments for physical therapy services, occupational therapy

services, and speech-language pathology services in order to identify and eliminate improper payments.

#### *Durable Medical Equipment*

Required equipment suppliers to transfer the title of durable medical equipment (DME) in the capped rental category to the beneficiary after a thirteen month rental period.

Required suppliers of oxygen equipment (including portable oxygen equipment) to transfer the title to the beneficiary after a 36-month rental period. Required payments for oxygen to continue after title transfer in the recognized amount for the period of medical need.

#### *Imaging Services*

Provided that the reduced expenditures attributable to the multiple procedure payment reduction for imaging (under the final rule published November 21, 2005) is not to be taken into account for purposes of the budget neutrality calculation for 2006 and 2007. Declared that, for specified imaging services furnished on or after January 1, 2007, if the technical component (including the technical component of a global fee) exceeds the Medicare outpatient department (OPD) fee schedule amount established under the prospective payment system (PPS) for such service, the Secretary is to substitute the Medicare OPD fee schedule amount, adjusted by the relevant geographic adjustment factor.

#### *Part B Premiums*

Revised requirements for the reduction in Medicare Part B premium subsidy based on income. Increased the monthly adjustment amounts, and accelerated their phase-in for higher income enrollees, with the provision fully effective in 2009.

#### *Part B Covered Services*

Authorized Medicare coverage of ultrasound screening for abdominal aortic aneurysms for an individual meeting certain criteria. Included ultrasound screening for abdominal aortic aneurysms in the package of services provided in the initial preventive service exam offered to new Medicare enrollees.

#### *Part B Deductibles*

Made the Part B deductible inapplicable to ultrasound screening for abdominal aortic aneurysm. Made the Part B deductible inapplicable to colorectal cancer screening tests.

#### *Part B Enrollment*

Permitted delayed enrollment under Medicare Part B without a delayed enrollment penalty to individuals who: (1) serve as volunteers outside the United States through a program sponsored by a tax-exempt organization that covers at least 12 months; and (2) demonstrate health insurance coverage while serving in the program. Created a special six-month special Part B enrollment period for such individuals, beginning on the first day of the month the individual was no longer in the program.

#### *Medicare Advantage*

Provided for the phase-out of risk adjustment budget neutrality over 2007 through 2010

in determining the amount of payments to Medicare Advantage Organizations. Directed the Secretary to establish a process and criteria to award site development grants to qualified Programs of All-inclusive Care for Elderly (PACE) providers that have been approved to serve a rural area.

*Program Integrity*

Increased Medicare Integrity Program funding amounts by \$100 million for FY2006.

TAX RELIEF AND HEALTHCARE ACT (TRHCA) OF 2006, (P.L. 109-432)

*Hospitals*

Extended through September 30, 2007, the reclassification of subsection (d) hospitals (those that receive payment under the IPPS) wage index which would have expired on March 31, 2007. Directed the Secretary to include in the proposed rule for FY2009 one or more proposals to revise such wage index adjustment. Extended through June 30, 2007, Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas.

*Outpatient Hospitals*

Required a 2% reduction in any annual increase (update) to the outpatient department (OPD) services fee schedule for the failure of a subsection (d) hospital to report on quality measures data about hospital outpatient services, or of an ambulatory surgical center to report on such data about its services. Directed the Secretary to develop measures of the quality of care furnished by hospitals in outpatient settings, reflecting consensus among affected parties, including measures set forth by national consensus building entities. Required the Secretary to establish procedures for making quality reporting data available to the public.

*Physicians*

Provided for an increase in the Medicare physician fee schedule conversion factor for 2007; (2) directed the Secretary to implement a system for the reporting by eligible professionals of data on specified quality measures; (3) provided for transitional bonus incentive payments to eligible professionals for quality reporting in 2007; (4) directed the Secretary to establish a Physician Assistance and Quality Initiative Fund available for physician payment and quality improvement initiatives; and (5) directed the Secretary to provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund of a specified amount to the Centers for Medicare and Medicaid Services Program Management Account for FY2007-FY2009 to implement these measures. Extended through 2007 the mandatory 1.0 floor for the work geographic index adjustment for Medicare payment of physicians' services. Extended through 2007 specified requirements for the treatment of certain physician pathology services under Medicare.

*Therapy Services*

Extended through 2007 the exceptions process for Medicare therapy caps.

### *Dialysis Services*

Revised the mandatory increase in the amount of the composite rate component of the basic case-mix adjusted system for dialysis services furnished on or after January 1, 2006. Limited the current rate component increase to services furnished before April 1, 2007. Required the current rate component for services furnished after April 1, 2007, to be increased by 1.6% above the amount of the rate component for services furnished on March 31, 2007.

### *Part B Drugs*

Revised the payment process under the competitive acquisition process (CAP) for drugs and biologicals to: (1) require payment for drugs and biologicals to the applicable contractor only upon receipt of a claim for one supplied by the contractor for administration to a beneficiary; and (2) direct the Secretary to establish a post-payment review process to assure that payment is made for a drug or biological only if it has been administered to a beneficiary.

### *Vaccines*

Provided, in the case of a vaccine administered during 2007 that is a covered Part D drug, that the administration of such vaccine shall be paid under Medicare Part B. Required the administration of vaccines to be included in the coverage of Part D drugs beginning in 2008.

