The Patient Protection and Affordable Care Act Reference Implementation Timeline April 1, 2010

The MGMA Government Affairs Department developed a reference implementation timeline focusing on major issues of interest to MGMA members. Some provisions are effective immediately, while others will take years to implement. A significant number of provisions in the legislation contain language directing the Secretary of the Department of Health and Human Services (HHS) to develop implementing regulations. The reference timeline contains changes to be implemented by year, with an additional section of provisions where no timeframe is specified included. MGMA will be heavily involved in working with the Secretary to make sure that group practice interests are represented as implementing regulations are proposed and finalized. In addition, we anticipate that the Centers for Medicare & Medicaid Services (CMS) will issue guidance concerning bill provisions that may impact current regulations. MGMA will continue to communicate changes and updates to the healthcare reform legislation.

Questions about the implementation timeline or healthcare reform?

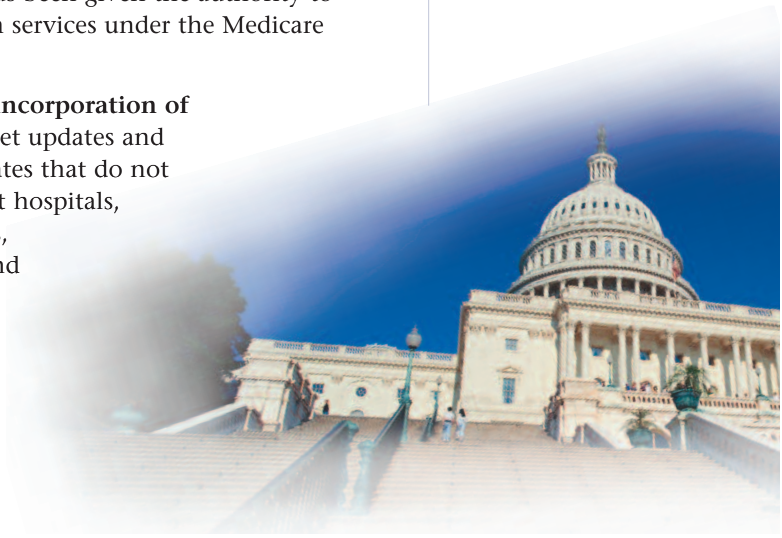
- Contact the MGMA Government Affairs Department, 877.ASK.MGMA (275.6462), ext. 1300 or e-mail govaff@mgma.com.
- Discuss your questions in the *"Federal Legislation and Red Tape Forum"* in the MGMA Member Community.

(Citations below are to the Patient Protection and Affordable Care Act or, where indicated, to the Health Care and Education Reconciliation Act of 2010 (Recon.))

2010

Reimbursement

- **Imaging:** Payment for the technical component of diagnostic services will be reduced by 50 percent for subsequent procedures on consecutive body parts beginning July 1. This is an increase from the current 25 percent reduction (Sec. 3135).
- **Geographical Practice Cost Index (GPCI) work floor:** Extended through Dec. 31, 2010. The GPCI work floor had expired at the end of 2009 (Sec. 3102).
- **Therapy cap exception process:** Extended through Dec. 31, 2010 (Sec. 3103).
- **Potentially misvalued physician services codes:** HHS has been given the authority to periodically identify and adjust the relative values of such services under the Medicare physician fee schedule (Sec. 3134).
- **Revision of certain Part A market basket updates and incorporation of productivity improvements**: Revises certain market basket updates and incorporates a full productivity adjustment into any updates that do not already incorporate such adjustments, including inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals and



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inpatient rehabilitation facilities. This does not apply to physician payments, which are already subject to a productivity adjustment. For inpatient and outpatient hospitals, the market basket update will be reduced by:

- 0.25% for FY 2010-2011;
- 0.1% for FY 2012-2013;
- 0.3% for FY 2014;
- 0.2% for FY 2015-2016;
- 0.75% for FY 2017-2019.

(Sec. 3401, as modified by Secs. 10319, 10322).

- **Practice expense geographic practice cost index (GPCI) adjustment:** Retroactively effective from Jan. 1, 2010, HHS is required to revise the calculation method of the practice expense (PE) portion of the GPCI. This revision results in increased PE GPCIs for certain rural areas. Implementation of this provision will likely require CMS to reprocess certain 2010 claims (Sec. 3102, as modified by Recon. Sec. 1108).

Employer Requirements

- **Small Business Tax Credit:** Effective calendar year 2010, the law establishes a tax credit of up to 35% of an employer's contribution for health insurance premiums for qualified small businesses contributing to their employees' health insurance. There is also a tax credit of up to 25% for small nonprofit organizations. Qualified small businesses are defined as employers with 25 or fewer full-time equivalent employees and average wages of less than $50,000. To be eligible for the tax credit, the employer must also contribute at least 50% of the total premium cost or 50% of a benchmark premium (Sec. 1421, as modified by Sec. 10105).

Workforce Requirements

- **Tax Relief for Health Professionals with State Loan Repayment:** (Effective for amounts received by an individual in tax year 2009 and beyond). This provision excludes gross income payments made under any state loan repayment or loan forgiveness program intended to provide for the increased availability of healthcare services in underserved areas or health professional shortage areas (HPSAs), (Sec. 10908).
- **Grant Program for Primary Care Residency Programs:** Effective Fiscal Year 2010, the Secretary of HHS shall establish a grant program for new or expanded primary care residency programs at teaching health centers. Twenty-five million dollars are authorized for FY2010, and the amount increases to $50 million in FY2011 and FY2012. An additional $230 million will be used to cover expenses of qualifying teaching health centers for training primary care residents in certain expanded or new programs (Sec. 5508).
- **Healthcare Workforce Loan Repayment Program:** Effective Fiscal Year 2010, the Secretary of HHS shall establish a loan repayment program for pediatric subspecialists and providers of behavioral and mental health services to children and adolescents who are

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or will be working in a HPSA or, Medically Underserved Area or serving Medically Underserved Populations (Sec. 5203).

