"Preserving Access to Medicare Act of 2008"
Summary
June 11, 2008

Title I – MEDICARE IMPROVEMENTS

Subtitle A – Craig Thomas Rural Hospital and Provider Equity Act of 2008

Sec. 101. Temporary Improvements to the Medicare Inpatient Hospital Payment Adjustment for Low-volume Hospitals.
In FY2009 hospitals that are located more than 15 road miles from another comparable hospital and have 2,000 discharges of individuals entitled to or enrolled for Medicare Part A benefits would receive a low-volume payment adjustment for Medicare inpatient hospital services. The Secretary would determine the applicable percentage increase using a linear sliding scale ranging from 25% for low-volume hospitals below a certain threshold to no adjustment for hospitals with greater than 2,000 discharges of individuals with Medicare Part A benefits.

Section 102. Improvement to the Medicare Dependent Hospital (MDH) Program.
For discharges in FY 2009, MDH payments would not be adjusted for area wages unless it would result in improved payments.

Section 103. Ambulance Services.
Provides for an add-on payment for ground ambulance services of 3% in rural areas and 2% in urban areas for the period July 1, 2008 – December 31, 2009. Provides an 18 month hold harmless for air ambulance areas previously designated as rural and clarifies the medically necessary requirement for air ambulance services.

Section 104. Extension and Improvement of Medicare FLEX Program.
The provision would extend the Medicare Rural Hospital Flexibility Grant Program through FY2010, increases authorization for appropriations and provides for grants for quality improvement and performance measurement activities.

Section 105. Rebasing for Sole Community Hospitals (SCHs).
Starting for discharges on January 1, 2009, SCHs would be able to elect payment based on their FY2006 hospital-specific payment amount per discharge.

Section 106. Extension and Expansion of the Medicare Hospital Outpatient Department Hold Harmless Provision for Small Rural Hospitals.
The provision would establish that in CY 2009, small rural hospitals, including Medicare Dependent Hospitals and Sole Community Hospitals under 100 beds, would receive 85% of the difference between payments made under the Medicare Hospital Outpatient Prospective Payment System and those made under the prior reimbursement system.

Section 107. Clarification of Payment for Clinical Laboratory Tests Furnished by Critical Access Hospitals (CAHs).
Under this provision, clinical diagnostic laboratory services furnished by a CAH starting in July 1, 2009 would be reimbursed at 101% of costs as outpatient hospital services without regard to whether the specimen was collected from a patient of the CAH so long as the individual from whom the specimen was collected was in the same county as the CAH.

Section 108. Extension of Floor on Work GPCI.
Extends for eighteen months the work geographic index (GPCI) floor of 1.0 through December 31, 2009.

Section 109. Extension of Treatment of Certain Physician Pathology Services.
Extends for eighteen months the provision that allows independent laboratories to continue to bill Medicare directly for the technical component of certain physician pathology services provided to hospitals as authorized by the Balanced Budget Act of 1997 through December 31, 2009.

Section 110. Adding Hospital-Based Renal Dialysis Centers as Originating Sites for Telehealth Services.
The provision would permit a hospital-based or critical access hospital-based renal dialysis center (including satellites) to be an originating site for the provision of telehealth services as of January 1, 2009.

Section 111. Adding Skilled Nursing Facilities as Originating Sites for Telehealth Services.
The provision would permit otherwise qualifying skilled nursing facilities to be an originating site for the provision of telehealth services as of January 1, 2009.

Section 112. Applying Rural Home Health Add-on Policy for 2009.
Reinstates the five percent home health add-on payment for rural home health agencies in 2009.

Subtitle B – Other Provisions Related to Part A

Section 121. Extension of Reclassification of Certain Hospitals Under the Medicare Program.
Extends until September 30, 2009, provisions that have allowed certain hospitals to be eligible for wage index reclassification that were otherwise unable to qualify for administrative wage index reclassification.

Section 122. Institute of Medicine Study and Report on Post-Acute Care.
Requires the Secretary would enter into a contract with the Institute of Medicine (IOM) of the National Academy of Sciences to conduct a study on short-term and long-term steps to reform Medicare's current post-acute care payment and delivery system.

Section 123. Revocation of Unique Deeming Authority of the Joint Commission
This provision would revoke the unique statutory authority granted to the Joint Commission of Healthcare Organizations (JCAHO) to accredit hospitals for participation in Medicare. Hospitals, like other Medicare provider entities, would be accredited by national accrediting organizations approved by the Secretary. The Secretary would have the authority to recognize JCAHO as a national accreditation body.