### *Care Coordination*

Directed the Secretary to establish a medical home demonstration project to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations. Required such project to provide that: (1) care management fees are paid to persons performing services as personal physicians; and (2) incentive payments are paid to physicians participating in practices that provide services as a medical home.

### *Program Integrity*

Required the Secretary to enter into contracts with recovery audit contractors to identify underpayments and overpayments and recoup overpayments for all services for which payment is made under Medicare Part A or Medicare Part B. Required the Secretary to provide for activities in all states under such a contract by January 1, 2010. Made appropriations to the Health Care Fraud and Abuse Control Account for FY2007-FY2010 and ensuing fiscal years.

MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT (MMSEA) OF 2007 (P.L. 110-173)

### *Inpatient Hospitals*

Extended the expiration date for certain wage index geographic reclassifications and special exceptions through FY2008 (as originally established by Section 508 of the MMA). Directed the Secretary, in the case of certain acute care hospitals, to apply a

higher wage index in specified circumstances.

#### *Long Term Care Hospitals*

Directed the Secretary to study and report to Congress on the establishment of: (1) a national long-term care hospital (LTCH) facility primarily engaged in providing inpatient services to Medicare beneficiaries whose medically complex conditions require a long hospital stay; and (2) patient criteria for purposes of determining medical necessity, appropriateness of admission, and continued stay at, and discharge from, LTCHs. Prohibited the Secretary from applying, for a three-year period, the 25% patient threshold payment adjustment to freestanding and grandfathered LTCHs. Provided that payment to an applicable LTCH or satellite facility located in a rural area, or co-located with an urban single or MSA dominant hospital, shall not be subject to any payment adjustment if no more than 75% of the hospital's Medicare discharges are admitted from a co-located hospital. (An "MSA-dominant hospital" is one that has discharged more than 25% of the total hospital Medicare discharges in the metropolitan statistical area (MSA) in which the hospital is located.) Provided that payment to an applicable LTCH or satellite facility co-located with another hospital shall not be subject to a specified payment adjustment if no more than 50% of the hospital's Medicare discharges (with certain exceptions) are admitted from a co-located hospital. Prohibited the Secretary from making the one-time prospective adjustment to LTCH prospective payment rates. Directed the Secretary to impose a moratorium for purposes of the Medicare program: (1) on the establishment and classification of a LTCH (with certain exceptions) or satellite facility, other than an existing one; and (2) on an increase of LTCH beds in existing LTCHs or satellite facilities (except for bed increases in an existing LTCH or satellite facility during the moratorium). Provided for prospective payment updates for LTCHs.

#### *Inpatient Rehabilitation Facilities*

Froze the payment for inpatient rehabilitation facility (IRF) services in FY2008-FY2009. Required the Secretary to require a compliance rate no greater than 60% in the classification criterion used under the IRF regulation to determine whether a hospital or hospital unit is an inpatient rehabilitation facility under Medicare. Required the Secretary, for cost reporting periods beginning on or after July 1, 2007, to include patients with comorbidities in the applicable inpatient population. Directed the Secretary to analyze and report to Congress on: (1) Medicare beneficiaries' access to medically necessary rehabilitation services; (2) alternatives or refinements to the 75% rule policy for determining criteria for inpatient rehabilitation hospital and unit designation under the Medicare program; and (3) certain conditions for which individuals are commonly admitted to certain inpatient rehabilitation hospitals.

#### *Physicians*

Increased the physician payment updated; revised the Physician Assistance and Quality Initiative Fund, adding limitations on expenditures; and extended through 2009 the physician quality reporting system. Provided for transitional bonus incentive payments for quality reporting in 2008, and waived the payment limitation for 2008 and 2009. Extended through June 30, 2008: (1) the Medicare incentive payment program for physician scarcity areas; and (2) the floor on work geographic adjustment under the

Medicare physician fee schedule. Extended the specified treatment of certain physician pathology services under Medicare for the first six months of 2008.

*Part B Drugs*

Provided for application of alternative volume weighting in computation of average sales price with respect to payment of Medicare Part B multiple source and single source drugs furnished after April 1, 2008. Provided for a special rule for payment, beginning April 1, 2008, of single source drugs or biologicals treated as a multiple source drug.

*Laboratory Services*

Extended through June 30, 2008, Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas.

*Medicare Advantage*

Extended until January 1, 2010, the authority of specialized Medicare advantage plans for special needs individuals to restrict enrollment. Delayed until January 1, 2009, any application of the limitation on extension or renewal of Medicare reasonable cost contract plans. Decreased the amount of funding available to the Medicare Advantage Regional Plan Stabilization Fund during 2013.

*Medicare as Secondary Payer*

Required any entity serving as an insurer or third party administrator for a group health plan, as well as the administrator or fiduciary of any self-insured, self-administered group health plan, to: (1) secure from the plan sponsor and plan participants information necessary to identify situations where the group health plan is or has been a primary plan to the Medicare program; and (2) submit such information to the Secretary. Required an applicable plan to determine: (1) whether a claimant is entitled to Medicare benefits on any basis; and (2) submit specified information about any entitled claimant to the Secretary. Established civil money penalties for enforcement.

*Medicare Commission*

Made the Medicare Payment Advisory Commission (MedPAC) a congressional agency.

**MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT (MIPPA)  
OF 2008 (P.L. 110-275)**

*Hospitals*

Extended the authorization for FLEX (Medicare rural hospital flexibility program) grants through FY2010. Included among FLEX grant purposes providing support for critical access hospitals for quality improvement, quality reporting, performance improvements, and benchmarking. Authorized the Secretary to award grants to eligible critical access hospitals to assist them to transition to skilled nursing facilities (SNFs) and assisted living facilities. Permitted substitution of a specified rebased target amount for the amount ordinarily calculated in Medicare payments to sole community hospitals for inpatient hospital services. Extended through FY2009 the reclassification of certain hospitals. Extended and expanded the Medicare hold harmless provision under the prospective

payment system for hospital outpatient department (OPD) services for certain hospitals.

Repealed the unique deeming authority under which an institution accredited as a hospital by the Joint Commission on Accreditation of Hospitals shall be deemed to be a hospital eligible for Medicare payments.

#### *Physicians*

Increased the update for physicians' payments for the second half of 2008 and for 2009. Extended through calendar 2009 the 1.0 floor on the Medicare work geographic adjustment under the Medicare physician fee schedule. Modified the funding for the physician assistance and quality initiative (PAQI) Fund (originally created by TRHCA), effectively eliminating monies from the fund in 2013 and 2014. As modified by the Supplemental Appropriations Act, 2008 (P.L. 110-252), \$4.96 billion was removed from the fund in 2013-2015 and returned to the Medicare Part A and Part B Trust Funds, to be made available for other purposes.

Directed the Secretary to increase by 5% the fee schedule otherwise applicable for specified psychotherapy services during the period from July 1, 2008, through December 31, 2009. Set forth a special 100% fee schedule payment rule for teaching anesthesiologists. Directed the Secretary to make specified adjustments to payments to teaching certified registered nurse anesthetists.

Extended the physician quality reporting system, which had been scheduled to run through 2009, through 2010 and beyond. Established a physician feedback program, with the intent to improve efficiency and to control costs, and required the Secretary to develop a plan to transition to a value-based purchasing program for payment under the Medicare program for covered professional services.

#### *Telehealth Services*

Added a hospital-based or critical access hospital-based renal dialysis center, a SNF, and a community mental health center as originating sites for purposes of payment for telehealth services.

#### *Preventive Services*

Added "additional preventive services," including body mass index and end-of-life planning to the list of Medicare-covered preventive services. Waived the deductible for the initial preventive physical exam (also known as "Welcome to Medicare") and extended the eligibility period for this service from the first six months to the first year of Part B enrollment.

#### *Mental Health Services*

Increased the percentage that Medicare generally pays for mental health services from 50% to 80% over the 2010-2014 period; when the provision is fully phased-in in 2014 and outpatient psychiatric services will be paid on the same basis as other Part B services.

#### *Imaging Services*

Established an accreditation requirement for advanced diagnostic imaging services.

Directed the Secretary to conduct a demonstration project to assess the appropriate use of imaging services.

#### *Clinical Laboratory Services*

Repealed the Medicare competitive bidding demonstration project for clinical laboratory services. Specified that the clinical laboratory fee schedule update otherwise slated to occur each year would be reduced each year from 2009 through 2013 by 0.5 percentage points. Provided that clinical diagnostic laboratory services furnished by a critical access hospital are to be treated as being furnished as part of outpatient critical access services without regard to whether the outpatient is physically present in the critical access hospital, or in a skilled SNF or a clinic (including a rural health clinic) operated by such a hospital, at the time the specimen is collected.

Extended through 2009 specified treatment of certain physician pathology services under Medicare.

#### *Therapy Services*

Extended the exceptions process for Medicare physical therapy caps through December 31, 2009.

#### *Durable Medical Equipment*

Terminated all contracts under the first round of the Durable Medical Equipment, prosthetics, orthotics, and other medical supplies (DMEPOS) competitive acquisition program, set to start July 1, 2008. Required the Secretary to re-bid the first round in 2009 and delayed the second round of bidding until 2011. To pay for the cost of the program delay, the Act required a 9.5% reduction in the fee schedule payments for all round 1 DMEPOS items and services both inside and outside of competitive acquisition areas. Prescribed requirements for application of accreditation in implementing quality standards. Set forth a special rule for the competitive acquisition program for diabetic testing strips.

#### *Ambulance Services*

Extended increased Medicare payments for ground ambulance services. Set forth a special payment rule for air ambulance services under the ambulance fee schedule.

#### *Dialysis Services*

Revised requirements for payments for renal dialysis services. Reduced the composite rate factor in the updates for renal dialysis services furnished during calendar year 2009, and those furnished on or after January 1, 2010. Directed the Secretary, for dialysis services furnished on or after January 1, 2011, to implement a (bundled) payment system under which a single payment is made to a service provider or a renal dialysis facility for renal dialysis services in lieu of any other payment. Institutes a system of quality incentives for service providers and renal dialysis facilities in the end-stage renal disease (ESRD) program. Directed the Comptroller General to report to Congress on implementation of the ESRD bundling payment system and quality initiative.

### *Medicare Advantage*

Phased out Medicare indirect medical education (IME) payments to private health plans. Revised requirements for certain non-employer Medicare Advantage (MA) private fee-for-service plans (PFFS), as well as MA plans for special needs individuals, including, respectively, among other changes, requirements to assure access to network coverage and care management requirements for all special needs plans. Requires MA PFFS plans and Medicare Savings Account (MSA) plans to have a quality improvement program.

