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Medicare Improvements for Patients and Providers Act of 2008

Implications for Medicare Advantage and Prescription Drug Plans

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Introduction

- Medicare Improvements for Patients and Providers Act of 2008 ("MIPPA") was enacted on July 15, 2008.
  - Veto by President Bush
  - Override by Congress
- MIPPA prevents a mandated reduction in the physician fee schedule--offset by reductions in payments to Medicare Advantage organizations.
- MIPPA also makes significant changes to the Part C and Part D programs.

Goal of Webinar

- Goal of Webinar: Review significant MIPPA provisions that affect Medicare Advantage and Prescription Drug Plans.
- We will cover:
  - Medicare Advantage and Prescription Drug Plan marketing limitations and restrictions
  - Medicare Advantage payment changes
  - Private-fee-for-service plan changes
  - Special Need Plans changes
  - Prescription Drug Plan changes

Marketing Limitations and Restrictions

- Restrictions and prohibitions apply to both MA and PD plans.
- Certain requirements apply for plan years beginning January 1, 2009.
- CMS must establish limitations with respect to other activities to be effective by November 15, 2008.
- CMS issued a Proposed Rule on May 16, 2008 that addresses many of these activities (73 Fed. Reg. 28556).
- Anticipate that CMS will issue regulations shortly.

Marketing Changes (cont.)

- MA and PD plans are prohibited from:
  - Unsolicited direct contact, such as door-to-door sales and outbound telemarketing (Similar to Proposed Rule; door-to-door sales currently prohibited under Medicare Marketing Guidelines)
  - Cross-selling non-health products (annuities and life insurance) (Similar to Proposed Rule)
  - Providing meals (Similar to Proposed Rule; preamble states that "[r]efreshments are allowed, such as coffee, soft drinks, and snacks." 73 Fed. Reg. 28583.)
  - Marketing in health care setting and at educational events (Similar to Proposed Rule).

Effective for plan years beginning January 1, 2009.

Required Marketing Limitations

- CMS must establish limitations on at least the following to be effective no later than November 15, 2008:
- Scope of marketing appointments.
  - Limitation to require advance agreement with prospective beneficiary on scope of marketing appointment and documentation of agreement. Written documentation required where marketing appointment is in person.
  - Proposed Rule also requires documentation of agreed-upon scope.
  - Medicare Marketing Guidelines currently prohibit organizations from soliciting Medicare beneficiaries door-to-door prior to receiving an invitation from the beneficiary to provide assistance in the beneficiary's residence.

Required Marketing Limitations (cont.)

- Co-branding
  - Limitation to address use of name or logo of co-branded network provider on plan membership and marketing materials.
  - Proposed Rule prohibits inclusion of name and/or logo of co-branded providers on member ID cards. Other marketing materials that include name and/or logo of co-branded network provider must indicate that other providers are available in the network.
  - Medicare Marketing Guidelines contain the same requirements as the Proposed Rule.

Required Marketing Limitations (cont.)

- Limitation of gifts to nominal value.
  - Limitation to address the offering of gifts and other promotional items other than those of nominal value to prospective enrollees at promotional events.
  - Proposed Rule prohibits gifts to potential enrollees, unless of nominal value and offered to all eligible members without discrimination.
  - Similar to Medicare Marketing Guidelines.

Required Marketing Limitations (cont.)

- Compensation of agents and brokers.
  - Guidelines shall ensure that the use of compensation creates incentives for agents and brokers (reps) to enroll beneficiaries in plan that is intended to best meet their health care needs.
    - Proposed Rule requires commission (term includes other compensation) in first year not to exceed commission the rep would receive for servicing or selling the policy in subsequent years.
    - Proposed Rule also requires commission to be the same for all plans and all plan product types offered by the organization or sponsor's parent.
    - Medicare Marketing Guidelines do not include commission standards.
      - Potential for reps to market some plans and not others
      - Potential for reps to promote plans that don't meet beneficiary's health needs
      - Incentivize reps to encourage beneficiaries to switch plans every year

Required Marketing Limitations (cont.)

- Required training, annual retraining and testing of agents, brokers and other third parties.
  - Required limitation on the use of any agent, broker or third party who has not completed an initial training and testing program and does not complete an annual retraining and testing program.
  - Proposed Rule is similar.

