



CMA Weekly Alert – August 23, 2007

WHY THE *CHAMP* ACT IS GOOD MEDICINE FOR MEDICARE BENEFICIARIES – PART 3

On August 1, 2007, the House of Representatives passed H.R. 3162, the Children's Health and Medicare Protection (CHAMP) Act of 2007. Contrary to statements by health insurance plans and other providers, CHAMP protects Medicare by reducing costly overpayments that threaten the integrity of the whole Medicare program. Also contrary to statements by providers, CHAMP expands, not reduces, Medicare benefits and coverage, particularly for individuals with low incomes. (For more information, see the Center for Medicare Advocacy's *Weekly Alert* of July 12, 2007 regarding disinformation being spread about MA plans, at http://www.medicareadvocacy.org/MA_07_07.12.MAHype.htm.) CHAMP, in fact, includes the most comprehensive and extensive improvement in protections for individuals with low-incomes in almost twenty years.

This *Weekly Alert*, part three of our series on the key aspects of CHAMP, describes provisions that affect beneficiary cost-sharing, expansion of preventive benefits, other payment and coverage improvements, including End Stage Renal Disease (ESRD) management and patient education, and changes in physician reimbursement. The summary is grouped in order of relevance to beneficiary access and coverage concerns.

Saving the Medicare Program for All Beneficiaries

Section 902. Repealing the “45% rule”: This provision protects the integrity of Medicare by repealing a terribly important, but little noted section of the Medicare Act of 2003 (MMA). This provision established a standard to review Medicare’s solvency based on the source of Medicare funding rather than on program costs. The MMA provision *requires* the President to recommend Medicare reductions when the Medicare Trustees' project, for two consecutive years, that 45% of Medicare funding will come from general revenues at a set future date. Note that Medicare Part B and D were designed by Congress to be funded primarily from general revenue, thus the arbitrary 45% mark is all but guaranteed to be reached.

Section 903. Repealing the comparative cost adjustment program: This provision repeals a demonstration program mandated by the MMA that would require traditional Medicare to compete with Medicare Advantage (MA) plans in a number of locations around the country. Because Medicare Advantage plans are paid more than traditional Medicare, the plans would be able to submit lower bids, resulting in further harm to the traditional program and an increase in Part B premiums for beneficiaries who live in demonstration project areas.

Medigap Improvement

Section 907. Improving the Medigap program: This provision authorizes CMS to provide for the implementation of recommendations made by the National Association of Insurance Commissioners (NAIC) for changes in their model rules. It requires insurers to offer standard plans C and F, in addition to the basic plan, plan A. The provision also eliminates the only two statutorily-mandated plans, plans K and L, which required beneficiaries to incur substantially more cost-sharing than other Medigap plans.

Medicare Beneficiary Improvements

Section 203. Parity for mental health coinsurance: For expenses for any calendar year "before 2008," this provision provides that for outpatient treatment of an individual's mental, psychoneurotic and personality disorders, incurred expenses would be recognized at only 62.5% of each such expense. By eliminating the 62.5% limit on the recognized incurred amount for 2008 and beyond, this provision raises the amount Medicare will pay for outpatient mental health treatment from 50% to 80% (generally, what Medicare pays for other outpatient services).

Section 202(a) Waiver of deductible for colorectal cancer screening tests: This provision provides that the Medicare deductible will be waived for colorectal cancer screening tests regardless of the coding, subsequent diagnosis, ancillary tissue removal or other procedures. It is effective for items and services furnished on or after January 1, 2008.

Section 201. Coverage and Waiver of Cost-sharing for Preventive Services: This provision allows the Secretary to add new Medicare preventive benefits, including mental health services, that are reasonable and necessary for the prevention or early detection of an illness or disability. It eliminates the co-insurance and deductible for current preventive benefits and for future preventive benefits added in accord with this provision. The provision would be effective January 1, 2008.

Section 601. Payment for Therapy Services: This provision extends the exceptions process for the Medicare outpatient therapy caps through 2009. In general, under this process, if the cost of medically necessary therapy services exceeds the payment cap, the beneficiary may request an exception from the uniform dollar limitation. If the Secretary does not make a decision on a request for an exception within 10 business days of the date of the Secretary's receipt of the request, the Secretary shall be deemed to have found the services to be medically necessary.

The provision also requires the Secretary to develop alternative or refined payment systems to the current Medicare payment cap, and to submit a report to Congress by not later than January 1, 2009.

Section 602. Medicare Separate Definition of Outpatient Speech-Language Pathology Services: This provision allows speech-language pathologists to bill Medicare directly for their services, although a referral by a physician will still be required for speech therapy.

Section 608. Rental and Purchase of Power-Driven Wheelchairs: Effective January 1, 2008, Durable Medical Equipment (DME) provisions are revised to provide that for such DME furnished on or after January 1, 2008, payment shall be made on a monthly basis for the rental of the item during the period of medical need of no longer than 13 months. Immediate purchase of power driven wheelchairs will be prohibited.

Section 609. Rental and Purchase of Oxygen Equipment: This provision clarifies that with respect to oxygen generating portable equipment, after 36 months of payments, title is transferred to the Medicare beneficiary. For persons receiving oxygen equipment under this provision on December 31, 2007, the counting of the 36 months begins on January 1, 2008, but in no case is to exceed a rental period of 36 months. In addition, the Secretary shall conduct a study to examine the service component and the equipment component of the provision of oxygen to Medicare beneficiaries. The report is to be submitted to Congress no later than 18 months after the date of the enactment of legislation.