Extended through January 1, 2010, reasonable cost reimbursement contracts the Secretary may enter with organizations whose capacity to bear the risk of potential losses under a risk-sharing contract is in doubt. Placed a limitation on out-of-pocket costs (cost-sharing) for dual eligibles and qualified Medicare beneficiaries enrolled in a specialized MA plan for special needs individuals. Prescribed prohibitions on certain sales and marketing activities under MA plans and prescription drug plans. Reduced the initial funding to the MA Regional Plan Stabilization Fund to one dollar. (When the fund was first established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173, MMA), it had an initial funding level of \$10 billion.)

### *Outpatient Prescription Drug Benefit (Part D)*

Includes barbiturates and benzodiazepines as covered part D drugs beginning in 2013. Requires prompt payment of clean claims by prescription drug plans (PDPs) and MA-prescription drug plans (MA-PDs). Requires interest payments on late claims. Directed the Secretary to identify categories and classes of drugs for which: (1) restricted access would have major or life threatening clinical consequences for individuals who have a disease or disorder treated by them; and (2) there is significant clinical need for such individuals to have access to multiple drugs within a category or class because of unique chemical actions and pharmacological effects of such drugs, such as drugs used in the treatment of cancer. Requires PDP sponsors to include all covered Part D drugs in a formulary in the categories and classes identified by the Secretary, unless the Secretary establishes exceptions according to a specified process. Revised the definition of "medically accepted indication for drugs."

### *Low-Income Beneficiaries*

Increased, effective January 1, 2010, the assets tests applicable under the Medicare Savings program (MSP) to those applicable under the low-income subsidy program (LIS) under the Medicare Part D prescription drug program (\$6,290 for an individual, \$9,440 for a couple in 2008, updated annually). Eliminated Medicare Part D late enrollment penalties payable by subsidy-eligible individuals. Excluded life insurance policies from being counted as an asset for purposes of determining LIS eligibility.

### *Demonstrations*

Authorized the Secretary to expand the duration and the scope of the Medicare Medical Home Demonstration Project if such expansion is expected to: (1) improve the quality of patient care without increasing spending under the Medicare program; and (2) reduce spending under the Medicare program without reducing the quality of patient care.

Directed the Secretary to establish a demonstration project for development and testing of new community health integration models in certain rural counties for the delivery of acute care, extended care, and other essential health services to Medicare beneficiaries.

*Medicare Improvement Fund*

Established a Medicare Improvement Fund, available to the Secretary, to make improvements under the original Medicare fee-for-service program under Parts A and B for Medicare beneficiaries. MPPA, together with a provision in the Supplemental Appropriations Act, 2008 (P.L. 110-252), made \$2.22 billion from the Parts A and B Trust Funds available for services furnished during FY2014 and an additional \$19.9 billion available for fiscal years 2014 through 2017.

*Supplementary Insurance*

Requires a Medigap policy issuer to make available to an eligible individual at least Medicare supplemental policies classified as "C" or "F."

AMERICAN RECOVERY AND REINVESTMENT ACT (ARRA) OF 2009 (P.L. 111-5)

*Health Information Technology: Medicare Incentives*

Established specified incentive payments for eligible physicians who adopt and use certified electronic health record (EHR) technology meaningfully, beginning in 2011. Prohibited incentive payments after 2016. Reduced Medicare payments for any eligible professional who is not a meaningful EHR user beginning in 2015, except in certain circumstances where compliance with meaningful EHR requirements would result in a significant hardship. Applied such payment incentives for certain Medicare Advantage (MA) organizations for adoption and meaningful use of such technology.

Established incentive payments for certain eligible hospitals that adopt and meaningfully use certified EHR technology beginning in FY2011. Reduced the market basket update for any eligible hospital that has not adopted a certified system beginning in 2015, except in certain circumstances where compliance with meaningful EHR requirements would result in a significant hardship.

Made appropriations for FY2009-FY2016 for implementation of these provisions. Prohibited taking payment incentives made by this Act into account for computation of monthly Medicare premiums for individuals.

*Hospice*

Prohibited the Secretary from phasing out or eliminating the budget neutrality adjustment factor in the Medicare hospice wage index before October 1, 2009. Required the Secretary to recompute and apply the final index for FY2009 as if there had been no reduction in the budget neutrality adjustment factor.

*Physicians*

Made the Medicare Improvement Fund available for increases in the conversion factor in

the formula used to determine the payment for physicians' services.

*Comparative Effectiveness Research*

Established a Federal Coordinating Council for Comparative Effectiveness Research to: (1) assist federal offices and agencies in coordinating the conduct or support of comparative effectiveness and related health services research; and (2) advise the President and Congress on strategies regarding the infrastructure needs of comparative effectiveness research within the federal government, and related matters.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) OF 2010 (P.L. 111-148) AS AMENDED BY THE HEALTH CARE AND EDUCATION AFFORDABILITY RECONCILIATION ACT (HCERA) OF 2010 (P.L. 111-152)

*Fee-for-Service Provider Payments*

Revised certain market basket updates and incorporates a full productivity adjustment into any updates that do not already incorporate such adjustments, including inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals, inpatient rehabilitation facilities, and certain Part B providers.

