



THE HOSPITAL & HEALTHSYSTEM
ASSOCIATION OF PENNSYLVANIA

**The Patient Protection and Affordable Care Act
(PPACA) of 2010 and the Health Care and
Education Affordability Reconciliation Act
(HCEARA) of 2010**

Summary of Provisions Related to:

- Coverage Expansion
- Medicare and Medicaid Payment Policies
- Medicare and Medicaid Delivery System Reforms
- Additional Provider Issues
- Health Insurance Market Reforms
- Administrative Simplification



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Coverage Expansion

(PPACA Sections 1101, 1323, 1334, 1401, 1421, 1501, 1512, and 2001; HCEARA Sections 1002, 1003, and 1201)

The PPACA and HCEARA increase insurance coverage for American citizens by:

- Expanding the Medicaid program;
- Creating a high risk insurance pool;
- Allowing individuals up to age 26 to be covered under their parents' insurance plans;
- Requiring insurance companies to cover individuals with pre-existing conditions;
- Establishing state-based health insurance market places known as "Exchanges" where individuals not covered by employer-based or governmental health insurance can buy coverage;
- Offering subsidies to low to moderate income Americans who buy insurance through the newly established exchanges;
- Requiring all employers of 50 or more persons to provide health insurance coverage to their employees; and
- Requiring all American citizens not covered by an employer-based or governmental plan to purchase health insurance.

The Acts will eventually expand health insurance coverage to 32 million Americans who are currently uninsured, for total health coverage of 95% of all Americans. This means that 400,000 more Pennsylvanians will have insurance to cover the cost of their healthcare. However, based on Congressional Budget Office estimates, twenty-one million individuals would remain uncovered in ten years.

Medicaid Program Expansion: Beginning in 2014, the Medicaid program will be expanded to cover non-elderly individuals, including parents; children; and childless adults, up to 133% of the federal poverty level (FPL).

For most states, a federal matching rate of 100% will be provided for newly eligible individuals. The federal matching rate will decrease to 95% in 2017; 94% in 2018; 93% in 2019; and 90% thereafter. For “expansion” states (those with Medicaid programs that already cover non-pregnant, childless adults up to 133% of the FPL), federal support will be provided to reduce the state’s share by 50% in 2014; 60% in 2015; 70% in 2016; 80% in 2017; and 90% in 2018 for this portion of their Medicaid population. In 2019, expansion states will receive the same federal matching percent, 90%, for the costs of covering non-pregnant, childless adults as non-expansion states.

Creation of a High Risk Pool: 90 days after enactment of PPACA, a \$5 billion national high-risk insurance pool will be created to allow individuals with a pre-existing medical condition, who currently are unable to purchase private health insurance, to access insurance. This pool ends when the state-based exchanges become operational.

Dependent Coverage for Young Adults up to 26 Years Old: Six months after enactment of PPACA, any group plan or plan purchased on the individual market that provides dependent coverage for children, must continue to offer such coverage until the child turns 26 (if the dependent child is not eligible for employer-sponsored coverage on his/her own).

Children with Pre-existing Medical Conditions: Six months after enactment of PPACA, private insurance companies will be prohibited from denying coverage to children due to a pre-existing condition. This requirement applies to all employer plans and new plans in the individual market. (This provision will apply to all individuals in 2014.)

Establishment of State-Based Health Insurance Exchanges: No later than January 1, 2014, each state will establish state-based health insurance exchanges open to the individual and small group market. Small employers, with 50 or fewer employees, will be able to shop for coverage in the Small Business Health Options Program (SHOP) exchange. The exchanges will be overseen by state insurance commissioners; the financial integrity of the Exchanges will be overseen by the Secretary of the U.S. Department of Health and Human Services.

- **Plan Requirements:** Several levels of standardized, comprehensive benefit packages will be available at different levels of cost sharing.
- **Essential Health Benefits Package:** There will be a requirement that all qualified health benefit plans including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges offer at least the essential health benefits package. The essential health benefits package to be defined by the Secretary will provide a comprehensive set of services, cover at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits (\$5,950/individual and \$11,900/family in 2010) and is not more extensive than the typical employer plan. Nothing shall prevent a plan from providing benefits in excess of the essential health benefits. Specifically the essential health benefits shall include the following general categories: ambulatory; emergency; hospitalization; maternity and newborn; mental health and substance use disorder; prescription drugs, rehabilitative services; lab services; preventive and wellness services and chronic disease management; pediatric services including oral and vision care. A plan must

provide coverage for emergency department services without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan. If emergency department services are provided out-of-network the cost-sharing requirement (i.e. co-payment or co-insurance amount) is the same requirement that would apply if such services were provided in-network.

