Order Code RS22904
Updated July 17, 2008

CRS Report for Congress

Summary of Major Provisions in P.L. 110-275: Medicare Improvements for Patients and Providers Act of 2008

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Summary

P.L. 110-275, the Medicare Improvements for Patients and Providers Act (MPPA) became law on July 15, 2008, after Congress overrode a presidential veto on H.R. 6331. The Act is designed to avert a statutory Medicare reduction in payments for physicians and make other changes. The bill freezes physician fees at the June 2008 level until January 2009. In January 2009, fees will increase by 1.1%. In 2010, fees will revert back to current law levels, resulting in a 21% reduction in Medicare physician payments, according to the Congressional Budget Office (CBO). CBO estimates that the physician payments provision cost $9.7 billion (over the 2008-2010 period). Other provisions in the bill will offset these and other costs, so that in total, the provisions in MPPA will reduce deficits (or increase surpluses) by an estimated $0.1 billion over the 2008-2013 period and by less than an estimated $50 million over the 2008-2018 period.[1] The main source for these offsets comes from reductions in spending for (1) the Medicare Advantage program and (2) the physician assistance and quality initiative (PAQI) fund. The Act also makes further changes to Medicare, Medicaid, and other programs under the Social Security Act. This report focuses on the major provisions of MPPA, with the most significant budgetary impacts, and is not meant to reflect all of the provisions.

Physician Payments and Other Physician Issues

MPPA is designed to avert the Medicare reduction in payments for physicians, which was otherwise required by law beginning on July 1, 2008.[2] Annual payment updates for

[1] The CBO cost estimate for H.R. 6331 (now P.L. 110-275) is available at [http://cbo.gov/ftpdocs/94xx/doc9494/RangelLtrHR6331.pdf]. The total budgetary effect is estimated in the memorandum of the cost estimate, which assumed passage of the Supplemental Appropriations Act of 2008, now P.L. 110-252.

[2] On June 27, 2008, the Centers for Medicare and Medicaid Services (CMS) announced plans to instruct its contractors not to process any physician and non-physician practitioner claims for (continued...)

physicians are linked to a formula (typically referred to as the Sustainable Growth Rate, or SGR formula).[3] Under the formula, if cumulative spending on Medicare physician services since April 1996 exceeds cumulative target expenditures over the same period, a reduction in the update for physician payments is required (i.e., a reduction in the conversion factor). This has been the case since 2002; however, Congress has overridden the reduction since 2003.

The previous override, included in the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173, MMSEA), increased the update to the conversion factor for Medicare physician payment by 0.5% (compared with 2007 rates) for the first six months of 2008. Prior to the passage of MPPA, the formula would have required a reduction in the fee schedule of 10.6% for physician reimbursement for services provided between July 1 and December 31, 2008, and by additional amounts annually for at least several years thereafter. MPPA temporarily averts this reduction by extending the 0.5% increase in the physician fee schedule that was set to expire on June 30, 2008, through the end of 2008. Also, for 2009 the update to the conversion factor will be 1.1%. The conversion factor for 2010 and subsequent years will be computed as if these modifications had never applied, resulting in a 21% reduction in the conversion factor in 2010, according to CBO. CBO estimates that these changes will cost $9.7 billion over the 2008-2010 period.

MPPA modifies the funding for the physician assistance and quality initiative (PAQI) Fund (originally created by the Tax Relief and Health Care Act of 2006 — P.L. 109-432, 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 are 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.

The physician quality reporting system, which currently runs through 2009, will be extended through 2010 and beyond. Under current law, eligible professionals who provide covered professional services are eligible for the incentive payment if (1) there are quality measures that have been established under the physician reporting system that are applicable to any services furnished by such professional for the reporting period, and (2) the eligible professional satisfactorily submits data to the Secretary on the quality measures.

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[2] (...continued)
the first 10 business days of July. According to existing law, electronic claims are not to be paid any sooner than 14 days (29 days for paper claims) and not later than the 30th day they are submitted (otherwise, CMS must pay interest on those claims). CMS stated that by holding claims for services that were delivered on or after July 1, it would not be making any payments on the 10.6% reduction until July 15, at the earliest. On July 16, 2008, following enactment of MPPA, CMS announced that it had instructed its contractors to implement the changes, but that it might take up to 10 days. Contractors will begin to automatically reprocess any claims paid at a lower rate, in a timely manner.

[3] For a further explanation of how physicians are paid under Medicare and why this reduction would occur, see CRS Report RL31199, *Medicare: Payments to Physicians*, by Jennifer O'Sullivan.

MPPA also makes other changes for physicians by establishing a physician feedback program, with the intent to improve efficiency and to control costs, and requires the Secretary of Health and Human Services to develop a plan to transition to a value-based purchasing program for payment under the Medicare program for covered professional services.

CBO estimates that changes in Section 131 of MPPA (including the changes to physician payment, the PAQI Fund, and other changes described above) will cost $6.4 billion over the 2008-2013 period and $4.5 billion over the 2008-2018 period.

The Act establishes 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), makes $2.22 billion from the Part A and B Trust Funds available for services furnished during FY2014 and an additional $19.9 billion available for fiscal years 2014 through 2017. CBO estimates that these changes and interactions will cost $0.1 billion over the 2008-2013 period and $24.2 billion over the 2008-2018 period.