*Hospitals*

Extended "Section 508" hospital reclassifications until September 30, 2010, with a special rule for FY2010. ("Section 508" refers to Section 508 of the Medicare Modernization Act of 2003, which allows the temporary reclassification of a hospital with a low Medicare area wage index, for reimbursement purposes, to a nearby location with a higher Medicare area wage index, so that the "Section 508 hospital" will receive the higher Medicare reimbursement rate.)

Directed the Secretary to report to Congress a plan to reform the hospital wage index system. Requires application of the budget neutrality requirement associated with the effect of the imputed rural floor on the area wage index under the Balanced Budget Act of 1997 through a uniform national, instead of state-by-state, adjustment to the area hospital wage index floor.

Specified reductions to Medicare disproportionate share (DSH) payments for FY2014 and ensuing fiscal years, especially to acute care hospitals, to reflect lower uncompensated care costs relative to increases in the number of insured.

Extended for two years: (1) certain payment rules for long-term care hospital services; and (2) a certain moratorium on the establishment of certain hospitals and facilities.

Required the Secretary to determine if the outpatient costs incurred by inpatient prospective payment system-exempt cancer hospitals, including those for drugs and biologicals, with respect to Medicare ambulatory payment classification groups, exceed those costs incurred by other hospitals reimbursed under the outpatient prospective

payment system (OPPS). Requires the Secretary, if this is so, to provide for an appropriate OPPS adjustment to reflect such higher costs for services furnished on or after January 1, 2011. Extended through 2010 hold harmless provisions under the prospective payment system for hospital outpatient department services.

Removed the 100-bed limitation for sole community hospitals so all such hospitals receive an 85% increase in the payment difference in 2010. Extended from July 1, 2010, until July 1, 2011, the reasonable cost reimbursement for clinical diagnostic laboratory service for qualifying rural hospitals with under 50 beds.

Extended the Rural Community Hospital Demonstration Program for five additional years. Expanded the maximum number of participating hospitals to 30, and to 20 the number of demonstration states with low population densities. Extended the Medicare-dependent Hospital Program through FY2012. Modified the Medicare inpatient hospital payment adjustment for low-volume hospitals for FY2011-FY2012. Revised requirements for the Demonstration Project on Community Health Integration Models in Certain Rural Counties to allow additional counties as well as physicians to participate. Allowed a critical access hospital to continue to be eligible to receive 101% of reasonable costs for providing: (1) outpatient care regardless of the eligible billing method such hospital uses; and (2) qualifying ambulance services. Extended through FY2012 FLEX grants under the Medicare Rural Hospital Flexibility Program. Allowed the use of grant funding to assist small rural hospitals to participate in delivery system reforms.

Established floors: (1) on the area wage index for hospitals in frontier states; (2) on the area wage adjustment factor for hospital outpatient department services in frontier states; and (3) for the practice expense index for services furnished in frontier states. Directed the Secretary to provide for a specified payment for FY2011 and FY2012 to qualifying acute care hospitals located in counties ranked in the lowest quartile of adjusted Medicare Part A and B spending (adjusted by age, sex, and race).

#### *Graduate Medical Education*

Reallocated unused residency positions to qualifying hospitals for primary care residents for purposes of payments to hospitals for graduate medical education costs. Revised provisions related to graduate medical education costs to count the time residents spend in nonprovider settings toward the full-time equivalency if the hospital incurs the costs of the stipends and fringe benefits of such residents during such time. Included toward the determination of full-time equivalency for graduate medical education costs time spent by an intern or resident in an approved medical residency training program in certain nonprovider settings. Directed the Secretary, when a hospital with an approved medical residency program closes, to increase the resident limit for other hospitals based on proximity criteria.

#### *Home Health*

Required the Secretary, starting in 2014, to rebase home health payments by an appropriate percentage, among other things, to reflect the number, mix, and level of intensity of home health services in an episode, and the average cost of providing care.

### *Hospice*

Required the Secretary, by January 1, 2011, to begin collecting additional data and information needed to revise payments for hospice care. Directed the Secretary, not earlier than October 1, 2013, to implement, by regulation, budget neutral revisions to the methodology for determining hospice payments for routine home care and other services, which may include per diem payments reflecting changes in resource intensity in providing such care and services during the course of an entire episode of hospice care. Requires the Secretary to impose new requirements on hospice providers participating in Medicare, including requirements for: (1) a hospice physician or nurse practitioner to have a face-to-face encounter with the individual regarding eligibility and recertification; and (2) a medical review of any stays exceeding 180 days, where the number of such cases exceeds a specified percentage of them for all hospice programs.

Directed the Secretary to establish a Medicare Hospice Concurrent Care demonstration program under which Medicare beneficiaries are furnished, during the same period, hospice care and any other Medicare items or services from Medicare funds otherwise paid to such hospice programs.

### *Physicians*

Extended through calendar 2010 the floor on geographic indexing adjustments to the work portion of the physician fee schedule. Revised requirements for calculation of the practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011. Extended the physician fee schedule mental health add-on payment provision through December 31, 2010. Directed the Secretary periodically to identify physician services as being potentially misvalued and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule. Required Medicare incentive payments for: (1) primary care practitioners providing primary care services on or after January 1, 2011, and before January 1, 2016; and (2) general surgeons performing major surgical procedures on or after January 1, 2011, and before January 1, 2016, in a health professional shortage area.