- **OPM Plans:** Each Exchange will provide access to multi-state, private plans under the supervision of the federal Office of Personnel Management (OPM). OPM is the agency that regulates and administers the Federal Health Employee Benefit Plan.
- **Co-ops:** Federal funding for start-up loans and grants will be provided to qualified organizations to assist in the establishment of nonprofit, member-run health insurance Consumer Operated and Oriented Plans (Co-Ops). These plans would offer health insurance through the health insurance exchange.
- **Provider Payments:** Providers will negotiate rates with the private plans offered through the exchanges, much the same as is currently done.
- **Insurance Market Reforms:** All plans operating in the exchanges will be subject to new insurance market reforms (see section of Insurance Market Reforms).

Subsidies for Health Insurance Coverage: Premium assistance in the form of refundable and advanceable tax credits will be provided on a sliding scale to individuals and families with incomes between 100% and 400% of the FPL. The premium credits will be tied to the second lowest-cost silver plan¹ in the area and will be set on a sliding scale such that the individual's/family's premium contributions are limited to 2.0% of income for those between 100% and 133% of the FPL up to 9.5% of income for those between 300% and 400% of the FPL. (Individuals with incomes less than 133% FPL are intended to get their coverage through Medicaid.) The expected contributions will increase annually based upon premium growth rates.

Provides small employers (with no more than 25 employees and average annual wages of less than \$50,000) that purchase health insurance for employees with a tax credit.

Individual Mandate: Effective January 1, 2014, most individuals who are not covered by employer-based or governmental plans will be required to obtain acceptable health insurance coverage. Failure to purchase such coverage will result in a financial penalty equal to: the greater of \$95 or 1% of income in 2014; \$325 or 2% of income in 2015; \$695 or 2.5% in 2016; and continued indexed amounts after 2016, up to the cap of the national average "bronze" plan premium. Families with children will pay half of the penalty amount for children, up to a cap of \$2,250 for the entire family.

¹ The PPACA establishes four levels of plans that can qualify for offering through an exchange: bronze, silver, gold, and platinum (Section 1302). As listed here, the plans increase in the coverage value of benefits with the bronze level covering 60% of the actuarial value of total benefits and platinum covering 90% of the actuarial value of total benefits.

Employer Mandate: Effective March 1, 2013, employers will be required to provide notice to employees of their health insurance options, including options available via the exchanges. Employers with 200 or more employees will be required to automatically enroll employees in health insurance plans, allowing individuals to opt-out. Employer penalties will apply for failure to provide affordable coverage as follows:

- Employers with 50 or more full-time workers, that do not offer health insurance coverage will pay an assessment of \$2,000 per full-time worker (not including the first 30 workers) if any of their employees receive a tax credit to purchase insurance through the exchange.
- Employers that offer unaffordable health insurance or a plan that does not cover at least 60 percent of allowable costs will pay \$3,000 for any employee that receives a tax credit in the exchange up to an aggregate cap amount set at \$2,000 multiplied by the number of full-time employees.

Internet Portal to Affordable Coverage Options: By July 1, 2010, the Secretary of Health and Human Services (the Secretary) must establish a mechanism, including an internet website, through which a resident of any state may identify affordable health insurance coverage options in that state. The internet website must provide information on private health insurance (including coverage offered through the state exchanges and co-ops, when applicable), the high risk pool, Medicare, and Medicaid.

Medicare and Medicaid Payment Policies

Medicare Update Factor Reductions (PPACA Section 3401; HCEARA Section 1105)

Savings: U.S.—\$156.6 billion over ten years; Pennsylvania—\$5,419.6 million (excludes the impact of Home Health marketbasket reductions which are included in the Home Health Agency section below).