Insurance Reform

- **Medicare prescription drugs:** Medicare Part D enrollees who enter the “doughnut hole” in 2010 are provided a $250 rebate assistance check check (Recon. Sec. 1101).
- **Public reporting of performance information:** Before 2011, HHS must develop a Physician Compare Web site that includes information on physicians enrolled in the Medicare program and on providers that participate in the Physician Quality Reporting Initiative (Sec. 10331).
- **Temporary High-Risk Health Insurance Pool:** Effective June 21, 2010 until 2014, the Secretary of HHS shall create a high-risk pool for adults with pre-existing conditions who have been uninsured for at least six months. The Secretary may establish the program directly or by contracting with nonprofit private entities or states that apply and are selected. Individuals can receive premium subsidies. The pool will expire in 2014 when Insurance Exchanges are implemented (Recon. Sec. 1101).
- **Coverage for preventative services and immunizations:** Effective Sept. 23, 2010, individual and new group plans must cover certain preventative services and immunizations without cost-sharing (Sec. 1001).
- **Elimination of pre-existing condition exclusion for children:** Effective Sept. 23, 2010, individual and group health plans are prohibited from imposing pre-existing condition exclusions on children (Sec. 10103).
- **Extension of dependent coverage to young adults up to age 26:** Effective Sept. 23, 2010, all individual and group health insurance plans are required to allow uninsured children to remain on their parents’ health insurance through age 26 (Sec. 1001).
- **Rescissions:** Effective Sept. 23, 2010, insurance companies can no longer rescind existing health insurance coverage, except in cases of intentional misrepresentation or fraud (Sec. 1001).
- **Elimination of lifetime limits and restriction of annual limits:** Effective Sept. 23, 2010, insurance plans are prohibited from establishing lifetime limits on coverage, and there will be new restrictions on the use of annual limits until 2014. The Secretary of HHS will define the restricted annual limits that may be used by plans prior to 2014, at which point all plans are prohibited from establishing any lifetime or annual limits on the dollar value of benefits (Sec. 1001, as modified by Sec. 10101).

Compliance

- **Expansion of the Recovery Audit Contractors (RACs) program:** Before 2011, state Medicaid agencies must contract with one or more RACs, which will identify underpayments and overpayments, and recover overpayments made for services provided under state Medicaid plans as well as state plan waivers (Sec. 6411).

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- **Imaging/self-referral:** Physicians who refer their patients for magnetic resonance imaging, computed tomography or positron emission tomography (and any other "designated health services" the Secretary deems appropriate) on the "in-office ancillary services" exception to the Stark/physician self-referral law must provide a written notice to their patients. The notice must inform the patient that he or she may obtain the services elsewhere. The patient must also be supplied with a written list of alternative suppliers in the area where he or she resides. The law makes this requirement effective Jan. 1, 2010; providers should begin complying immediately (Sec. 6003).
- **Self-referral:** By Sept. 23, the Secretary of HHS must develop a protocol that allows providers and suppliers to self-disclose an actual or potential violation of the physician self-referral/Stark law. The Secretary is authorized to reduce the violations for providers who self-disclose (Sec. 6409).
- **Physician-owned hospitals:** Existing physician-owned hospitals will be restricted in their ability to expand and still qualify for the physician self-referral exception beginning March 23. In addition, new physician-owned hospitals must have their provider agreements in place by Dec. 31 in order to qualify for physician self-referral/Stark law protection. The number of operating rooms, procedure rooms and beds must not exceed the number on the later of March 23 or the date of the provider agreement unless a hospital meets the requirements of an exceptions process to be established by the Secretary relating to community need (Secs. 6001, 10601, as modified by Recon. Sec. 1106).
- **Provider screening:** By Sept. 23, the Secretary, in consultation with the Office of Inspector General, will establish procedures for screening providers and suppliers under the Medicare, Medicaid and CHIP programs. For new providers, screening will begin in March 2011. Screening of existing providers will begin in March 2012. The procedures will apply to revalidation of enrollment beginning in September (Sec. 6401).
- **Submission of Medicare claims:** Effective Jan. 1, Medicare Part B claims must be submitted no later than 12 months after the date of service. For services furnished before Jan. 1, 2010, a bill or request for payment must be submitted no later than Dec. 31, 2010 (Sec. 6404).
- **Required documentation for referrals:** Effective Jan. 1, the Secretary may revoke enrollment and has the authority to exclude providers who do not give the Secretary access to documentation relating to written orders or requests for Durable Medical Equipment (DME), certification for home health services or referrals for other services specified by the Secretary (Sec. 6406).
- **Face-to-face encounters required for DME and home health:** For home health services certified after Jan. 1, a physician, nurse practitioner, clinical nurse specialist or certified nurse midwife must document a face-to-face encounter with the individual during the six-month period before certification. For DME, the order must be pursuant to a face-to face encounter with a physician, physician assistant, nurse practitioner or clinical nurse specialist within the preceding six months (or other timeframe to be specified by the Secretary). This requirement applies to both Medicare and Medicaid services. The Secretary has authority to expand this to other items or services upon a finding that it would reduce fraud (Sec. 6407).
- **Civil Monetary Penalties:** Effective Jan. 1, the list of offenses subject to the Civil Monetary Penalties Statute is expanded. (Sec. 6408).

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- **Permissive exclusions:** Effective Jan. 1, the Secretary has permission to exclude individuals or entities that obstruct program audits or investigations (Sec. 6408).
- **Ordering/referring physicians:** Beginning July 1, all physicians ordering DME or home health services must be enrolled in the Medicare program. The Secretary has the authority to expand this requirement to all other categories of items or services under Medicare (Sec. 6405).
- **False Claims Act:** Amends the False Claims Act to allow the federal government to prevent dismissal of a whistleblower suit even if it is based on allegations that were publicly disclosed and specifically defines public disclosure as information disclosed in a federal hearing, federal report or the news media. Also allows a whistleblower to be an "original source" of information even after public disclosure as long as he or she materially adds to the publicly disclosed information (Sec. 10104).
- **Temporary enrollment moratorium:** The Secretary may impose a temporary moratorium on the enrollment of new providers and suppliers in order to combat fraud, waste or abuse. The moratorium could be limited to specific categories of providers or suppliers. There is no judicial review of the Secretary's decision to impose a temporary moratorium. States have the option of imposing similar moratoria with respect to Medicaid providers or suppliers (Sec. 6401).
- **Access to claims and payment databases:** The HHS OIG and the Attorney General will have access to claims and payment data from HHS and its contractors. The OIG will also have broad authority to obtain information necessary to protect the integrity of the Medicare and Medicaid programs (Sec. 6402).
- **Exclusion authority:** The Secretary may exclude from participation in any federal healthcare program individuals or entities that make false statements on their applications, agreements, bids or contracts to provide services under a federal healthcare program (Sec. 6402). The Secretary has testimonial subpoena authority in exclusion cases (Sec. 6402).
- **Civil Monetary Penalties statute:** The list of offenses subject to civil monetary penalties is expanded to include ordering services while excluded, making false statements on applications and failing to return or report an overpayment (Sec. 6402). Certain practices are excluded from the definition of "remuneration" in the patient inducement provisions of the Civil Monetary Penalties statute, including some that provide reduced price or free items or services for individuals with financial need (Sec. 6402).
- **Healthcare fraud statute:** The healthcare fraud statute found at 18 U.S.C. § 1347 adds a provision stating that the phrase "knowingly," contained in the statute, does not require a person to have actual knowledge of the law or a specific intent to violate the law. In other words, a person who knowingly acts, regardless of his or her knowledge of the law, would meet the statute's intent requirement (Sec. 10606).
- **Antikickback statute:** Violations of the Antikickback Statute constitute false or fraudulent claims for purposes of the False Claims Act (Sec. 6402). The intent requirement of the Anti-kickback statute is revised; a person need not have actual knowledge of the law or specific intent to violate the law to meet the requirement. This change makes it easier for the government to prove intent for purposes of a prosecution (Sec. 6402).