### *Preventive Services*

Provided coverage of personalized prevention plan services, including a health risk assessment, for individuals. Prohibited cost-sharing for such services. Eliminated cost-sharing for certain preventive services recommended by the United States Preventive Services Task Force. Authorized the Secretary to modify Medicare coverage of any preventive service consistent with the recommendations of such Task Force.

### *Therapy Services*

Extended the process allowing exceptions to limitations on medically necessary therapy caps through December 31, 2010.

### *Ambulance Services*

Extended the bonus and increased payments for ground ambulance services until January 1, 2011. Extended the payment of certain urban air ambulance services until January 1,

2011.

*Imaging Services*

Increased the presumed utilization rate for calculating the payment for advanced imaging equipment other than low-tech imaging such as ultrasound, x-rays and EKGs. Increased the technical component payment "discount" for sequential imaging services on contiguous body parts during the same visit.

*Laboratory Services*

Directed the Secretary to conduct a demonstration project under Medicare Part B of separate payments for complex diagnostic laboratory tests provided to individuals.

*Durable Medical Equipment*

Restricted the lump-sum payment option for new or replacement chairs to the complex, rehabilitative power-driven wheelchairs only. Eliminated the lump-sum payment option for all other power-driven wheelchairs. Made the rental payment for power-driven wheelchairs 15% of the purchase price for each of the first three months (instead of 10%), and 6% of the purchase price for each of the remaining 10 months of the rental period (instead of 7.5%).

Required the Secretary to: (1) expand the number of areas to be included in round two of the competitive bidding program from 79 to 100 of the largest metropolitan statistical areas; and (2) use competitively bid prices in all areas by 2016. Exempted certain pharmacies from accreditation requirements until the Secretary develops pharmacy-specific standards.

*Medicare Advantage*

Phases-in Medicare Advantage (MA) benchmarks that are closer-to or below the level of per capita fee-for-service spending in each county. Adjusted benchmarks based on the quality of each plan, as measured on a 5-star rating system established by the Secretary, with higher benchmark adjustments in certain areas. Adjusted rebates based on plan quality as well, with new rebate levels at between 50% and 70% of the difference between the bid and the benchmark. Required the Secretary to continue to apply a coding intensity adjustment to account for the differences in coding patterns between MA and original Medicare. Repeals the Comparative Cost Adjustment program. Applied a minimum Medical Loss Ratio requirement starting in 2014. Restricted cost sharing for certain items and procedures (chemotherapy treatment, renal dialysis, skilled nursing care, and services identified by the Secretary) to no more than that required under original Medicare. Clarifies the Secretary's authority to deny plan bids. Shifted the annual coordinated election period for MA and Part D plan enrollment to earlier each fall (October 15 through December 7). Prohibited beneficiaries from switching MA plans after the start of the benefit year, but allowed beneficiaries to return to original Medicare during the first 45-days of the calendar year (January 1 – February 15). Eliminated the MA regional plan stabilization fund.

Extended special needs plans (SNPs) authority through December 31, 2013. Extended

through January 1, 2013, the length of time reasonable cost plans may continue to operate regardless of any other MA plans serving the area. Repealed the Comparative Cost Adjustment Program created by the Medicare Modernization Act of 2003.

Allowed beneficiaries to disenroll from an MA plan and only return to the traditional Medicare fee-for-service program from January 1 to March 15 of each year. Revised requirements for annual beneficiary election periods.

#### *Medicare Part D Prescription Drug Plans and MA-PD Plans*

Directed the Secretary to establish a manufacturer coverage gap discount program. Required prescription drug manufacturers to participate in the Medicare coverage gap discount program for its drugs to be covered under Medicare Part D. Gradually reduces beneficiary cost sharing during the coverage gap. In 2020, Part D enrollees will be responsible for 25% of the cost of both brand name and generic drugs during the coverage gap. Directed the Secretary to provide a one-time \$250 rebate in 2010 to all Medicare part D enrollees who enter the Medicare part D coverage gap (also known as the Medicare donut hole). Allowed the costs incurred by AIDS drug assistance programs and by the Indian Health Service (IHS) in providing prescription drugs to count toward the annual out-of-pocket threshold. Authorized the Secretary to identify classes of clinical concern through rulemaking, including anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants for the treatment of transplant rejection. Required prescription drug plan sponsors to include all drugs in these classes in their formularies.

Excluded the MA rebate amounts and quality bonus payments from calculation of the regional low-income subsidy benchmark premium for MA monthly prescription drug beneficiaries. Directed the Secretary to permit a prescription drug plan or an MA-PD plan to waive the monthly beneficiary premium for a subsidy eligible individual if the amount of such premium is *de minimis*. Eliminated cost sharing for certain dual eligible individuals receiving care under a home and community-based waiver program who would otherwise require institutional care.

#### *Medicare Part B and Part D Premiums*

Required Part D enrollees who exceed certain income thresholds to pay higher premiums. Maintains the 2010 income thresholds used to establish Part B and Part D premiums for the period of 2011 through 2019. Revised the authority of the IRS to disclose income information to the Social Security Administration for purposes of adjusting the Part B subsidy.