Greater Involvement of States in Marketing

- New requirements to strengthen states' ability to act in collaboration with CMS to address fraudulent or inappropriate marketing practices:
  - Must use agents and brokers who have been licensed under state law to sell MA and PD plans.
  - Must comply with state appointment law (if any).
    - CMS had previously decided state appointment laws do not apply
  - Must report to the state all terminations (including reason for termination) of agents and brokers.
  - Must comply with "**any request**" by state for information regarding agent, broker or third party performance as part of state investigation of agent, broker or third party.
- Effective for plan years beginning January 1, 2009.

Medicare Advantage Payment Changes

- Elimination of Indirect Medical Education (IME) from Medicare Advantage Payment.
  - IME is intended to compensate teaching hospitals for higher costs they incur for offering broader scope of services and treating patients in poorer health.
    - IME paid directly to teaching hospitals under Traditional Medicare, but is included in overall payments to Medicare Advantage organizations.
  - Beginning in 2010, MA benchmarks will be adjusted to phase-out IME.
  - Reason for the phase-out is to avoid Medicare paying twice for IME.

Medicare Advantage Payment Changes (cont.)

- Adjustments to Medicare Advantage Regional Stabilization Fund.
  - Fund was created by Medicare Modernization Act of 2003 to incentivize Regional PPOs to participate in Medicare Advantage by providing for bonus payments to regional PPOs that were new entrants (as national or regional plan) or remained in underserved areas.
  - Originally funded at $10 billion, but subsequent legislation reduced amount to $1.79 billion. Portion of the savings derived from the regional plan bidding process is added to the Fund.
  - MIPPA reduces the original funding to $1. Savings from the bidding process will continue to flow into Fund.
  - MIPPA also delays payments from the Fund until 2014.

Private Fee-For-Service Plan Changes

- In the Individual Market, private fee-for-service ("PFFS") plans operating in a "network area" can only meet CMS access standards through a contracted provider network and not in whole or in part through "deeming."
  - "Network area" to be identified by CMS as having at least two network-based plans:
    - Coordinated care plan
    - Network-based MSA plan
    - Reasonable cost reimbursement plan
  - Regional PPO plans that don't rely on a contracted provider network are not network-based plans.
- No similar exception for the Employer Market.
- Effective plan year 2011.

PFFS Plan Changes (cont.)

- Elimination of Exemption for PFFS Plans from Quality Improvement Program Requirements.
  - Effective plan year 2010, PFFS plans*:
    - Must have chronic care improvement program
    - Must provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality.
      - Requirements may not exceed those applicable to MA plans that are local PPOs. In addition, for plan year 2010, PFFS plans' obligation is limited to claims data.
    - *Exemption for MSA plans also eliminated.

PFFS Plan Changes (cont.)

- Why Were PFFS Plans So Popular to Offer?
  - Attractive CMS payment rates.
  - No provider network requirement.
  - Ability to offer national plan.
  - Offering Part D benefit optional.
  - If Part D benefit offered, CMS access requirements satisfied without having a contracted pharmacy network.
  - Quality improvement program requirements not applicable

PFFS Plan Changes (cont.)

- What Does the Future Hold for PFFS Plans?
  - MIPPA's changes to PFFS plans intended to cause PFFS enrollment to switch to Traditional Medicare.
  - Can PFFS plans still rely on deeming after 2011?
    - Yes in the individual market if there are not two network-based plans in the area.
    - For both the individual and employer market, answer appears to be yes but only after plan has an adequate contracted provider network.
  - No risk-sharing with providers.
  - Quality improvement program requirements apply.
  - Part D benefit still optional?