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- **Prepayment review limitations repealed:** The provisions limiting Medicare administrative contractors' ability to conduct prepayment review have been repealed (Recon. Sec. 1302).

2011

Reimbursement

- **Primary care incentives:** For 2011 through 2016, primary care providers (family medicine, internal medicine, geriatrics and pediatrics physicians or nurse practitioners, clinical nurse specialists and physician assistants) must charge at least 60 percent of their total allowed Medicare charges as office, nursing facility or home visits in order to qualify for a 10 percent bonus payment. This payment will be distributed on a monthly or quarterly basis (Sec. 5501).
- **General surgery in HPSA incentive:** For 2011 through 2016, general surgeons furnishing major procedures (10-day or 90-day global service period) in a health professional shortage area (HPSA) will be eligible for a 10 percent bonus payment to be paid on a monthly or quarterly basis (Sec. 5501).
- **Imaging:** For Medicare physician fee schedules for 2011 and thereafter, the utilization assumption for services using "expensive diagnostic imaging equipment" (currently defined by CMS to include magnetic resonance imaging and computed tomography) will be set at 75percent. The utilization assumption is used to calculate the practice expense relative value units in the technical component payment. Through 2009, the utilization assumption for such equipment was set at 50 percent. In 2010, CMS increased the assumption to 90 percent, to be phased in over four years; this means that the 2010 assumption is roughly 60 percent. By increasing the assumption to 75 percent on Jan. 1, 2011, practices could see a further cut in the technical component payment for services using this equipment. However, beginning in 2012, this cut will be less than it would have been under the 90 percent assumption. (Sec. 3135, as modified by Recon. Sec. 1107).
- **Ambulatory surgery centers (ASCs):** Annual updates will be reduced by a productivity adjustment (Sec. 3401(k)). In addition, by Jan. 1, the Secretary of HHS must submit a plan to Congress to implement value-based purchasing for ASCs. This may result in payment adjustments for ASCs that meet certain quality and efficiency standards (Sec. 10301).
- **Value-based payment modifier under the physician fee schedule:** Before 2012, HHS must publish the quality and cost measures, the implementation dates and the initial performance period associated with a new Part B value-based payment modifier. The modifier provides for differential payments to physicians or groups of physicians based on the quality of care furnished compared to the cost of care during a performance period. This modifier begins to affect payments in 2015 based off 2014 performance data (Sec. 3007).
- **Physician Quality Reporting Initiative (PQRI):** The incentive payment for successful participation in the 2011 PQRI shall be 1 percent of a practice's total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period. By Jan. 1, 2011, at the latest, the Centers for Medicare & Medicaid Services (CMS) must establish an informal appeals process for PQRI participants that did not satisfactorily participate. Beginning in 2011, CMS will offer an additional participation method through a

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continuous assessment program, such as a qualified American Board of Medical Specialties Maintenance of Certification (ABMS MOC) program. Practices that utilize this new method for PQRI reporting years 2011 through 2014 will be eligible for an additional 0.5 percent incentive payment (Sec. 3002).

- **Medicare's Physician Resource Use and Measurement Reporting Program:** This provision requires HHS to publicly develop episode grouper measurement systems before 2012 so that HHS can use claims data to provide physicians or group practices with confidential reports that measure the resources involved in furnishing care to Medicare patients (Sec. 3003).
- **Center for Medicare and Medicaid Innovation (CMI):** By Jan. 1, 2012 at the latest, the CMS must establish a CMI to test innovative payment and service delivery models to reduce program expenditures. HHS must provide preference to models that also improve the coordination, quality and efficiency of healthcare services, and HHS will have the authority to limit model testing to certain geographic areas (Sec. 3021).
- **Medicare Advantage payments freeze:** Effective Jan. 1, 2011, Medicare Advantage payments will be frozen at 2010 levels. The freeze in 2011 indicates the start of an overall reduction in Medicare Advantage payments (Recon. Sec. 1102).
- **IMA cost-sharing restrictions:** Effective Jan. 1, 2011, Medicare Advantage plans are prohibited from charging beneficiaries cost-sharing that is greater than the amount charged under traditional Medicare fee-for-service program for covered Medicare services. If Medicare Advantage plans choose to provide extra benefits, the plans must give higher priority to cost-sharing reductions, preventative care and wellness, and give lower priority to benefits not covered under Medicare (Sec. 3202).

Employer Requirements

- **Reporting healthcare coverage costs on W-2:** Beginning in the 2011 tax year, employers are required to report the value of their employees' healthcare benefits on each employee's annual W-2 tax form (Sec. 9002).
- **Grants for employers to offer wellness programs:** Effective FY2011, the Secretary of HHS shall establish grants for employers with 100 or fewer employees to offer wellness programs. Programs must meet criteria determined by HHS including such things as maximizing employee engagement, creating a workplace environment that encourages healthy lifestyles and implementing health awareness initiatives and programs designed to change unhealthy behaviors. The grants will be available for up to five years (Sec. 10408).

Workforce Requirements:

- **Redistribution of unused GME training slots:** Effective July 1, 2011, a new Graduate Medicare Education (GME) policy will be established allowing unused training slots to be re-distributed to increase primary care training at other sites. Special preferences will be given to programs in states with a low ratio of physician residents to the general population and states with the highest ratio of people living in HPSAs relative to the general population (Sec. 5503).

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Administrative Simplification

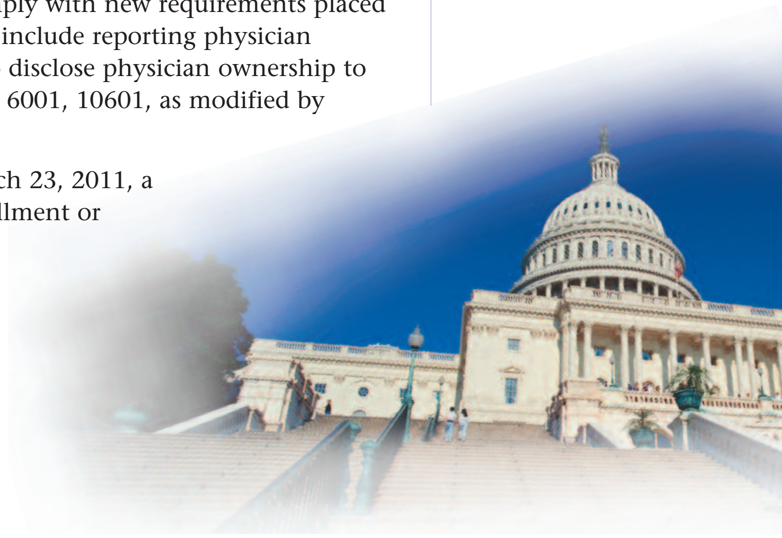
- **Operating Rules for the Eligibility and Claim Status Electronic Transactions:** Operating rules for the HIPAA eligibility verification transaction and the health claim status transaction are required by July 1, 2011, with the goal of creating as much uniformity in the implementation of the electronic standards as possible. The operating rules are to be consensus-based, and will reflect the necessary business rules affecting health plans and healthcare providers and the manner in which they operate. The rules may allow for the use of a machine readable identification card (Sec. 1104).