The update factors for all Medicare Part A and B providers who are subject to a marketbasket or Consumer Price Index (CPI) update will be reduced to reflect estimated gains in productivity. A measure of multifactor productivity gains for the non-farm, general economy will be used (currently estimated at 1.3%) to reduce the update for inpatient and outpatient hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, nursing homes, home health, and hospice care providers.

Further update reductions beyond the productivity adjustment will also be applied.

No floor is established to protect provider updates from falling below zero.

Productivity Offsets:

Inpatient and Outpatient Hospitals, Inpatient Rehabilitation Facilities, Inpatient Psychiatric Facilities, Long-term Care Hospitals and Skilled Nursing Facilities: Beginning in 2012 and every year thereafter, productivity adjustments will be applied to these providers' Medicare update.

Hospice Providers: Productivity reductions will begin in 2013.

Home Health Agencies: Productivity reductions will begin in 2015.

Update Factor Reductions in Addition to Productivity Offsets:

Inpatient and Outpatient Hospitals, Inpatient Rehabilitation Facilities, and Inpatient Psychiatric Facilities: Marketbasket updates will be reduced by 0.25 percentage points in 2010 and 2011. The reduction for hospital inpatient and rehabilitation applies to discharges after March 31, 2010. In addition to the annual productivity adjustment, the following marketbasket reductions will be applied: 0.10 percentage points in 2012 and 2013; 0.30 percentage points in 2014; 0.20 percentage points in 2015 and 2016; and 0.75 percentage points annually in 2017 through 2019.

Long-Term Care Hospitals: The annual update factors for long-term care hospitals will be reduced by 0.25 percentage points in 2010 and 0.50 percentage points in 2011. In addition to the annual productivity adjustment, the following marketbasket reductions will be applied: 0.10 percentage points in 2012 and 2013; 0.30 percentage points in 2014; 0.20 percentage points in 2015 and 2016; and 0.75 percentage points annually in 2017 through 2019.

Home Health Agencies: Reduces the annual update factors for home health agencies by 1.0 percentage point in 2011, 2012, and 2013.

Hospice Providers: In addition to the annual productivity adjustment, the update factors for hospice providers will be reduced by 0.30 additional percentage points annually in 2013 through 2019.

Medicare and Medicaid Disproportionate Share Hospital (DSH) Payment Reductions

(PPACA Sections 2551 and 3133; HCEARA Sections 1104 and 1203)

Savings: U.S.—\$36.1 billion over ten years; Pennsylvania—\$502.5 million (Medicare Only)

The PPACA and HCEARA reduce Medicare and Medicaid DSH payments to adjust for reductions to the number of uninsured individuals.

Medicaid DSH Reductions: Federal Medicaid DSH allotments will be reduced by \$14.1 billion over ten years, beginning with a \$500 million cut in FFY 2014, and increasing to a \$5.6 billion cut in FFY 2019. This represents an approximate 50% reduction compared to the \$11.3 billion federal DSH allotment in FFY 2009.

The Secretary is required to develop a methodology for reducing federal DSH allotments to each state. The largest DSH reductions would be imposed on the states that have the lowest uninsured percentages and on states that do not distribute DSH payments based on Medicaid inpatient volumes and uncompensated care (excluding bad debt).

Medicare DSH Reductions: Medicare DSH payments, provided as part of the inpatient PPS, will be reduced by \$22 billion over ten years, beginning in FFY 2014.

25% of DSH payments are considered to be the “empirically justified” component of DSH and will continue to be paid to each hospital based on the current methodology

75% of DSH payments will be subject to reductions to reflect reductions in the uninsured population. For every percentage point reduction in the uninsured rate, DSH funding will be proportionally reduced. The calculation of the reduction in the uninsured population is modified to artificially increase the reduction of uninsured by an additional 0.1 percentage points in 2014 and 0.2 percentage points in 2015 through 2019; thereby increasing the level of Medicare DSH cuts. After reduction, this portion of DSH funds would be distributed to hospitals based on each hospital’s level of uncompensated care compared to total uncompensated care for all hospitals.

Medicare Home Health Agency Payment Changes (PPACA Section 3131)

Savings: U.S.—\$39.7 billion over ten years; Pennsylvania—\$1,353.5 million

Payment Rebasing: PPACA calls for a rebasing of home health agency (HHA) payment rates, thereby reducing payments. Rebasing would take into account changes in the average number and types of visits per episode, intensity of visits, and growth in cost per episode. Reduced, rebased payments are to be phased-in over four years, beginning in 2014; reductions cannot exceed 3.5% each year.