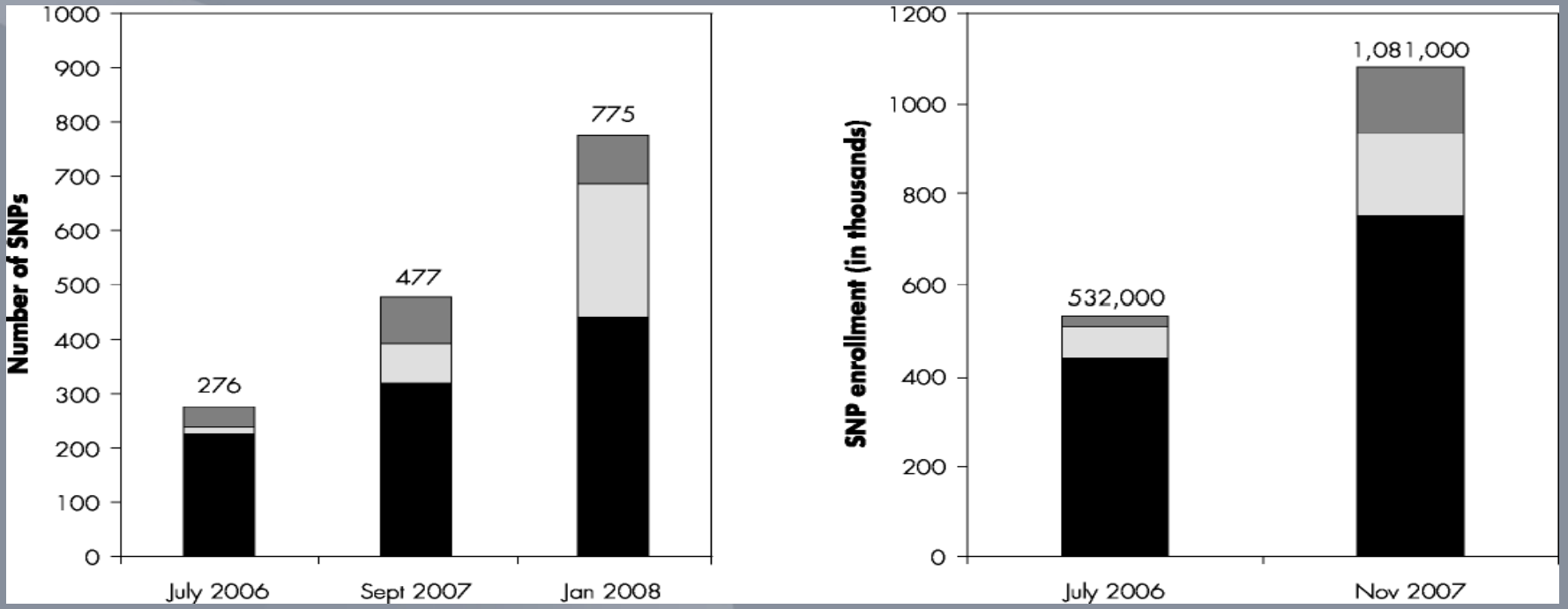
Special Needs Plans

- Extends authority to December 2010.
- Extends moratorium on new disproportionate SNPs.
- All new members must have qualifying condition (January 1, 2010).
- Evidenced-based model of care required (January 1, 2010).
- Plan specific requirements:
  - Dual SNP
  - Chronic SNP
  - Institutional SNP

Special Needs Plans (cont.)

- Moratorium extended.
  - Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) provided authority for SNPs—to expire December 2008.
  - Medicare, Medicaid and SCHIP Extension Act of 2007 extended the authority until December 2009.
  - MIPPA extends the authority for an additional year until December 2010.
- Yearly extensions will make long-term planning difficult.

Special Needs Plans (cont.)



Black is dual-eligible; dark gray is institutional and light gray is chronic condition

- Note: SNP (special needs plan).
- The number of SNP's increased from 2006 to 2008 and enrollment increased between 2006 and 2007.
- Source: CMS special needs plans fact sheet and data summary, February 14, 2006; CMS SNP comprehensive reports, September and November 2007; CMS SNP Report for January 2008, November 2007; and CMS annual report by plan, July 26, 2006.
- Adopted from MedPAC Report to Congress, 2008.

Special Needs Plans (cont.)

- Moratorium on new disproportionate SNPs.
  - Disproportionate SNPs may enroll beneficiaries without special needs as long as proportion to non-special needs individuals is greater than the area served by the plan.
  - Concern that non-special needs beneficiaries dilutes the focus.
- Significant growth in disproportionate SNPs but many enrollees do not have special condition.
  - CMS stated in preamble to the Proposed Rule that "[o]ur expectation was that only a limited number of non-special needs individuals would be likely to enroll in a SNP, such as spouses or children of special needs individuals who wish to enroll in the same MA plan as the spouse or parent." 73 Fed. Reg. 28557.
  - CMS also stated that between 25 and 40% of enrollment in Dual Disproportionate SNPs weren't dual eligible. 73 Fed. Reg. 28558.

Special Needs Plans (cont.)

- New SNP members must have qualifying condition (January 1, 2010).
  - Proposed Rule required 90% of new members must have special condition.
  - Proposed Rule provided additional requirements for confirming that applicants had the special condition.
  - MedPAC had recommended that 95% of members have the special condition.

Special Needs Plans (cont.)

- Evidenced-Based Model of Care.
  - Must have an evidenced-based model of care with appropriate network of providers.
  - Conduct initial assessment and annual reassessment of member's physical, psychosocial and functional needs.
  - Develop a care management plan, with input from individual if feasible with measurable outcomes.
  - Use an interdisciplinary care management team.

  CMS must audit SNP compliance with these requirements.