Insurance Reform

- **Medicare prescription drugs:** CMS begins to gradually phase out the Medicare Part D "doughnut hole," filling the doughnut hole by 2020. It establishes a 50 percent discount on brand name drugs, and initiates generic coverage to Part D enrollees in the doughnut hole (Recon. Sec. 1101).
- **Health insurance plans requirement to report MLRs:** Effective 2011, health plans are required to report to the Secretary of HHS their Medical Loss Ratio (MLR), which is the proportion of premium dollars spent on clinical services and quality versus all other non-claims costs. Insurance companies will be required to meet certain MLRs or provide enrollees with rebates if the plan does not meet the required MLR. Group plans must have an MLR of 85% and individual plans must have an MLR of 80%. Beginning in 2011, insurers must report their MLR for the previous year and pay rebates if necessary (Sec. 1001, as modified by Sec. 10101).
- **Authority of HHS to deny plan bids:** Effective January 1, 2011, the Secretary of HHS may deny bids submitted by MA and prescription plans, which propose to significantly increase beneficiary cost sharing or decrease benefits offered under the plan (Sec. 3209).

Compliance

- **Expansion of the Recovery Audit Contractor (RAC) program:** After 2010, HHS shall contract with RACs to ensure that each Medicare Advantage plan under Part C and each Prescription Drug Plan under Part D have an effective anti-fraud plan in place (Sec. 6411).
- **Medical liability reform:** States will be eligible to receive grants for the development, implementation and evaluation of alternatives to tort litigation for resolving disputes allegedly caused by healthcare providers or organizations. Grants can be awarded for no more than five years. A total of $50 million is available (Sec. 10607).
- **Physician-owned hospitals:** Existing hospitals must comply with new requirements placed on such hospitals by September 2011. New requirements include reporting physician ownership to the Secretary, having procedures in place to disclose physician ownership to patients and the public, among other requirements (Secs. 6001, 10601, as modified by Recon. Sec. 1106).
- **Pre-enrollment/revalidation disclosure:** Beginning March 23, 2011, a provider or supplier who submits an application for enrollment or



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revalidation must disclose any current or former affiliation with any provider or supplier that has been subject to payment suspension under a federal healthcare program, excluded from Medicare, Medicaid or CHIP or has had its billing privileges denied or revoked. The Secretary will have the authority to deny enrollment based on such disclosures, subject to appeal (Sec. 6401).

- **NPI on all applications and claims:** By Jan. 1, 2011, all Medicare and Medicaid providers and suppliers that qualify for an NPI must include their NPI on all enrollment applications and claims (Sec. 6402).
- **Entities outside the U.S.:** Beginning Jan. 1, 2011, states may not pay entities or financial institutions for items or services if such entity is located outside of the United States (Sec. 6505).
- **Medicaid exclusion:** Beginning Jan. 1, 2011, individuals or entities terminated from the Medicare program will also be excluded from the Medicaid program (Sec. 6501). States must exclude an individual or entity from participation in the state plan if such individual or entity owns, controls, or manages an entity that has unpaid overpayments, is suspended or excluded, or is affiliated with an individual or entity that was suspended, excluded or terminated (Sec. 6502).
- **Enhanced oversight of new providers/suppliers:** The Secretary shall establish a provisional period of enhanced oversight for new providers of services and suppliers lasting between 30 days and one year. The Secretary can designate categories of providers or suppliers subject to enhanced oversight, including prepayment review and payment caps (Sec. 6401). Beginning Jan. 1, 2011, the Secretary has the authority to withhold payment for certain DME suppliers for 90 days, beginning with the date the first claim was submitted (Recon. Sec. 1304).
- **Evaluation of Medicare Program Integrity Contractors:** Beginning no later than 180 days after fiscal year 2011, entities that contract with the Medicare program to carry out program integrity activities must provide HHS with performance statistics. Such entities will be evaluated at least every three years. (Sec. 6402).
- **Waiver of copay by PDP or MA-PDP organization:** Beginning Jan. 1, 2011, the waiver by a prescription drug plan sponsor or a Medicare Advantage prescription drug plan of any copayment for the first fill of a generic drug for individuals enrolled in such plans does not constitute remuneration for purposes of the patient inducement provisions of the Civil Monetary Penalties statute (Sec. 6402).
- **Additional requirements for charitable hospitals:** Requires tax-exempt charitable hospitals (501(c)(3)) to conduct a community health needs assessment every two years and implement a written financial assistance policy. Imposes a penalty tax for failure to comply with this requirement (Sec. 9007, as modified by Sec. 10903).

2012

Reimbursement

- **Medicaid and Children's Health Insurance Program (CHIP) pediatric Accountable Care Organization (ACO) demonstration project:** Beginning in 2012, states

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may apply to HHS to participate in the program with a minimum commitment of three years. Participating states are allowed to recognize pediatric medical providers that meet HHS specified requirements to be recognized as an ACO for purposes of receiving incentive payments. ACOs that meet the performance guidelines established by HHS and achieve savings greater than the annual minimal savings level established by the state shall receive an incentive payment for that year equal to a portion (as determined appropriate by HHS) of the amount of such excess savings. HHS may establish an annual cap on incentive payments for an ACO. The demonstration project begins Jan. 1, 2012, and ends Dec. 31, 2016 (Sec. 2706).