Cap on Outlier Payments: Beginning in 2011, reduces the HHA outlier pool from 5% of total payments to 2.5% and establishes a 10% cap on the reimbursement a home health provider can receive from outlier payments. This mandates the policy that has already been adopted by CMS in its final rate year 2010 rule.

Rural Home Health Add-on: Provides a 3% add-on payment for home health service provided to Medicare beneficiaries in rural areas from April 1, 2010 through December 31, 2015.

Marketbasket Reductions: See Medicare Update Factors section above.

Medicare Skilled Nursing Facility Payment Changes (PPACA Section 10325)

Delay in Implementation of RUGs-IV: Temporarily delays implementation of Version 4 of the Resource Utilization Groups (RUGs-IV) for one year, from FFY 2011 to FFY 2012. Requires that the Secretary implement a component of RUGs-IV specific to therapy furnished on a concurrent basis. Revises the look-back period to ensure that only those services furnished after admission to a skilled nursing facility are used as factors in determining a case-mix classification under the Skilled Nursing Facility Prospective Payment System.

Medicare Rural Provisions

(PPACA Sections 3121, 3122, 3123, 3124, 3125, 3126, 3127, 3128, 3129, and 3131)

Spending: U.S.—\$300 million over ten years; Pennsylvania—\$0.7 million (excludes the impact of the HHA rural add-on, which is included in the Home Health Agency section above).

Extension of Outpatient Hold-Harmless Payments: Extends outpatient PPS hold-harmless payments for one year, through December 31, 2010. These hold-harmless payments are also expanded to apply to all Sole Community Hospitals, not just those with fewer than 100 beds.

Medicare Dependent Hospitals (MDHs): Extends the MDH classification, which is set to expire on September 30, 2011, for one additional year, through September 30, 2012.

Critical Access Hospital Outpatient Payments: Makes a technical correction clarifying that CAHs which elect an all-inclusive outpatient payment will receive 101% of reasonable costs for facility services, not 100% as interpreted by CMS in the 2010 inpatient rule.

Clinical Diagnostic Laboratory Services: Reinstates reasonable cost payment for clinical lab tests performed by hospitals with fewer than 50 beds in qualified rural areas for the period July 1, 2010 through June 30, 2011. A qualified rural area is one with a population density in the lowest quartile of all rural county populations.

Medicare Payment Adjustment for Low-Volume Hospitals: Modifies the current low-volume Medicare payment adjustment for FFYs 2011 and 2012. Allows hospitals to qualify for an adjustment if they are more than 15 road miles from another acute hospital and have less than 1,600 discharges during the fiscal year (currently, a low volume hospital must be more than 25 road miles from another acute hospital and have less than 800 discharges). The Secretary is required to determine the low-volume add-on amount using a linear sliding scale ranging from 25% for low-volume hospitals with Medicare discharges below a certain threshold, to no adjustment for hospitals with more than 1,600 Medicare discharges.

Rural Community Hospital Demonstration Program: Extends, for five additional years, through December 31, 2014, the rural community hospital demonstration project which provides cost-based inpatient payment for rural hospitals with fewer than 51 beds. The Act also increases the number of participating hospitals from 15 to 30 and expands the eligible sites from the 10 states with the lowest population densities to the 20 lowest density states.

Rural Home Health Add-on: See Medicare Home Health Agency Payment Changes section above.

Expansion of Community Health Integration Models in Rural Areas: Expands the demonstration which provides cost-based payment for integrated acute and post-acute care service models in certain rural counties within qualifying states. Eligible hospitals must be located in a State in which at least 65 percent of the counties in the State have six or less residents per square mile. The demonstration is restricted to four states selected by the Secretary. The PPACA removes the current limit of six counties per state and extends the demonstration to allow inclusion of physician services.

MedPAC Review of Medicare Payments for Rural Areas: Requires MedPAC to review payment adequacy for rural health care providers serving the Medicare program and report to Congress by January 1, 2011.

