The Medicare Prescription Drug, Improvement and Modernization Act:

Status of Regulatory Changes

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Overview

- Fee-For-Service Contracting Reform
- Changes to Medicare Appeals Process
- Medicare Managed Care Expansion

FFS Contracting Reform

- Medicare Administrative Contractors ("MACs") replace FIs and carriers
- Beginning 10/2005, CMS will compete and award 23 MAC contracts
  - 15 Primary A/B MACs
  - 4 Specialty MACs servicing majority of HH/hospice providers
  - 4 Specialty MACs servicing suppliers of DME

Contracting Reform

- Key changes
  - Consolidated contracting services for Part A and Part B
  - Revised termination procedures
  - Balance among jurisdictions in number of beneficiaries, practitioners and claims
  - Ks will include significant internal control and compliance program requirements

How Will Changes Affect Providers?

- Single point of contact for all claims-related business
- Better service by virtue of financial incentives and competition
- IT Improvements
- Provider education and training for small providers and suppliers

Timeline for Transition to MACs

- Oct. 2005 to Oct. 2011
- **Stage 1**
  - DME MAC award expected 12/2005 and Jurisdiction 3 Primary A/B MAC award expected 6/2006, with 6-13 month transition phase
- **Stage 2**
  - RFP issued 9/2006 for 7 of the remaining Primary A/B MAC jurisdictions (CT included)
  - Anticipated award date 9/2007 and 6-13 month transition
- **Stage 3**
  - RFP issued 9/2007 for remaining A/B MAC jurisdictions and HH/hospice MACs. Award date 9/2008 and 6-13 month transition

Managed Care Reform

- Medicare Advantage replaced M+C program
- New Medicare Advantage Plan Options
  - Regional PPO contracting option beginning Jan. 2006
  - Special Needs Plans for individuals with specific health conditions
- New payment system

Regional PPO Plan Option

- Logistics
  - 26 regions
  - Plan must cover at least one entire region
  - Multiple plans may cover single region
  - Contracts to be signed by 9/15/2005
- Mandatory Elements
  - Provide all Medicare-covered benefits
  - Single Part A/B deductible
  - Catastrophic cap on out-of-pocket expenses for in-network and out-of-network Medicare benefits

New Payment System for MA Organizations

- Payment based on organization's monthly costs for the average beneficiary
  - i.e., How much government $ does the plan need to offer its benefits package?
- Bidding System
  - 1st Monday in June each year, beginning 2005

Bidding System, cont'd

- Bid is sum of 3 parts:
  - Cost of providing basic A/B benefits
  - Cost of providing basic prescription drug benefit if Plan offers Part D
  - Cost of providing supplemental benefits, if any
- Plans get paid total bid, through combination of government $ and beneficiary premiums

Bidding System, cont'd

- CMS "benchmark" is compared to bid to determine whether plan will:
  - Have savings and offer rebates; or
  - Have to charge premium
- Benchmark for local and regional PPOs is set annually; risk-adjusted

Payment to PPOs, cont'd

- Bid below benchmark = savings + rebates
  - Government pays bid, plus 75% of difference between bid and benchmark
  - Difference must be returned to enrollee in the form of additional benefits or reduced premiums
    - No rebates for optional supplemental benefits

Regional PPO Incentives

- Moratorium on new local PPOs
- CMS will share risk with regional plans for costs that exceed set target
  - Protects plans from cost overruns
  - Allows government to share in cost savings
- $10 billion stabilization fund available 1/2007

Changes to Appeals Process for Part A & Part B Fee-for-Service Claims

- Interim Final Rule published March 8, 2005 (42 C.F.R. Part 405)
  - New appeal rights for providers effective May 1, 2005
  - New second-level of contractor appeal
  - Changes to Administrative Law Judge ("ALJ") hearings

New Second Level of Appeal

- "Reconsideration" by Qualified Independent Contractor ("QIC")
  - Did not previously exist for Part A claims
  - Replaces fair hearing level of appeal for Part B claims
- Panel of health care professionals with sufficient medical, legal and other expertise and knowledge of Medicare
  - Must include a physician if claim pertains to items or services provided by a physician

Reconsideration cont'd

- No amount-in-controversy requirement
- All evidence must be submitted with request
  - Evidence not submitted cannot be introduced at subsequent appeal levels, absent good cause
- Decision required within 60 days
  - Or provider/supplier can escalate appeal to ALJ
  - Extended if evidence submitted after request for reconsideration is filed

QIC Implementation

- Part A Claims
  - QIC procedures took effect on May 1, 2005 for all appeals from FI re-determinations issued on or after that date
- Part B Claims
  - QIC procedures will take effect for carrier re-determinations issued on or after 1/1/2006.

Changes to ALJ Hearings

- More Prominent Role for CMS
  - ALJ can request (but not require) CMS or its contractor to file position paper or give testimony
    - No right to call or cross-examine witnesses
  - CMS may on its own motion elect to act as a party (with right to call and cross-examine witnesses)
    - CMS can appeal to Medicare Appeals Council

ALJ Hearings, cont'd

- Substantial deference to CMS
  - LCDs, Local Medical Review Policies, program memoranda, CMS manuals
- Hearings by videoteleconference
  - In-person hearing requires approval of Managing Field Office ALJ and special or extraordinary circumstances

Appeals Reform, cont'd

- MMA requires transfer of ALJ hearing responsibility from SSA to HHS no later than Oct. 2005
- March 2004 report to Congress
  - Beginning July 1, 2005 new appeal requests will go to HHS
  - SSA slated to finish processing all pending appeals by Sept. 20, 2005

Resources

- http://www.cms.hhs.gov/medicarereform/
- 2005 HHS Report to Congress, Medicare Contracting Reform

Questions?

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