- **Medicare Accountable Care Organization (ACO) program:** By Jan. 1, 2012, at the latest, HHS will establish a Medicare shared savings program that promotes accountability for a patient population, coordinates items and services under Parts A and B and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. In this program, groups of service providers and suppliers that meet the criteria specified by the HHS may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an ACO. ACOs that meet quality performance and risk adjusted standards established by the Secretary are eligible to receive payments for shared savings. Among other requirements, the ACOs must enter into an agreement with HHS for at least three years, include a sufficient number of primary care providers to provide care for at least 5,000 Medicare beneficiaries that HHS assigns to the ACO, have a defined management structure, practice evidence-based medicine and report on quality and cost measures (Sec. 3022).
- **Independence at home demonstration program:** HHS must establish a medical home demonstration program by 2012 for high-cost Medicare beneficiaries. The program tests a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures (e.g. preventable hospitalizations and readmissions, reducing emergency room visits) and improve health outcomes, efficiency and patient satisfaction. Participating providers must use health information systems, report on quality measures determined by HHS, and be available 24 hours a day, 7 days a week to care for at least 200 applicable Medicare beneficiaries, including home visits. Practices may participate for no more than a three year period and the total number of Medicare beneficiaries affected by the entire demonstration program shall not exceed 10,000. HHS will establish an annual per capita, risk adjusted spending target for participating practices. Practices are eligible to receive an incentive payment if actual annual expenditures for enrolled beneficiaries are less than the HHS established spending target. The incentive amount will then be a portion, determined by HHS, of the amount by which actual expenditures for applicable beneficiaries under parts A and B are estimated to be less than five percent less than the estimated spending target for such year (Sec. 3024).
- **Physician Quality Reporting Initiative (PQRI):** The incentive payment for successful participation in the 2012 through 2014 PQRI shall be 0.5 percent of a practice's total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period. By Jan. 1, 2012, at the latest, CMS must provide timely feedback to PQRI participating practices (Sec. 3002).
- **Medicare's Physician Resource Use and Measurement Reporting Program:** Starting in 2012, HHS shall provide physicians and group practices with reports that compare patterns of resource use by the individual physician to such patterns of other physicians (Sec. 3003).

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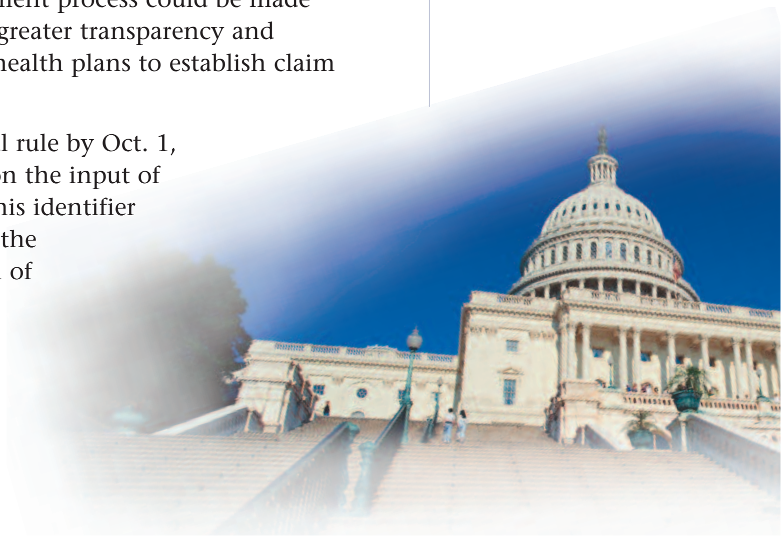
- **Practice expense geographic adjustments:** As of Jan. 1, 2012, the Medicare physician fee schedule will include budget neutrality adjustments by HHS to ensure accurate geographic practice expense adjustments across fee schedule areas (Sec. 3102).
- **Medicare Advantage payment reductions:** Effective Jan. 1, 2012, Medicare Advantage benchmarks are reduced relative to current levels. Benchmarks will vary from 95% of Medicare spending in high cost areas to 115% of Medicare spending in low cost areas. The changes will be phased in over three to seven years, depending on the magnitude of the reduction. The provision creates an incentive system to increase payments to high quality plans by at least 5%. It also extends CMS authority to adjust risk scores in Medicare Advantage for observed differences in coding patterns relative to fee for service (Recon. Sec. 1102).
- **Hospital value-based purchasing program:** HHS shall establish a hospital value-based purchasing program on or after Oct. 1, 2012, under which value-based incentive payments are made in a fiscal year to hospitals that meet performance standards for the fiscal year. Additionally, HHS shall establish value-based purchasing demonstration programs for critical access hospitals and hospitals excluded from the program because of insufficient numbers of measures and cases (Sec. 3001).
- **Medicaid Disproportionate Share Hospital (DSH) Payments:** Reduces state DSH allotments, except for Hawaii, by 50% or 35% once a state's uninsurance rate decreases by 45%, depending on whether they have spent at least 99.9% of their allotments on average during FY 2004 and FY 2008. Requires a reduction of only 25% or 17.5% for low DSH states, depending on whether they have spent at least 99.9% of their allotments on average during FY 2004-FY 2008. Prescribes allotment reduction requirements for subsequent fiscal years. Revises DSH allotments for Hawaii for the last three quarters of FY 2012, and for FY 2013 and succeeding fiscal years (Sec. 2551, as modified by Sec. 10201).

Administrative Simplification

- **Operating Rules for EFT and Payment and Remittance Advice:** HHS is required to adopt, by July 1, 2012, a set of operating rules for electronic funds transfers (EFT) and the HIPAA transactions standards healthcare payment and remittance advice (allowing for automated reconciliation of the electronic payment with the remittance advice) (Sec. 1104).
- **Electronic Funds Transfers:** HHS is required to adopt a final rule by Jan. 1, 2012, that would establish a standard for EFT. For physician practices, standardized EFT would greatly improve the claims payment process (Sec. 1104).
- **Standardized Health Plan Enrollment and Claim Edits:** The HHS Secretary is to seek input by Jan. 1, 2012, on whether the health plan enrollment process could be made electronic and standardized, and whether there could be greater transparency and consistency of the methodologies and processes used by health plans to establish claim edits (Sec. 10109).
- **Health Plan Identifier:** HHS is required to develop a final rule by Oct. 1, 2012, establishing a unique health plan identifier based on the input of the National Committee on Vital and Health Statistics. This identifier will greatly assist practices by simplifying and improving the routing of healthcare transactions and the administration of healthcare plan benefits (Sec. 1104).



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Compliance

- **Release of Medicare claims data for performance measurement:** For research purposes, by Jan. 1, 2012, HHS shall make Medicare claims data for Parts A, B, and D available to qualified entities for a fee (Sec. 10332).
- **Government Accountability Office (GAO) reports:** By March 23, 2012 (two years after enactment of The Patient Protection and Affordable Care Act), the GAO must submit to Congress reports on the implementation of several sections, including changes to the Physician Quality Reporting Initiative, modifications to the Physician Resource Use and Measurement Reporting Program, use of the physician fee schedule value-based payment modifier and the establishment of the Center for Medicare and Medicaid Innovation (Sec. 3512).
- **Drug samples:** By April 1, 2012, (and each year thereafter), drug manufacturers and authorized distributors must submit to the Secretary information relating to the quantity and identity of practitioners to which drug samples were distributed during the year (Sec. 6004).