Special Needs Plans (cont.)

- Dual SNPs
  - Must have a contract with the State Medicaid agency "to provide benefits, or arrange for benefits to be provided" under the Medicaid program. Such benefits may include long-term care services. If no contract, can continue to operate but beginning January 1, 2010 cannot expand service area.
  - Provide each prospective enrollee with a comprehensive statement that describes benefits and cost-sharing that the individual is entitled to under the State Medicaid program and which of those benefits and cost-sharing are covered by the SNP.
  - Dual SNP cannot "impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such plan." (January 1, 2010).

Special Needs Plans (cont.)

- Chronic Care SNPs.
  - Clarification of the definition of a severe or disabling SNP.
  - CMS will convene a panel of clinical advisors to determine the conditions that meet the definition of severe and disabling conditions. First CMS meeting on September 10th.

Special Needs Plans (cont.)

- Institutional SNPs.
  - If individual lives in community but requires institutional level of care, may be eligible if a determination is made that the individual requires an institutional level of care using a State assessment tool by an entity other than the SNP.

MIPPA Part D Provisions - Summary

- Claims Processing Deadlines
- Drug Coverage/Formulary Expansion
- Miscellaneous

MIPPA Part D Provisions – Claims Processing

- Section 171 – Prompt Payment by PDPs and MA-PDs.
  - Effective 1/1/10, all "clean" claims must be paid:
    - Within 30 days of receipt if submitted by paper.
    - Within 14 days of receipt if submitted electronically.
  - Clock starts upon Plan's receipt of claim:
    - Five days after postmark or time stamp of transmission for paper claims.
    - The day after electronic transfer of claim.

MIPPA Part D Provisions – Claims Processing

- Section 171 cont'd
  - Clean claim" defined as one without a "defect or impropriety (including lack of any required substantiating document) or particular circumstance requiring special treatment…."
  - "Deemed Clean Claims" arise if Plan Sponsor does not provide timely notice of any deficiency:
    - Within 10 days of an electronic claim, or
    - Within 15 days of claims "submitted otherwise"
    - Within 10 days of receipt of any additional information requested by the Plan Sponsor.
  - Claim payment occurs:
    - Upon electronic transfer of funds
    - Payment submitted to USPS or other common carrier for delivery.

MIPPA Part D Provisions – Claims Processing

- Section 171 cont'd
  - Interest owed on late payment at the average of three month Treasury bill rate plus .1%.
    - Interest payments are not an allowable administrative expense
    - Interest payments are not drug costs for risk corridor adjustments
  - Secretary has discretion to waive interest for "exigent circumstances."
  - EFT payment required if requested by pharmacy.
  - Retaliation Prohibited.
  - Nothing in Section 171 shall be construed as government approval of or acquiescence regarding a claim.

MIPPA Part D Provisions – Claims Payments

- Section 172 – LTC Pharmacy Claims.
  - LTC Pharmacies have at least 30, but, more than 90 days to submit claims.
  - Effective 1/1/10.
- Section 173 – Pricing Standards.
  - Effective 1/1/09, pricing standards, *e.g.,* AWP, must be updated every seven days.

MIPPA Part D Provisions – Covered Drugs

- Section 175 – Effective 1/1/13, Barbiturates and Benzodiazepines are to be Part D covered drugs.
  - Coverage is diagnoses dependant (epilepsy, cancer, chronic mental health disorder).
  - Coverage currently excluded.
- Section 176 – Effective 1/1/10, HHS will be empowered to identify "certain categories and classes" of drugs that Part D Plans are required to cover, if such drugs meet two criteria:
  - Restricted access would have "major or life threatening consequences" and
  - There is a significant clinical need for multiple drug treatment, such as for cancer.
  - Exception permitted if based on scientific evidence or medical standards and exceptions go through public notice and comment.

MIPPA Part D Provisions – Miscellaneous

- Section 181 – Part D data are available for public health research purposes, including to congressional support agencies (GAO, CRS, etc.)
- Section 182 – "medically accepted indication" for drugs defined to include any FDA-approved use or, in the case of an FDA-approved drug, any other use supported by compendia specified by law or deemed authoritative by the Secretary of HHS.
  - Effective 1/1/10, the Secretary shall only accept compendia for Medicaid purposes that are based on a "publicly transparent process for evaluation therapies and for identifying conflicts of interest."
  - For anti-cancer chemotherapy, Part D Plans are "authorized," based on HHS guidance, to determine whether use is medically accepted.

Questions

Questions and Answers

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Thank you for your participation

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