Section 610. Adjustment for Mental Health Services: This provision provides a temporary payment adjustment for certain mental health services. Payment for such services furnished under the physician fee schedule for mental health services is increased by 5% for the period beginning on January 1, 2008 and

ending on December 31 of the year before the effective date of the first relative value unit review, for services provided after January 1, 2008.

Section 612. Payment for Part B drugs: This provision revises payment methodologies for drugs and biologicals covered under Part B and makes improvements to the competitive acquisition program (CAP), including physician education and outreach about the program.

Section 631. Chronic Kidney Disease Demonstration Projects: This provision requires the Secretary, acting through the National Institutes of Health (NIH), to establish demonstration projects to (1) increase awareness about the factors that lead to, and prevent, chronic kidney disease; (2) increase screening and use of prevention techniques for chronic kidney disease, and; (3) enhance surveillance systems and expand research to better assess the prevalence and incidence of chronic kidney disease.

The provision limits these demonstration projects to 5 years and requires the Secretary to make recommendations for legislation and administrative action thereafter.

Section 632. Medicare coverage of kidney disease patient education services: This provision creates coverage of kidney disease education services which are defined as education services that are furnished to an individual with Stage IV chronic kidney disease who, according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant.

Section 633. Required training for patient care dialysis technicians: This section requires training and certification for patient care dialysis technicians.

Section 634. MEDPAC Report on treatment modalities for patients with kidney disease: This provision requires the Medicare Payment Advisory Commission (MEDPAC) to submit a report to the Secretary and to Congress evaluating the barriers that exist to increasing the number of individuals with end-stage renal disease (ESRD) who elect to receive home dialysis under the Medicare program.

Section 703. Extending Medicare Secondary Payer for beneficiaries with end stage renal disease (ESRD) for large group health plans: This section extends the period, from 30 to 42 months, for which large employer group health plans are primary to Medicare coverage for individuals with ESRD; it applies to employers with 100+ employees.

Physicians' Service Payment Reform

Section 301. Establishment of Separate Target Growth Rates for Service Categories: This section provides for a .5% update in physician reimbursements for 2008 and 2009. Effective January 1, 2008, each of the following categories of physicians' services shall be treated as a separate "service category": (a) Evaluation and management services for primary care and preventive services; (b) Evaluation and management services not described above; (c) Imaging Services and diagnostic tests (other than clinical diagnostic laboratory tests); (d) Procedures that are subject to a 10-day or 90-day global period (as determined by the Secretary as 'major procedures'); (e) Anesthesia services and (f) Minor procedures and any other physicians' services that are not described in a preceding subparagraph.

Beginning in 2008, the Secretary is to apply multiple conversion factors to determine reimbursement rates and is to provide updates for each of the physician service categories. In addition, the Secretary is to include information in the annual physical fee schedule proposed rule on the change in the rate of growth of actual expenditures for clinical diagnostic laboratory tests or drugs, biologicals, and radiopharmaceuticals for which payment is made under Part B.

Section 302. Improving accuracy of relative values under the Medicare physician fee schedule: This provision requires the Secretary to establish an expert panel to identify, through data analysis, physician's services for which the relative value under current Medicare law is "misvalued," particularly those services for which a relative value may be over-valued. The panel is to assess whether misvalued services warrant review using existing procedures and to advise the Secretary with respect to any re-valuing that should occur.

Section 303. Feedback mechanism on practice patterns: By not later than July 1, 2009, the Secretary shall develop and implement a mechanism to measure resource use on both a per capita and per-episode basis in order to provide confidential feedback to physicians in the Medicare program on how their practice patterns compare to physicians generally, both in the same locality as well as nationally. The Secretary shall consider extending such mechanism to other suppliers as necessary.

Section 304. Payments for efficient areas. This provision provides payment incentives for physicians working in "efficient areas." Efficient areas are defined as those counties in the lowest 5th percentile of Medicare utilization, based on per capita spending for services provided under Parts A and B in 2007. Physicians in an "efficient area," will be paid an additional amount equal to 5 percent of the payment amount for services in "efficient areas."

Section 305. Recommendations on Refining the Physician Payment Schedule: Not later than December 31, 2008, the Comptroller General of the United States is to provide to Congress recommendations on consolidated coding for services commonly performed together. The Comptroller General is also to report on recommendations to identify opportunities for an increased use of "bundled" payments. This report is due no later than December 31, 2008.

Section 306. Improved and Expanded Medical Home Demonstration Project: This provision requires the Secretary to establish expanded "Medical Home" demonstration projects. These projects supersede those established under the Medicare Improvement and Extension Act of 2003. The expanded projects are to provide accessible, continuous, comprehensive, and coordinated, care to Medicare beneficiaries. The projects will operate during a period of three years, beginning not later than October 1, 2009. Small practitioners will be encouraged to participate.

Section 307. Repeal of Physician Assistance and Quality Initiative Fund: This provision repeals the discretionary fund of over 1 billion dollars which was made available to the Secretary for physician payment and quality improvement initiatives in the 2008 calendar year.

Section 309. Payment for Imaging Services: This provision establishes new payment rules for diagnostic imaging services and requires that such services meet certification requirements as provided in the Public Health Services Act.

Section 310. Reduces the Frequency of meetings of the Practicing Physician's Advisory Council: This provision makes such meetings annual rather than quarterly.

[Click here to read a Judith Stein editorial on the CHAMP Act.](#)

For further information on the provisions discussed above, please contact attorney Vicki Gottlich (vgottlich@medicareadvocacy.org) or Alfred J. Chiplin, Jr. (Achiplin@medicareadvocacy.org) in the Center for Medicare Advocacy's Washington, DC office at (202) 216-0028.