2013

Reimbursement

- **Medicaid/Medicare payment parity:** Medicaid payments to primary care physicians (specialties designated as family medicine, general internal medicine or pediatric medicine) furnishing evaluation and management services and immunizations are raised to match Medicare rates for 2013 and 2014. Additional federal funds are allocated to states to account for this payment increase (Recon. Sec. 1202).
- **National Pilot Program on Payment Bundling:** By Jan. 1, 2013, at the latest, HHS must establish a five year, voluntary pilot program on payment bundling for integrated care by inpatient/outpatient hospital services, physician services and post acute care services during an applicable episode of care (three days prior to admission and 30 days following discharge) provided to a Medicare fee for service beneficiary around a hospitalization. HHS will select 10 chronic, acute, surgical or medical conditions. HHS may extend the pilot after 2016, if certain criteria are met (Sec. 3023).

Administrative Simplification

- **Effective Date for the Operating Rules for the Eligibility and Claim Status Electronic Transactions:** Effective Jan. 1, 2013, operating rules for the HIPAA insurance eligibility verification transaction (270/271) and the health claim status transaction (276) will be set with the goal of creating as much uniformity in the implementation of the electronic standards as possible, and this may allow for the use of a machine readable identification card (Sec. 1104).
- **Health Plan Compliance:** Health plans must file a statement with the Secretary by Dec. 30, 2013, certifying that data and information systems are in compliance with any applicable standards and associated operating rules for EFT, eligibility for a health plan, health claim status and healthcare payment and remittance advice (Sec. 1104).

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Compliance

- **Physician payments from and ownership/investment in manufacturers:** Beginning March 31 and each year thereafter, drug and device manufacturers must report to the Secretary any payment or transfer of value made to a physician or teaching hospital, excluding transfers of value less than $10 and product samples intended for patient use (i.e. not to be sold) among other exclusions. Manufacturers must also report physician ownership or investment (excluding publicly traded securities and mutual funds). Such information (excluding National Provider Identifiers) will be made public with certain exceptions (Sec. 6002).

2014

Reimbursement

- **Mandates Medicare Advantage MLR:** Effective Jan. 1, 2014, Medicare Advantage plans are required to have a Medical Loss Ratio (MLR) of 85%. If the Secretary of HHS determines that a plan fails to achieve the stipulated MLR, the MA plan must pay a rebate to HHS and could possibly face suspension of their beneficiary enrollment or contract termination (Recon. Sec. 1103).
- **Independent Payment Advisory Board (IPAB):** By Jan. 15, the non-elected IPAB may begin to develop and submit to Congress advisory reports on matters related to the Medicare program. The IPAB is given authority to formulate comprehensive regulatory and legislative recommendations to slow the growth in national health spending. In certain circumstances, the IPAB would have the authority to make binding Medicare policy recommendations and non-binding private payer policy recommendations to Congress. Empowering an IPAB with authority to make binding Medicare policy recommendations based on expenditure targets inflicts physicians with an additional expenditure constraint in addition to the sustainable growth rate formula. No later than July 1, and annually thereafter, the IPAB shall produce a public report containing standardized information on system-wide healthcare costs, patient access to care, utilization, and quality of care that allows for comparison by region, types of services, types of providers and both private and public payers (Sec. 3403, as modified by Sec. 10320).

Employer Requirements

- **Employer contribution requirement:** Effective Jan. 1, 2014, penalties are implemented on employers with 50 or more employees who do not offer coverage and have at least one full-time employee who receives the premium assistance tax credit. The penalty is equal to $2,000 per year for each full-time employee, but the first 30 employees are not counted. For employers with more than 50 employees that do offer coverage but have at least one full-time employee receiving a premium tax credit, the penalty is the lesser of either $2,000 per full-time employee, or $3,000 for each employee receiving the premium credit. Employees receiving the premium tax credit must meet the income criteria, and the coverage offered by their employer must be considered unaffordable. Coverage is considered unaffordable if the required employee contribution exceeds 9.5% of the

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employee's household income or if the employer plan pays for less than 60% of covered expenses (Sec. 1513, as modified by Recon. Sec. 1003).

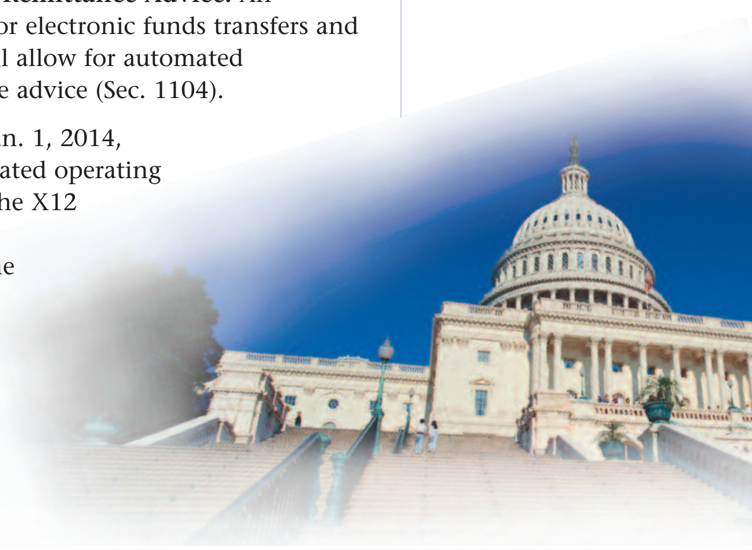
- **Expansion of small business tax credits:** Effective Jan. 1, 2014, eligible employers who purchase coverage through the State Exchange can receive a tax credit for two years of up to 50 percent of their contribution. Tax-exempt small businesses may receive tax credits of up to 35 percent of their contribution. Qualified small businesses are defined as having 25 or fewer full-time equivalent employees and average wages of less than $50,000. To be eligible for the tax credit, the employer must also contribute at least 50% of the total premium cost or 50% of a benchmark premium (Sec. 1421, as modified by Sec. 10105).
- **Small business participation in Exchanges:** Effective Jan. 1, 2014, employers with up to 100 employees may enroll in the state-based Small Business Health Options Program (SHOP) (Sec. 1311).
- **Automatic enrollment in Employed-Sponsored Insurance:** Effective Jan. 1, 2014, employers with 200 or more employees are required to automatically enroll new full-time employees in health insurance coverage offered by the company, after giving adequate notice and any waiting period expires. Employees may choose to opt out of coverage (Sec. 1511).