Section 124. MedPAC Study and Report on Hospice Care
The provision would require the Medicare Payment Advisory Commission (MedPAC) to submit a report to Congress on payments for hospice services. The report should include recommendations for potential changes in payment methodologies, including revisions to the aggregate cap.

Section 125. Introducing the Principles of Value-Based Health Care into the Medicare Program
The provision would require the Secretary to design and implement a system under which a portion of Medicare provider payments for hospitals would be based on the quality of provider performance.

Subtitle C – Other Provisions Relating to Part B

Section 131. Physician Payment Update.
Replaces the scheduled 10.1% cut to the Medicare physician reimbursement rate with an 18-month update. Continues the 0.5% increase through December 31, 2008 and provides an additional 1.1% update for 2009 as recommended by the Medicare Payment Advisory Commission (MedPAC). Revises the Physician Assistance and Quality Initiative fund in 2013 and deposits excess savings to help fund a physician update in subsequent years.

Quality Improvements.
Extends and improves the physician quality reporting system through 2010 and increases PQRI incentive payments to 2.0% in 2009 and 2010. Requires Secretary to accept aggregate data from group practices on PQRI measures that target high-cost chronic conditions and preventive care. Includes changes enacted in MMSEA to allow reporting on groups of measures for certain conditions, alternative reporting periods, and reporting via registries. Includes audiologists as eligible professionals for PQRI. Requires the Secretary to establish a confidential physician feedback program regarding resource use as of 2009. Requires the Secretary to develop a value-based purchasing plan for physicians and other professionals and submit a report to Congress.

Section 132. Incentives for Electronic Prescribing.
Provides positive incentive payments for the use of a qualified e-prescribing system by eligible professionals from 2009 through 2013. Requires the use of a qualified e-prescribing system in 2010 and reduces payment for eligible physicians who fail to use e-prescribing beginning in 2011. Incentive payments are based on allowed charges for all covered Medicare services. Allows for significant hardship exceptions, such as professionals in rural areas without sufficient Internet access, and excludes those who write a small number of prescriptions.

Section 133. Increasing the Number of Sites for Electronic Health Records Demonstration.
Provides funding for a demonstration project on electronic health records.

Section 134. Primary Care Improvements.
Establishes new Physician Scarcity Area incentive payments for primary care services furnished in Physician Scarcity Areas, as of January 1, 2011. Expands the Medicare Medical Home Demonstration Project established in the Tax Relief and Health Care Act of 2006. Authorizes the Secretary to expand the duration and scope of the project if certain quality of care or spending conditions are met and provides additional funding. Reapplies the budget-neutrality adjustment to the conversion factor rather than to work relative value units with respect to the most recent 5-year review of work RVUs, effective January 1, 2009.

Section 135. Medicare Anesthesia Teaching Program Improvements.
Eliminates the 50 percent teaching rule and requires CMS to provide 100 percent payment for teaching anesthesiologists. Requires payment for teaching certified registered nurse anesthetists to be consistent with adjustments made for teaching anesthesiologists.

Section 136. Medicare Coordinated Care Practice Research Network Demonstration.
Requires the Secretary to establish a demonstration project to test best practices and innovative coordinated care projects for Medicare beneficiaries with multiple chronic conditions, no later than October 1, 2009. Sites include organizations which were participants in the Medicare Coordinated Care Demonstration project and may include other organizations as determined by the Secretary.

Section 137. Imaging Accreditation, Appropriateness, and Disclosure Requirements.
Requires that facilities and other providers who furnish the technical component of advanced diagnostic imaging services (MRI, CT, and nuclear medicine, including PET) be accredited as of January 1, 2012. Establishes an accreditation process and requires the Secretary to designate accreditation organizations as of January 1, 2010.

Establishes a two-year demonstration project to be implemented by January 1, 2010 to assess the appropriate use of advanced diagnostic imaging services by collecting data regarding physician compliance with clinical appropriateness criteria. Requires referring physician to disclose ownership interest and provide beneficiary with a list of providers.

Section 138. Accommodation of physicians ordered to active duty in the Armed Services.
Makes permanent a provision permitting physicians in the armed services to engage in substitute billing arrangements for longer than 60 days when they are ordered to active duty.

Section 139. Extension of Exceptions Process for Medicare Therapy Caps.
Ensures Medicare beneficiaries access to therapy services through December 31, 2009.

Section 140. Speech-Language Pathology Services.
Allows speech-language pathologists practicing independently to bill Medicare directly for their services.

Section 141. Coverage of Items and Services Under Cardiac Pulmonary Rehabilitation Programs.
The provision would provide coverage for items and services furnished under a cardiac rehabilitation program or under a pulmonary rehabilitation program within the definition of covered medical and other health services, as of January 1, 2009.