Medicare Rural Hospital Flexibility Program: Extends the “FLEX” program for an additional two years through 2012. Allows Small Rural Hospital Improvement grant program funding to support small rural hospitals’ participation in the delivery system reform programs outlined in this legislation (such as VBP, bundling, and accountable care organizations).

Medicare Hospital Wage Index (PPACA Sections 3137, 3141 and 10324)

Spending: U.S.—\$2.3 billion over ten years; Pennsylvania—\$52.7 million

Wage Index Reform: PPACA mandates that the Secretary report to Congress by December 31, 2011 with recommendations for comprehensive reform of the Medicare wage index system. The plan is required to take into account the 2007 MedPAC wage index report, including the proposed use of Bureau of Labor Statistics data and the recommended redefinition of wage areas.

Extension of Section 508 Legislative Medicare Wage Index Reclassifications: Extends for one year, through September 30, 2010, special Section 508 Medicare hospital wage index reclassifications. The financial impact for Pennsylvania for this extension is \$32.8 million. By April 1, 2010, CMS must recalculate the reclassified wage indexes to include the data for those hospitals that reclassify under Section 508. If the resulting reclassified wage index value for a Section 508 hospital is higher than the reclassified value paid prior to April 1, the Secretary must retroactively adjust its payments by December 1, 2010.

Restoration of Medicare Hospital Wage Index Reclassification Thresholds: Directs the Secretary to restore, for FFY 2011, the lower FFY 2008 Medicare hospital wage index reclassification thresholds used in 2008 to compare hospitals' average hourly wages (AHWs), for the purpose of determining wage index reclassifications (the AHW comparison criterion was made stricter over the past two years). This has an impact of \$19.9 million on Pennsylvania hospitals and health systems.

Application of Budget Neutrality for the Medicare Hospital Wage Index: Beginning in FFY 2011, requires that the application of budget neutrality associated with the effect of the Medicare wage index rural floor and imputed rural floor be applied on a national, rather than state-specific basis through a uniform, national adjustment to the area wage index. (The current methodology that applies the wage index floor budget neutrality adjustment at the state level was adopted by CMS in FFY 2009.)

Medicare Advantage Payments (PPACA Section 3201; HCEARA Section 1102)

Savings: U.S.—\$131.9 billion over ten years.

Freezes Medicare Advantage (MA) payments in 2011: Beginning in 2012, phases-in reductions to the Medicare Advantage county-level benchmark rates such that the average MA payment per beneficiary is about 100% of per capita spending for traditional fee-for-service (FFS) Medicare. Adjustments will be made to these benchmarks based measures of spending per capita and on MA plans' performance on quality and patient satisfaction measures. The base benchmarks will range from 95% of FFS spending per capita in the highest cost counties (top quartile) to 115% of FFS in the lowest cost counties (bottom quartile).

Independent Payment Advisory Board (IPAB) (PPACA Section 3403)

Savings: U.S.—\$13.3 billion over ten years.

Establishment of IPAB: Establishes an IPAB to submit proposals to Congress beginning in 2014 that would reduce Medicare spending by maximum targeted amounts (0.5 percentage point reduction in 2015 increasing to a 1.5 percentage point reduction in 2018 and beyond) if it is determined that there is excess cost growth in the Medicare program. Congress could modify or pass an alternative to the proposals, but is required to maintain the targeted level of Medicare savings for the year. The Board's original proposal must be implemented if Congress does not consider the Board's proposal.

Exemption from Board Proposals: Providers such as hospitals and hospices that are scheduled to receive a reduction to their marketbasket update in excess of a productivity-based reduction are exempt from any proposed reductions from the Board through 2019. CAHs are not exempt from the Board's proposals.

Other Medicare and Medicaid Payment Provisions **(PPACA Sections 10501, 3132, 3138, 3142 and 6411)**

Updating Outpatient Payments for PPS-Exempt Cancer Hospitals: Requires CMS to conduct a study to determine if the outpatient costs incurred by PPS-exempt cancer hospitals exceed the costs of other hospitals reimbursed under outpatient PPS. If appropriate, CMS will provide an adjustment for services starting January 1, 2011.

Expansion of the Recovery Audit Contractor (RAC) Program: The RAC program, which currently audits Medicare Part A and Part B claims, is expanded to include audits of Medicare Parts C and D.