Individual Provisions

- **Individual coverage requirement:** Effective Jan. 1, 2014, individuals are required to have acceptable health insurance coverage for themselves and their dependents or pay a fine. People with incomes below the filing threshold are exempt from fines. The penalty is the greater of either a flat fee ($95 in 2014) or a percent of income (1% in 2014). Individuals can qualify for tax credits and cost-sharing subsidies based on income (Sec. 1501, as modified by Sec. 10106 and Recon. Sec. 1002).

Administrative Simplification

- **Health Plan Identifier:** Jan. 1, 2014, is set as the effective date for a unique health plan identifier. This identifier will greatly assist practices by simplifying and improving the routing of healthcare transactions and the administration of healthcare plan benefits (Sec. 1104).
- **Electronic Funds Transfer:** Jan. 1, 2014, is set for the effective date for the final rule establishing a standard for EFT (Sec. 1104).
- **Electronic Funds Transfer and Health Care Payment and Remittance Advice:** An effective date of Jan. 1, 2014, for the set of operating rules for electronic funds transfers and healthcare payment and remittance advice transactions shall allow for automated reconciliation of the electronic payment with the remittance advice (Sec. 1104).
- **Health Claims Attachments:** HHS to issue a final rule by Jan. 1, 2014, establishing a transaction standard and a single set of associated operating rules for health claims attachments that is consistent with the X12 Version 5010 transaction standards. The use of standardized electronic claims attachments will significantly accelerate the claims adjudication process and eliminate costs associated



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with the copying and mailing of supporting documentation (Sec. 1104).

- **Health Plan Penalties for Non-Compliance:** No later than April 1, 2014, and annually after that, the HHS Secretary shall assess a penalty fee against a health plan that has failed to meet the requirements with respect to certification and documentation of compliance with standards and associated operating rules (Sec. 1104).
- **Operating Rules for Health Claims and Referral Certification and Authorization:** Adoption of operating rules by July 1, 2014, for health claims or equivalent encounter information, and referral certification and authorization transactions are required (Sec. 1104).

Insurance Reform

- **Medicare Prescription Drugs:** Reduces the out-of-pocket amount that qualifies a Part D enrollee for catastrophic coverage between 2014 and 2019. (Recon. Sec. 1101).
- **Pre-existing Conditions and Discrimination:** Effective Jan. 1, 2014, insurers can no longer deny coverage to people with pre-existing conditions. They may not discriminate based on medical history, health status, genetic information, disability, evidence of insurability or any other factor determined appropriate by HHS (Sec. 1201).
- **Rate Regulation:** Effective Jan. 1, 2014, insurers must follow new guidelines on rate differentials they can charge based on age (max. 3:1), family size, tobacco use (max. 1.5: 1) or geographic region. Insurers are prohibited from charging different rates based on health status, pre-existing conditions or gender (Sec. 1201).
- **Guarantee issue and renewability:** Effective Jan. 1, 2014, insurers are required to issue or renew health insurance coverage (Sec. 1201).
- **Annual and Lifetime Limits:** Effective Jan. 1, 2014, insurers are prohibited from imposing annual or lifetime monetary coverage limits (Sec. 1001, as modified by Sec. 10101).
- **Ensure Coverage for Individuals in Clinical Trials:** Effective Jan. 1, 2014, insurers are prohibited from denying routine care or dropping coverage if an enrollee participates in a clinical trial (Sec. 10103).
- **Requires Essential Health Benefits Package:** Effective Jan. 1, 2014, all qualified plans, except those which are grandfathered in, must provide the essential health benefits package including basic services and states may require additional benefits. The Secretary of HHS shall define essential health benefits for the individual and small markets (Sec. 1302).
- **No Excessive Insurance Waiting Period:** Effective Jan. 1, 2014, a group health plan and a health insurance issuer offering individual or group coverage can no longer utilize a waiting period that is longer than 90 days (Sec. 1201).
- **State Based Exchanges Open:** By Jan. 1, 2014, each state is required to establish an American Health Benefit Exchanges for individuals and a Small Business Health Options Program to facilitate the purchase of qualified health plans. States may choose to combine the individual and small employer Exchanges. If approved by participating state legislatures, states may form regional Exchanges with other states. The Secretary of HHS must establish the certification criteria for qualified health plans, ensuring things such as sufficient choice of providers, uniform

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enrollment form, standard form of presenting plan information and marketing criteria. The Secretary must also develop a rating system for qualified health plans, which includes information on enrollee satisfaction. Plans are required to provide information to enrollees on cost-sharing for specific items or services. The Exchanges will certify the qualified health plans and operate toll-free hotlines and websites to present information on the qualified plans, eligibility and enrollment (Sec. 1311).

- **HHS May Establish Exchanges in States:** Effective Jan. 1, 2014, if states fail to establish their own state-based health insurance Exchange, HHS will establish an Exchange in that state (Sec. 1321).
- **At Least Two Multi-State Plans Offered in Each State:** Effective Jan. 1, 2014, the Office of Personnel Management (OPM) will contract with health insurers to offer at least two multi-state health plans through the Exchanges in each state. OPM is required to negotiate these contracts in a similar manner as the Federal Employee Health Plan Benefits Program (FEHBP) plans are negotiated. The multi-state plans negotiated by OPM will have a risk pool separate from FEHBP (Sec. 10104).

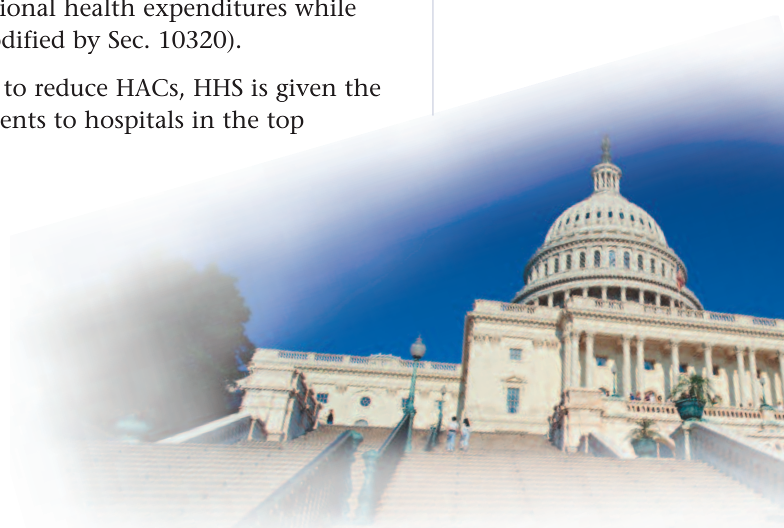
2015

Reimbursement

- **Physician Quality Reporting Initiative (PQRI):** In 2015, if a practice does not satisfactorily participate in the PQRI, a 1.5 percent penalty is applied to the practice's total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period (Sec. 3002).
- **Value-based payment modifier under the physician fee schedule:** The value-based payment modifier begins to affect payments in 2015 based on a provider's 2014 performance. The modifier provides for differential payments to physicians or groups of physicians based upon the quality of care furnished compared to the cost of care during a performance period. Such payment modifier shall be separate from geographic adjustment factors (Sec. 3007).
- **National Pilot Program on Payment Bundling:** HHS must submit to Congress an initial report on the status of this pilot program (Sec. 3023, as modified by Sec. 10307).
- **Independent Payment Advisory Board (IPAB):** 2015 is the first year IPAB has the authority to make Medicare cost reduction recommendations. No later than Jan. 15, 2015, and at least once every two years thereafter, the IPAB shall submit to Congress and the President its recommendations to slow the growth in national health expenditures while preserving or enhancing quality of care (Sec. 3403, as modified by Sec. 10320).
- **Hospital Acquired Conditions (HACs):** Starting in 2015 to reduce HACs, HHS is given the authority to add a 1 percent penalty adjustment in payments to hospitals in the top quartile of rates of HACs (Sec. 3008).