Section 142. Repeal of Transfer of Ownership of Oxygen Equipment.
Repeals title transfer after 36 months and allows oxygen suppliers to retain ownership of oxygen equipment, effective January 1, 2009.

Section 143. Extension of Payment Rule for Brachytherapy and Radiopharmaceuticals.
Extends the current "charges to cost" methodology which provides a separate payment for brachytherapy services and therapeutic radiopharmaceuticals.

Section 144. Clinical Laboratory Tests.
Repeals the competitive bidding demonstration program for clinical laboratory services. Reduces payments for clinical laboratory tests by -0.5% for 2009-2013.

Section 145. Sense of the Senate on Delayed Implementation of DMEPOS Competitive Bidding Program.
Implementation of competitive bidding for durable medical equipment, prosthetics, orthotics, and supplies should be delayed by 18 months to address concerns and ensure beneficiaries continued access to quality medical equipment and supplies.

Subtitle D – End Stage Renal Disease Program Reforms

Section 151. Kidney Disease Education and Awareness Provisions.
Establishes pilot projects to increase awareness of chronic kidney disease in at least three states. Provides coverage of kidney disease patient education services furnished by qualified providers to those requiring dialysis or a kidney transplant consisting of comprehensive information on managing comorbidities, preventing complications, and explaining options for renal replacement therapy, including home dialysis.

Section 152. Renal Dialysis Provisions.
Provides a 1.0 percent update to the composite rate for renal dialysis services as of January 1, 2009, and another 1.0 percent update as of January 1, 2010. Creates a site-neutral composite rate for dialysis services furnished on or after January 1, 2009 to equalize payments for hospital outpatient departments providing dialysis services and freestanding dialysis facilities.

Establishes a fully bundled payment system for renal dialysis services, effective January 1, 2011, for dialysis and related drugs, laboratory tests, and other items and services furnished to individuals for the treatment of end stage renal disease (ESRD). Establishes an annual update for providers and renal dialysis facilities (of MB minus 1.0 percent) as of 2012. Requires case mix adjusters as well as additional payments for high cost outliers and costs incurred by rural, low volume providers and facilities. Allows other payment adjustments the Secretary determines appropriate, such as pediatric and rural add-on payments. Provides an optional four year phase-in to bundling for providers and facilities, from 2011 to 2014.

Establishes a quality incentive program for providers and renal dialysis facilities, effective January 1, 2012. Requires that providers of ESRD services and renal dialysis facilities meet performance standards with respect to renal dialysis measures endorsed by a consensus-based organization.

Subtitle E – Provisions Relating to Part C

Section 161. Phase-out of Indirect Medicare Education Payments from Payments to Medicare Advantage Plans

Phases out inclusion of payments for indirect medical education (IME) in Medicare Advantage payments. The IME payments are phased out by reducing the Medicare Advantage payment rate by .6 percent each year until the amount accounted for by IME is exhausted.

Section 162. Revisions to Quality Improvement Programs.

Requires Medicare Advantage private fee-for-service (PFFS) plans and MSA plans to submit data for quality analysis and reporting, whether the services are provided under contract or not. Specifies that to the extent services are provided by non-contracted providers, the data required for analysis and reporting on quality is limited to administrative data and beneficiary survey data.

Section 163. Revisions Relating to Specialized Medicare Advantage Plans for Special Needs Individuals.

Extends the authority of specialized plans to target enrollment to certain populations through 2009. Lifts the moratorium on new plans and expanded service areas for special needs plans serving institutionalized populations and beneficiaries who are eligible for both Medicare and Medicaid ("dual-eligibles"). All special needs plans must meet additional requirements; 90 percent of new enrollment for all plans would have to be special needs individuals and special needs plans would have to have models of care targeted to the special needs populations they served. Special needs plans for dual Medicare- and Medicaid-eligibles would have three years to reach agreement with the states in which they operated. SNPs targeting dual-eligibles would have to protect enrollees from cost-sharing the state would have covered had these enrollees remained in fee-for-service Medicare. Retains the moratorium for special needs plans serving those with severe or disabling chronic conditions.

Section 164. Adjustment to the Medicare Advantage Stabilization Fund.
Removes $1.3 billion from the stabilization fund for regional preferred provider organizations in 2013.

Section 165. Access to Medicare Reasonable Cost Contract Plans.
Extends section 1876 authority for cost contracts through December 31, 2009. Requires that there be two unaffiliated Medicare Advantage plans in an area before the obligation for a cost plan to withdraw is triggered; clarifies that the minimum enrollment requirements for the MA plans would have to be met in the overlapping service area, not the MA plans' entire service area; and clarifies that a Medicare cost plan offered to beneficiaries in one MSA would not be forced to withdraw because of enrollment in Medicare Advantage plans in an adjoining MSA.