Expansion of the RAC Program to Medicaid: By December 31, 2010, each State must establish a similar program for Medicaid under which the State contracts with a recovery audit contractor. Payment to the Medicaid RAC must be made on a contingency basis.

Medicare Claims Submission: Beginning January 1, 2010, reduces the maximum period for requests for payment from three years to one year. All requests for payment for services furnished prior to January 1, 2010 must be submitted by December 31, 2010.

PPS for Federally Qualified Health Centers (FQHCs): Requires CMS to develop a FQHC PPS system. The PPS will be effective for cost reporting periods beginning on or after October 1, 2014.

Hospice Payment: Requires CMS to study possible revisions to the payment rates for hospice care and allows implementation of changes on or after October 1, 2013. The revisions may include adjustments to reflect changes in resource intensity in providing services during the course of the entire episode of hospice care.

Urban Medicare Dependent Hospital Study: Requires CMS to study and make recommendations to Congress by November 2010 on whether the Medicare Dependent Hospital (MDH) payment methodology that is currently applied to small rural hospitals should be extended to urban Medicare-dependent hospitals. Urban Medicare-dependent hospitals are defined as facilities with more than 60 percent of inpatient days or discharges covered by Medicare that do not receive any DSH or IME payments.

Medicare and Medicaid Delivery System Reforms

Medicare Readmissions Payment Policy (PPACA Sections 3025 and 3026)

Savings: U.S.—\$7.1 billion over ten years; Pennsylvania—\$383.0 million

Beginning in FFY 2013, acute care hospitals with higher than expected risk-adjusted readmission rates will receive reduced Medicare payments for every discharge. Payments will be reduced by the lower of a hospital-specific readmissions adjustment factor or a pre-determined floor (see below). In the first two years (FFYs 2013 and 2014), the payment policy will be based on readmissions related to three conditions: heart failure, heart attack, and pneumonia. By the third year (FFY 2015), the payment policy will be expanded to include chronic obstructive pulmonary disease (COPD), coronary artery bypass graft (CABG), percutaneous transluminal coronary angioplasty (PTCA), and other vascular procedures. The Secretary has the authority to expand the policy to additional conditions in future years, including all-cause readmissions.

Maximum Payment Reduction for Individual Facilities: 1.0% in FFY 2013, increasing to 3.0% in FFY 2015 and thereafter.

Sole Community Hospitals and Medicare-Dependent, Small Rural Hospitals: The payment adjustment for these hospitals will only be applied to the federal portion of the Medicare payment rate (not the hospital-specific amount, if applicable).

Critical Access Hospitals: CAHs are not included in the readmissions payment penalty policy.

Public Reporting of Hospital-Specific Readmissions Rates: Requires the Secretary to publicly post (on the CMS Hospital Compare website) all-payer readmission rates for identified conditions. This would require hospitals to submit all-payer claims-level data to CMS, either independently or through their state data agency. This provision applies to cancer, children's, rehabilitation, long-term care, and psychiatric inpatient facilities as well.

Assistance for High Readmission Hospitals: The Secretary is mandated to establish a quality improvement program by March 2012 for hospitals with high severity-adjusted readmission rates. Eligible hospitals would work with patient safety organizations to implement processes to improve readmission rates. In addition, beginning in January 2011, \$500 million in funding will be available over a five-year period to fund a Community Care Transitions Program for hospitals with high readmission rates and partnership organizations to implement care transitions using evidence-based interventions for targeted high-risk beneficiaries.

Post-Acute Care Providers: Requires reporting of all-patient claims data for posting of readmission rates on the Hospital Compare site (see above).

Establishment of a Medicare Value-Based Purchasing (VBP) Program (PPACA Sections 3001, 3006, 3007, and 10326)

Savings: Budget neutral

Inpatient Hospitals: The Medicare VBP payment program begins in FFY 2013 (reporting begins in FFY 2012) and will be budget-neutral, with each year's funding pool fully distributed to hospitals in that same year. The VBP program will be funded by Medicare inpatient payment reductions, beginning with a 1.0% reduction in FFY 2013 and increased by 0.25% each year until the reduction reaches 2.0% for FFY 2017 and subsequent years.