Individual Provisions

- **Individual Mandate Penalty Increases:** Effective Jan. 1,



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2015, individuals are required to have acceptable health insurance coverage for themselves and their dependents or pay a fine. People with incomes below the filing threshold are exempt. The penalty is the greater of either a flat fee ($325 in 2015) or a percent of income (2% in 2015). Individuals can qualify for tax credits and cost-sharing subsidies based on income (Sec. 1501, as modified by Sec. 10106 and Recon. Sec. 1002).

Administrative Simplification

- **Health Plan Compliance:** Health plans must file a statement with the Secretary by Dec. 30, 2015, certifying that its data and information systems are in compliance with any applicable standards and associated operating rules for claims, enrollment, premium payments, claims attachments, and referral certification/authorization (Sec. 1104).

2016

Reimbursement

- **Physician Quality Reporting Initiative (PQRI):** In 2016 and beyond, if a practice does not satisfactorily participate in the PQRI, a 2 percent penalty is applied to the practice's total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period. (Sec. 3002)
- **Medicaid and CHIP Pediatric ACO demonstration project:** Expires Dec. 31, 2016. (Sec. 2706)
- **National Pilot Program on Payment Bundling:** Final report from HHS to Congress due. (Sec. 3023, as modified by Sec. 10307)

Individual Provisions

- **Individual Mandate Penalty Increases:** Effective Jan. 1, 2016, individuals are required to have acceptable health insurance coverage for themselves and their dependents or pay a fine. People with incomes below the filing threshold are exempt. The penalty is the greater of either a flat fee ($695 in 2016) or a percent of income (2.5% in 2016). Individuals can qualify for tax credits and cost-sharing subsidies based on income (Sec. 1501, as modified by Sec. 10106 and Recon. Sec. 1002).

Administrative Simplification

- **Effective Date for Operating Rules for Health Claims Attachments:** The effective date of Jan. 1, 2016, is set for the health claims attachments standard and a single set of associated operating rules goes into effect (Sec. 1104).
- **Effective Date for Health Claims and Referral Certification and Authorization:** The effective date of Jan. 1, 2016, is set for operating rules for health claims or equivalent encounter information, and referral certification and authorization transactions goes into effect (Sec. 1104).

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Insurance Reform

- **Interstate Compacts:** Effective Jan. 1, 2015, if approved by the Secretary, states may form interstate or regional Exchanges in order to facilitate the purchase of health insurance (Sec. 1311).
- **Exchanges to be self-sustaining requirement:** Effective Jan. 1, 2015, state-based health insurance Exchanges are required to be self-sustaining (Sec. 1311).

2017

Insurance Reform

- **Open Exchanges to Larger Employer:** Effective 2017, states may choose to open the small business Exchange to employers with more than 100 employees (Sec. 1312).

2018

Employer Requirements

- **Tax on High-Cost Plans:** Effective 2018, a tax will be imposed on insurers providing employer-sponsored health insurance worth more than $10,200 for individuals and $27,500 for a family plan. The tax will be equal to 40% of the value of the plan above the individual or family threshold and will be indexed to inflation in future years (Recon. Sec. 1401).

No Specified Date:

Administrative Simplification

- **ICD-9 to ICD-10 CROSSWALK:** The Secretary must make appropriate revisions to the crosswalk between the International Classification of Diseases, 9th Revision (ICD-9) to ICD-10. Crosswalks between the old and the new code sets would allow at least temporary use of "legacy" billing systems. These crosswalks will be critical as physician practices and others are required under a 2009 regulation to transition to this new code set by Oct. 1, 2013 (Sec. 10109).

Compliance

- **Compliance programs required:** New providers or suppliers within particular industries or categories must have a compliance program in place as a condition of enrollment in Medicare, Medicaid or CHIP. The Secretary shall establish the core elements for a compliance program and the timeline for compliance (Sec. 6401).

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- **Data collection:** The Secretary will establish regulations to facilitation reporting of information on adverse actions against providers, supplier or practitioners by federal agencies, health plans and states. As part of this effort, the Healthcare Integrity and Protection Data Bank will be phased out and all information will be transferred to the National Practitioner Data Bank (Sec. 6403).
- **Authority to adjust payments:** The Secretary has the authority to make any necessary adjustments to payments to providers and suppliers with the same tax ID number as a provider or supplier that owes a past-due obligation under the Medicare program (Sec. 6401).
- **Terminated providers:** CMS will share with the states within 30 days the name, NPI and identifying information of providers or suppliers terminated from Medicare or CHIP (Sec. 6401).
- **Data sharing and matching:** The Secretary shall enter into agreements with other Department heads to share and match data in their records systems to identify potential fraud, waste and abuse in Medicare and Medicaid (Sec. 6402).
- **Beneficiary fraud:** The Secretary shall impose an additional administrative penalty for beneficiaries knowingly participating in Medicare or Medicaid fraud (Sec. 6402).
- **Reporting and returning overpayments:** Providers and suppliers must return overpayments within 60 days of the date it was discovered or the date that any corresponding cost report is due (Sec. 6402).
- **Exchange payments subject to False Claims Act:** Payments made in connection with an Exchange are subject to the federal False Claims Act if such payments include any federal funds (Sec. 1313).
- **Surety bond requirements:** The Secretary is granted authority to require a provider or supplier to provide the Secretary with a surety bond of no less than $50,000, commensurate with the volume of billing and based on the provider's level of risk, as determined by the Secretary (Sec. 6402).
- **Suspension of payment:** The Secretary may suspend payments to a provider or supplier pending an investigation of a credible allegation of fraud (Sec. 6402).
- **Sentencing guidelines:** The U.S. Sentencing Commission is directed to amend the Federal Sentencing Guidelines to strengthen penalties for healthcare fraud (Sec. 10606).

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