Section 166. MedPAC Study and Report on Medicare Advantage Payments.
Instructs MedPAC to study and report to Congress on ways to reimburse Medicare Advantage plans that do not rely on county-level Medicare payment area equivalents.

Section 167. Marketing of Medicare Advantage Plans and Prescription Drug Plans.
Prohibits Medicare Advantage and prescription drug plans from: paying cash for enrollment; offering gifts to potential enrollees; door-to-door sales, cold-calling, or other such personal contact; marketing non-health related products to potential enrollees; conducting a marketing appointment without an advance agreement; marketing in health-care-provider offices; or any marketing activity prohibited by the Secretary. In addition, MA and prescription drug plans must confirm that individuals have enrolled in and understand the plan. MA and prescription drug plans must use state-licensed and appointed marketing representatives. MA and prescription drug plans must comply with state requests for information about licensed agent or brokers. Requires the Secretary to issue rules governing commissions and other compensation. Requires training and testing of marketing representatives. Effective for marketing for plan year 2009 and on.

Subtitle F- Other Provisions

Section 171. Contract with a Consensus-based Entity Regarding Performance Measurement.
Requires the Secretary to contract with a consensus-based standards setting organization such as the National Quality Forum for four years to develop priorities for performance measurement, endorsement of measures, and maintenance of measures, and provides funding from 2009 through 2012.

Section 172. Use of Part D Data.
Gives the Secretary authority to use Medicare Part D data for improving public health and conducting congressional oversight.

Section 173. Inclusion of Medicare Providers and Suppliers in Federal Payment Levy and Administrative Offset Program.
Allows Treasury Department to levy a proportion of a Medicare provider's reimbursement against outstanding tax debt.

Title II – MEDICAID

Section 201. Extension of Transitional Medical Assistance and Abstinence Education Programs.
Extends the Transitional Medical Assistance program (TMA) through September 30, 2009. This program helps low-income individuals transition from welfare to work by maintaining healthcare for their children. Extends the current abstinence-only education program until September 30, 2009.

Section 202. Extension of Qualifying Individual (QI) Program.
Provides assistance through Medicaid for low-income seniors and individuals who need help meeting their Medicare premiums. Extends this program through September 30, 2009 to continue serving current populations.

Section 203. Medicaid DSH Extension.
Extends authority for disproportionate share hospital funding under section 1923 of the Social Security Act for Tennessee and Hawaii through December 31, 2009.

Section 204. Extension of Supplemental Security Income (SSI) Web-Based Asset Demonstration Project to the Medicaid Program.
Extends the existing SSI Web-based asset demonstration program to Medicaid to all 50 states.

Section 205. Application of Medicare payment adjustment for certain hospital-acquired conditions to payments for inpatient hospital services under Medicaid.
Requires states to develop Medicaid payment systems that reduce payments for certain hospital-acquired conditions consistent with the payment system used in Medicare.

Section 206. Elimination of Duplicative Administrative Costs.
Reduces payments for Administrative costs to prevent duplication of payments under Title IV (the Temporary Assistance for Needy Families)

Section 207. Clarification of Treatment of Regional Medical Center.
Clarifies that a regional medical center located on the border of multiple States may receive Medicaid reimbursement from any of those States.

Section 208. Outreach and Enrollment in Medicaid
Provides $25 million for outreach efforts to enroll eligible but uninsured children into Medicaid

Title III – MISCELLANEOUS

Section 301 Extension of TANF Supplemental Grants
Extends the Temporary Assistance for Needy Families (TANF) supplemental grants through September 30, 2009.

Section 302. Extension of Special Diabetes Program
Extends the Special Diabetes Program through September 30, 2011 to fund type 1 diabetes research and type 2 treatment and prevention programs for Native Americans and Alaska Natives

Section 303. Medicare Enrollment Assistance.
Provides $19 million for grants to states for state health insurance assistance programs and $6 million for grants to states for area agencies on aging and to Aging and Disability Resource Centers**.** Such funds will be allocated to states based on a combination of the state's low-income beneficiaries and the state's rural beneficiaries. Most of the grant money must be used to provide outreach to beneficiaries who may be eligible for Medicare savings programs or low-income subsidies.

Section 304. Extension of Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens
Extends Federal reimbursement of emergency health services furnished to undocumented aliens under section 1011 of the MMA through FY 2010 for $200 million per year.