The VBP program applies to all "subsection (d)" inpatient hospitals—all hospitals under the Inpatient Prospective Payment System (PPS) excluding psychiatric, rehabilitation, children's, cancer, and long-term care hospitals. Critical Access Hospitals (CAHs) and small hospitals with insufficient numbers of measures and/or cases are excluded from the program. The PPACA mandates that, within two years, the Secretary establish two separate, three-year VBP demonstration programs, one for CAHs and one for these small excluded hospitals. Each of the demonstration programs are to culminate in a report to Congress and recommendations for permanent VBP programs.

The Secretary is responsible for selecting measures, determining the scoring methodology, and determining the payment methodology. Hospitals that meet or exceed a performance standard set by the Secretary will be eligible to earn back the money contributed to the pool. The methodology must recognize both achievement of standards and improvement. Hospital scores will be determined in advance of the payment year using data from a prior period and hospitals that meet or exceed standards will receive an increase in the payment rate for that year.

In FFY 2013, measures must cover at least the following conditions: acute myocardial infarction (AMI), heart failure, pneumonia, surgeries from the Surgical Care Improvement Project, and healthcare-associated infections. Measures must also be selected related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS). No earlier than FFY 2014, the Secretary is required to include efficiency measures (including adjusted Medicare spending per beneficiary) as part of the VBP program. The use of readmissions measures as part of the VBP program is expressly prohibited.

Post-Acute Care Providers and Ambulatory Surgical Centers: The Secretary must submit plans to Congress for VBP programs for home health providers and skilled nursing facilities by October 1, 2011 (FFY 2012). A VBP plan for ambulatory surgical centers must be submitted by January 1, 2011.

Physicians: Establishes a value-based payment modifier that allows for differential payments to physicians based upon quality and cost indicators.

VBP Pilot Programs: Beginning in 2016, the Secretary is required to implement pilot programs to test VBP payments for inpatient psychiatric facilities, long-term care hospitals, inpatient rehabilitation facilities, cancer hospitals, and hospice programs. The pilots must be budget neutral. The programs may be expanded beginning in 2018.

Establishment of Delivery System Reform Programs, Pilots, and Demonstration Projects (PPACA Sections 2704, 2705, 2706, 2707, 3022, 3023, 10308, and 10504)

Savings: U.S.—\$4.9 billion over ten years.

Medicaid Demonstration Projects: The Secretary is authorized to conduct the following Medicaid demonstration projects:

- Medicaid bundled payment demonstrations to evaluate integrated care around a hospitalization, in up to eight states beginning in 2012;
- Medicaid global payment demonstrations for safety net hospitals in up to five states beginning in 2010;
- Pediatric Accountable Care Organization demonstrations beginning in 2012; and
- Medicaid emergency psychiatric demonstration projects beginning in 2011.

Medicare Payment Bundling Pilot: The Secretary will implement a national pilot program for bundling payments in 2013.

CMS will select ten conditions to be included in the pilot program. The bundled service would include care delivered three days prior to hospital admission and extend through 30 days following discharge; and would cover:

- acute care inpatient services including readmissions;
- outpatient hospital services including emergency room;
- physician care, including services in and out of the hospital; and
- post-acute care, including home health services, skilled nursing facility, inpatient rehabilitation, and long-term care hospital services.

An entity comprised of providers, including a hospital; a physician group; a skilled nursing facility; and a home health agency, could submit an application to join the pilot program. The Secretary is required to consult with representatives of small rural hospitals and Critical Access Hospitals regarding their participation in the pilot program.

The Secretary will develop bundled payment rates and will test payments based on bids submitted by the entities. Annual payments under the pilot to a single entity may not exceed what would otherwise be paid for the same services under the current Medicare program(s).

The Secretary may expand the duration and scope of the pilot at any time after January 1, 2016, if he/she determines the extension would result in improving the quality of patient care and reducing spending. In 2016, CMS must report to Congress on the results of the pilot program.

Medicare Accountable Care Organizations (ACOs): Establishes a program, beginning in 2012, to allow groups of providers to be recognized as ACOs and share in the cost savings they achieve for the Medicare program.

Hospitals can take the lead in formation of an ACO and ACOs may include:

- group practice arrangements;
- networks of individual physician practices;
- partnerships or joint-venture arrangements between hospitals and practitioners; and
- hospitals employing practitioners.