#### *Independent Payment Advisory Board*

Established a 15-member Independent Payment Advisory Board. Beginning in 2014, if the growth in Medicare per capita spending exceeds a certain rate, the Board is required to develop and submit detailed proposals to reduce the rate of growth in Medicare spending to the President for Congress to consider. The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or beneficiary cost-sharing. Established a consumer advisory council to advise

the Board on the impact of payment policies under this title on consumers.

#### *Physician Ownership and Other Transparency*

Prohibited physician-owned hospitals that do not have a provider agreement by December 31, 2010, to participate in Medicare. Allowed their participation in Medicare under a rural provider and hospital exception to the ownership or investment prohibition if they meet certain requirements addressing conflict of interest, bona fide investments, patient safety issues, and expansion limitations.

Required drug, device, biological and medical supply manufacturers to report to the Secretary transfers of value made to a physician, physician medical practice, a physician group practice, and/or teaching hospital, as well as information on any physician ownership or investment interest in the manufacturer. With respect to the Medicare in-office ancillary exception to the prohibition against physician self-referrals, required a referring physician to inform the patient in writing that the patient may obtain a specified imaging service from a person other than the referring physician, a physician who is a member of the same group practice as the referring physician, or an individual directly supervised by the physician or by another physician in the group practice. Required the referring physician also to provide the patient with a written list of suppliers who furnish such services in the area in which the patient resides.

#### *Nursing Home Transparency*

Required SNFs under Medicare and nursing facilities (NFs) under Medicaid to make available, upon request by the Secretary, the HHS Inspector General, the states, or a state long-term care ombudsman, information on ownership of the SNF or NF, including a description of the facility's governing body and organizational structure, as well as information regarding additional disclosable parties. Required SNFs and NFs to operate a compliance and ethics program effective in preventing and detecting criminal, civil, and administrative violations. Required the Secretary to publish on the Nursing Home Compare Medicare website: (1) standardized staffing data; (2) links to state websites regarding state survey and certification programs; (3) the model standardized complaint form; (4) a summary of substantiated complaints; and (5) the number of adjudicated instances of criminal violations by a facility or its employees. Required the Secretary to establish a nationwide program for national and state background checks on prospective direct patient access employees of long-term care facilities and providers.

#### *Program Integrity*

Required the Secretary to: (1) establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP; and (2) determine the level of screening according to the risk of fraud, waste, and abuse with respect to each category of provider or supplier. Required providers and suppliers applying for enrollment or revalidation of enrollment in Medicare, Medicaid, or CHIP to disclose current or previous affiliations with any provider or supplier that: (1) has uncollected debt; (2) has had its payments suspended; (3) has been excluded from participating in a federal health care program; or (4) has had billing privileges revoked. Authorized the Secretary to deny enrollment in a program if these affiliations pose an undue risk to it. Required providers and suppliers to

establish a compliance program containing specified core elements. Authorized the Secretary to exclude providers and suppliers participation in any federal health care program for providing false information on any application to enroll or participate. Appropriated additional amounts to the Health Care Fraud and Abuse Control account for FY2011-FY2020. Made additional appropriations to the Medicare Integrity Program for FY2010 and each subsequent year, indexed for inflation.

Required DME or home health services to be ordered by an enrolled Medicare eligible professional or physician. Required a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant to have a face-to-face encounter with an individual before issuing a certification for home health services or DME. Authorized the Secretary to exclude from participation in any federal health care program any individual or entity ordering, referring for furnishing, or certifying the need for an item or service that fails to provide adequate documentation to verify payment. Required the Secretary to: (1) withhold payment for a 90-day period after submission of a claim; and (2) conduct enhanced oversight in cases where the Secretary identifies a significant risk of fraud among newly enrolling durable medical equipment (DME) suppliers in a particular category or geographical area.

Applied specified enhanced sanctions and civil monetary penalties to MA or Part D plans that: (1) enroll individuals in an MA or Part D plan without their consent; (2) transfer an individual from one plan to another for the purpose of earning a commission; (3) fail to comply with marketing requirements and CMS guidance; or (4) employ or contract with an individual or entity that commits a violation. Required the Secretary to expand the RAC program to Medicare parts C (Medicare Advantage) and D (Prescription Drug Program).

#### *Medicare Improvement Fund*

Eliminated funding in the Medicare Improvement Fund in FY2014.

#### *Medicare Payroll Taxes*

Increased after December 31, 2012, the hospital insurance tax rate by .9% for individual taxpayers earning over \$200,000 (\$250,000 for married couples filing joint tax returns). ) Includes net investment income in the Medicare taxable base and imposes a 3.8% tax on such income, beginning in 2013. Excluded from such tax the net investment income of taxpayers with adjusted gross incomes of less than \$200,000 (\$250,000 for joint returns). Defined "net investment income" to include interest, dividends, annuities, royalties, rents, passive income, and net gain from the disposition of nonbusiness property.

#### *Medicare Eligibility*

Deemed eligible for Medicare coverage certain individuals exposed to environmental health hazards.

#### *Patient-Centered Outcomes Research*

Established the Patient-Centered Outcomes Research Institute to identify priorities for, and establish, update, and carry out, a national comparative outcomes research project

agenda. Prohibited the Secretary from using evidence and findings from Institute research to make a determination regarding Medicare coverage unless such use is through an iterative and transparent process which includes public comment and considers the effect on subpopulations.