Medicare Advantage

MPPA phases out Medicare indirect medical education (IME) payments to private health plans. IME payments account for a number of factors that may legitimately increase costs in teaching hospitals. Currently under the statutory rules for Medicare payments to Medicare Advantage (MA) plans, an MA plan whose payment is based on Medicare fee-for-service rates also may be eligible to receive a payment for IME. In addition, Medicare pays teaching hospitals directly for the cost of IME when an MA enrollee is treated in the hospital.

Beginning in 2010, this Act requires that the Medicare Advantage benchmarks (the maximum amount Medicare is willing to pay a private plan to provide required Medicare benefits) for every county be adjusted to phase out the cost of indirect medical education (IME). The amount phased-out each year will be based on a ratio of (1) a specified percentage (0.60% in the first year), relative to (2) the proportion of per capita costs in original Medicare in the county that IME costs represent. The effect of the ratio is to phase out a higher proportion of IME costs in areas where IME makes up a smaller percentage of per capita spending in original Medicare. After 2010, the numerator phase-out percentage will be increased by 0.60 percentage points each year. This provision does not apply to the benchmarks for MA plans in the PACE program (Programs of All-Inclusive Care for the Elderly).

MPPA also changes access requirements for Private Fee-for-Service plans (PFFS). Currently, PFFS, unlike most other MA plans, are not required to form networks of medical providers to meet certain access requirements. PFFS plans (both non-employer- and employer-sponsored) may fulfill access requirements by either establishing payment rates for medical providers that are no less than the rates under original Medicare, or by developing contracts and agreements with a sufficient number and range of providers within a category to provide covered services under the terms and conditions of the plan. Any provider who, before delivering a service, knows that a beneficiary is enrolled in the

PFFS plan, and has been given, or has reasonable access to, the PFFS plan's terms and conditions for participation, is a "deemed" provider.

Beginning in year 2011, this Act requires non-employer-sponsored MA PFFS plans (operating in areas with *at least* two other plans that have provider networks) to meet Medicare access requirements by establishing written contracts with providers. Non-employer sponsored MA PFFS plans (operating in areas with *less than* two other plans that have provider networks) may continue to meet Medicare access requirements through deeming.

Beginning in year 2011, employer-sponsored MA PFFS plans will be required to establish written contracts with providers. Employer-sponsored MA PFFS plans will no longer be able to meet access requirements, in whole or in part, by establishing payment rates that are equal to or greater than those under original Medicare.

Beginning in 2010, any PFFS plan that chooses to contract with providers is required to meet the general access requirements applicable to MA coordinated care plans.

CBO combined the savings estimates for the changes to IME and PFFS. It estimated that these provisions will save $12.5 billion over the 2008-2013 period and $47.5 billion over the 2008-2018 period.

The Act also reduces 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. Subsequent legislation reduced this amount to $1.79 billion. The MMA also required that a portion of the savings accrued in the regional plan bidding process be added to the Fund. This Act does not alter that funding stream, so that money from the regional plan bidding process will continue to flow into the Fund. Expenditures will be delayed one year, until 2014. CBO estimates that these MPPA changes save $1.3 billion over the 2008-2013 period and $1.8 billion over the 2008-2018 period.

Other Provisions

The sections of the Act described below are primarily other provisions with significant costs or savings of at least $2 billion over the 10-year period (2008-2018), as estimated by CBO.

MPPA adds "additional preventive services" to the list of Medicare-covered preventive services. The term "additional preventive services" means services not otherwise described in Medicare law that identify medical conditions or risk factors that the Secretary determines meet certain specified conditions. The Act also waives the deductible for the initial preventive physical exam (also known as "Welcome to Medicare") and extends the eligibility period for this service from the first six months to the first year of Part B enrollment. CBO estimates that these changes cost $1.4 billion over the 2008-2013 period and $5.9 billion over the 2008-2018 period.

MPPA increases 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, outpatient psychiatric services will be paid on the same basis as other Part B

services. CBO estimates that these changes cost $0.5 billion over the 2008-2013 period and $3 billion over the 2008-2018 period.

MPPA increases, effective January 1, 2010, the assets tests applicable under the Medicare Savings program (MSP) to those applicable under the low-income subsidy program under the Medicare Part D prescription drug program ($6,290 for an individual, $9,440 for a couple in 2008, updated annually). CBO estimates that these changes cost $1.6 billion over the 2008-2013 period and $7.0 billion over the 2008-2018 period.

The Act repeals the current law requirement for competitive bidding for clinical laboratory services. In addition, it specifies 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. CBO estimates that these changes save $0.6 billion over the 2008-2013 period and $2.0 billion over the 2008-2018 period.

The Act also makes changes to low-income programs for Medicare beneficiaries, as well as Medicaid. It makes changes to Medicare provisions for hospitals, renal dialysis coverage, and Medicare prescription drug coverage, among others. Finally, MPPA terminates 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. It requires the Secretary to re-bid the first round in 2009 and delays the second round of bidding until 2011. To pay for the cost of the program delay, the Act requires 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. CBO estimates that the changes to the DEMPOS competitive bidding program will have a negligible budgetary impact.