Health Reform: Key Medicare Changes Effective in 2012 and Beyond
What SHIPs and Beneficiaries Need to Know

The Patient Protection and Affordable Care Act (H.R. 3590) and the Health Care and Education Reconciliation Act of 2010 (H.R. 4872), signed into law on March 23, 2010 and March 30, 2010, respectively, encompasses significant changes and opportunities for Medicare beneficiaries, particularly those who are low-income. The following changes are effective in 2012 or later.

Medicare Part B

Independence at Home Demonstration Program

- Creates a new demonstration program to **begin no later than January 1, 2012**, for chronically ill Medicare beneficiaries. The purpose is to test a payment incentive and service delivery system that utilizes physician and nurse practitioner directed home-based primary care teams to reduce expenditures and improve health outcomes (Sec. 3024, H.R. 3590).

Physician Compare Website

- Adding to the new Physician Compare website (available no later than January 1, 2011), requires the Secretary of HHS to implement, **by January 1, 2013**, a plan for making available comparable information on physician performance including quality and patient experience measures, patient outcomes, coordination of care, safety, effectiveness and timeliness of care, and other information (Sec. 10331, H.R. 3590).
- Requires the Secretary to report to Congress on the Physician Compare website **by January 1, 2015**. Allows the Secretary to expand the information available on the website before the report is due (Sec. 10331, H.R. 3590).
- Allows the Secretary to establish a demonstration program and, **by January 1, 2019**, to provide financial incentives to beneficiaries who are furnished services by high-quality physicians (Sec. 10331, H.R. 3590).

Study to Improve Access to Home Health Care

- Directs the Secretary of HHS to study improving access to home health care for certain Medicare beneficiaries, including those with high-severity levels of illness, low-income and living in underserved areas. Also provides the Secretary the authority to conduct a demonstration program, **beginning in 2015 through 2018**, based on the results of the study.

Medicare Part C (Medicare Advantage)

Exceptions and Appeals

- Requires MA-PD plans to use a single, uniform exceptions and appeals process with respect to the determination of prescription drug coverage for an enrollee under the plan and to provide instant access to such process through a website and toll-free number. Effective for exceptions and appeals filed **on or after January 1, 2012** (Sec. 3312, H.R. 3590).

Payment Rates to MA Plans

- Reductions in payments to Medicare Advantage (MA) plans will be phased in over 3 to 7 years, **beginning in 2012**. Payments will be based on a new formula that adjusts for geographic variations. All MA plans must continue to provide all benefits guaranteed by Medicare (Sec. 1102, H.R. 4872).
- **Beginning in 2012**, high-quality MA plans, defined as those that receive 4 or more stars on a 5-star scale based on data currently collected, will receive bonus payments for their performance (Sec. 1102, H.R. 4872).

Savings from Limits on MA Plan Administrative Costs

- Beginning with contract year 2014, requires MA plans that do not have a medical loss ratio (MLR) of at least 85 percent for a contract year to remit to the Secretary the difference between the plan's MLR and 85 percent; for plans that do not have an 85 percent MLR for 3 consecutive contract years, prevents new enrollment in the plan; requires the Secretary to terminate the plan contract if the plan fails to have an 85 percent MLR for 5 consecutive contract years (Sec. 1103 of H.R. 3590).

Medicare Part D

Cost-sharing

- Effective **no earlier than January 1, 2012**, eliminates Part D cost-sharing for dual-eligible beneficiaries receiving services under a Medicaid home and community-based services (HCBS) waiver program (Sec. 3309, H.R. 3590).

Coverage Gap

- Continues to close the coverage gap, or "doughnut hole" by reducing the amount that beneficiaries pay out-of-pocket to reach the catastrophic limit (Sec. 1101, H.R. 4872). This is primarily done by:
    - Providing a $250 rebate, effective in **2010**, for beneficiaries who reach the coverage gap.

- Requiring drug manufacturers, effective **January 1, 2011**, to provide a 50 percent discount on brand-name drugs to those who fall into the coverage gap, thereby reducing the percentage of cost-sharing for beneficiaries by 50 percent.
- Gradually reducing the amount of cost-sharing for brand-name drugs that beneficiaries pay while in the coverage gap. Over a 9-year period, beginning in **2011 through 2020**, beneficiaries will pay a smaller percentage for brand-name drugs in the gap, starting at 50 percent and gradually reducing to 25 percent.
- Gradually reducing the amount of cost-sharing for generic drugs that beneficiaries pay while in the coverage gap. Over a 9-year period, beginning in **2011 through 2020**, beneficiaries will pay a smaller percentage for generic drugs in the gap, starting at 93 percent and gradually reducing to 25 percent.

Exceptions and Appeals

- Requires Part D plans to use a single, uniform exceptions and appeals process with respect to the determination of prescription drug coverage for an enrollee under the plan and to provide instant access to such process through a website and toll-free number. Effective for exceptions and appeals filed **on or after January 1, 2012** (Sec. 3312, H.R. 3590).

Medication Therapy Management (MTM)

- Beginning with plan years that begin on or after 2 years after enactment of H.R. 3590, Part D prescription drug plan sponsors are be required to offer Medication Therapy Management (MTM) services to targeted beneficiaries. The services shall include an annual comprehensive review of medications, either in person or through telehealth technology, by a licensed pharmacist or other qualified provider, which may result in the following: an action plan; a written summary of the review in a standardized format; and follow-up interventions as warranted based on the findings of the review. Sponsors are required to assess on at least a quarterly basis the medication use of individuals who are at risk but not enrolled in the MTM program. Plans must also enroll beneficiaries who qualify on a quarterly basis and allow for opt out (Sec. 10328, H.R. 3590).

Miscellaneous

- Protects and improves guaranteed Medicare benefits. Provides that nothing in the Act shall result in a reduction of guaranteed benefits under Medicare. Requires that savings generated for Medicare under the Act are used to: extend the solvency of the Medicare trust funds; reduce Medicare premiums and other cost-sharing for beneficiaries; and improve or expand guaranteed Medicare benefits and protect access to Medicare providers (Sec. 1030, H.R. 3590).
- Creates the Independent Payment Advisory Board (IPAB), a 15-member advisory board responsible for presenting Congress with comprehensive proposals to reduce excess

cost growth and improve quality of care for Medicare beneficiaries, **beginning in 2014** (Sec. 3403, H.R. 3590).

- Authorizes the Secretary of HHS to award grants to states and local health departments and Indian tribes to implement 5-year pilot programs to provide services, such as public health interventions, community preventive screenings, and clinical referrals or treatments for chronic diseases for individuals who are between ages 55 and 64. Directs the Secretary to conduct an annual evaluation of the pilot programs (Sec. 4202, H.R. 3590).
- Directs the Secretary of HHS to conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries. The Secretary shall report to Congress on its findings no later than **September 30, 2013** (Sec. 4202, H.R. 3590).