#### *Linking Payment to Quality Outcomes*

Directed the Secretary to establish a hospital value-based purchasing program under which value-based incentive payments are made in a fiscal year to hospitals that meet specified performance standards for a certain performance period. Directed the Secretary to establish value-based purchasing demonstration programs for: (1) inpatient critical access hospital services; and (2) hospitals excluded from the program because of insufficient numbers of measures and cases. Subjects hospitals to a penalty adjustment to hospital payments for high rates of hospital acquired conditions. Directed the Secretary to develop a plan to implement value-based purchasing programs for Medicare payments for SNFs, home health agencies, and ambulatory surgical centers. Directed the Secretary to conduct separate pilot programs, for specified kinds of hospitals and hospice programs, to test the implementation of a value-based purchasing program for payments to the provider.

Required long-term care hospitals, inpatient rehabilitation hospitals, and hospices, starting in rate year 2014, to submit data on specified quality measures. Required reduction of the annual update of entities which do not comply. Directs the Secretary, starting FY2014, to establish quality reporting programs for inpatient cancer hospitals exempt from the prospective payment system. Established a quality measure reporting program for psychiatric hospitals beginning in FY2014.

Extended through 2013 the authority for incentive payments under the physician quality reporting system. Prescribed an incentive (penalty) for providers who do not report quality measures satisfactorily, beginning in 2015. Required the Secretary to integrate reporting on quality measures with reporting requirements for the meaningful use of electronic health records. Required specified new types of reports and data analysis under the physician feedback program. Directed the Secretary to establish a value-based payment modifier, under the physician fee schedule, based upon the quality of care furnished compared to cost. Authorized an additional incentive payment under the physician quality reporting system in 2011 through 2014 to eligible professionals who report quality measures to CMS via a qualified Maintenance of Certification program.

Required the Secretary to: (1) develop a Physician Compare website with information on physicians enrolled in the Medicare program and other eligible professionals who participate in the Physician Quality Reporting Initiative; and (2) implement a plan to make information on physician performance public through Physician Compare, particularly quality and patient experience measures.

#### *Development of New Patient Care Models*

Created within CMS a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or

enhancing the quality of care furnished to individuals.

Directed the Secretary to establish a shared savings program that: (1) promotes accountability for a patient population; (2) coordinates items and services under Medicare Parts A and B; and (3) encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.

Directed the Secretary to establish a pilot program for integrated care (involving payment bundling) during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services.

Directed the Secretary to conduct a demonstration program to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services to applicable beneficiaries.

Required the Secretary to establish a hospital readmissions reduction program involving certain payment adjustments, effective for discharges on or after October 1, 2012, for certain potentially preventable Medicare inpatient hospital readmissions. Directed the Secretary to make available a program for hospitals with a high severity adjusted readmission rate to improve their readmission rates through the use of patient safety organizations.

Directed the Secretary to establish a Community-Based Care Transitions Program which provides funding to eligible entities that furnish improved care transitions services to high-risk Medicare beneficiaries.

Extended certain gainsharing demonstration projects through FY2011.

## MEDICARE AND MEDICAID EXTENDERS ACT OF 2010 (P.L. 111-309)

### *Hospitals*

Extended section 508 hospital reclassifications through FY2011. ("Section 508" refers to Section 508 of the Medicare Modernization Act of 2003 [MMA], which allows the temporary reclassification of a hospital with a low Medicare area wage index, for reimbursement purposes, to a nearby location with a higher Medicare area wage index, so that the "Section 508 hospital" will receive the higher Medicare reimbursement rate.)

Extended through 2011 hold harmless provisions under the prospective payment system for hospital outpatient department services. Extended from July 1, 2010, until July 1, 2012, the reasonable cost reimbursement for clinical diagnostic laboratory service for qualifying rural hospitals with under 50 beds.

### *Graduate Medical Education*

Revised specified requirements for reallocating unused residency positions to qualifying

hospitals for primary care residents for purposes of payments to hospitals for graduate medical education (GME) costs. Applied such requirements to hospitals which are members of the same affiliated group. Made the reference level for each such hospital the reference resident level with respect to the cost reporting period that results in the smallest difference between such level and the otherwise applicable resident limit.

*Physician Services*

Set the 2011 update to the single conversion factor in the formula for the physicians' fee schedule at zero (thus freezing the physician payment update for 2011). Required the conversion factor for 2012 and subsequent years to be computed as if the zero update for 2011 had never applied. Extended through calendar 2011 the 1.0 floor on geographic indexing adjustments to the work portion of the physician fee schedule. Extended the physician fee schedule mental health add-on payment provision through December 31, 2011.

*Therapy Services*

Extended through December 31, 2011, the process allowing exceptions to limitations on medically necessary therapy caps.

*Laboratory Services*

Extended until January 1, 2012, an exception to a payment rule that permits laboratories to receive direct Medicare reimbursement when providing the technical component of certain physician pathology services that had been outsourced by certain (rural) hospitals.

*Ambulance*

Extended the bonus and increased payments for ground ambulance services until January 1, 2012. Extended the payment of certain urban air ambulance services until January 1, 2012. Extended increased payments for super rural ambulance services until January 1, 2012.

*Medicare Improvement Fund*

Decreased the amounts available for expenditure from the Medicare Improvement Fund for FY2015.