To qualify, the organization must act as the primary care provider for at least 5,000 Medicare fee-for-service beneficiaries. ACO providers must agree to participate for at least three years.

Hospitals and other providers in the ACO would be allowed to share in the Medicare cost savings they achieve if: 1) the ACO meets quality performance standards established by the Secretary; and 2) average per capita Medicare expenditures are below a benchmark based on the claim history and characteristics of the patients assigned to the ACO.

Demonstration Project to Provide Access to Affordable Care: Within 6 months after enactment of PPACA, the Secretary (acting through HRSA) must establish a 3-year demonstration in 10 states to provide access to comprehensive health care services to uninsured individuals at reduced fees.

Addressing Geographic Variation in Health Spending (PPACA Section 3001; HCEARA Section 1109)

Spending: U.S.—\$400 million over two years

Use of Efficiency Measures in VBP: Requires the Secretary to include efficiency measures in an inpatient hospital VBP program by FFY 2014. Measures of Medicare spending per beneficiary adjusted for age, sex, race, severity of illness, and other factors that the Secretary determines to be appropriate must be included.

Payments to Qualifying Hospitals: Beginning in FFY 2011, HCEARA provides new Medicare funding - \$400 million over two years - to be allocated to hospitals located in counties within the lowest quartile of total Medicare Part A and Part B spending per enrollee nationwide. Spending must be adjusted to account for age, sex, and race.

Medicare and Medicaid Health Care-Acquired Conditions (HAC) Payment Policies (PPACA Sections 2702 and 3008)

Savings: U.S.—\$1.4 billion over ten years

The PPACA extends the existing Medicare HAC policy to the Medicaid program. Medicare currently reduces payments to hospitals for cases in which one of a select number of secondary diagnoses was not present on admission and, therefore, considered to be health care-acquired.

Medicare HAC Payment Policy: Beginning in FFY 2015, hospitals in the worst 25th percentile of risk-adjusted HAC rates will be subject to a 1.0% payment penalty under Medicare. The reduction will be applied in addition to current CMS payment adjustments for HACs. The Secretary must publicly report on hospitals' HAC measures and is required to study and report to Congress by January 1, 2012 on expanding the HAC policy to inpatient rehabilitation facilities, long-term care hospitals, hospital outpatient departments, skilled nursing facilities, ambulatory surgical centers, health clinics, and other hospitals excluded from the Inpatient PPS.

Medicaid HAC Payment Policy: Beginning on July 1, 2011, state Medicaid programs must adopt policies ensuring that higher Medicaid payments are not made for cases with conditions covered by the Medicare HAC policy. The Secretary may exclude certain Medicare HACs determined to be inapplicable to Medicaid populations.

Expansion of Medicare and Medicaid Quality Reporting Programs (PPACA Sections 2701, 3002, 3004, 3005, 3011 - 3015, 10322 and 10331)

The Secretary is required, through a transparent collaborative process, to establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health. The Secretary shall collaborate, coordinate, and consult with the state agencies responsible for administering the Medicaid program and the Children's Health Insurance Program with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with national priorities.

The PPACA calls for the creation of an Interagency Working Group to coordinate and streamline federal quality activities. The Group's first report must be issued no later than December 31, 2010.

Pay-for-Reporting: Implements Medicare pay-for-reporting programs for long-term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, and hospice providers in 2014. Providers that do not report will be subject to a two percentage point reduction in their annual marketbasket update. Establishes mandatory physician reporting beginning in 2015 with comparable penalties for non-compliance (a 2% reduction to payments by 2016).

Additional Medicare Quality Reporting: Requires reporting of quality and efficiency measures for cancer hospitals in 2014.

Quality Compare Websites: The Secretary is mandated to improve the functionality and ease of use for the various CMS quality comparison websites. The Secretary must make all data reported by providers under the pay-for-reporting program available for public inspection via the quality comparison websites.

Physician Compare Website: No later than January 1, 2013, the Secretary shall implement a plan for making publicly available, through a Physician Compare website, information on physician performance that provides comparable information on quality and patient experience measures with respect to physicians enrolled in Medicare. To the extent scientifically sound measures are available, such information, to the extent practicable, shall include measures collected under the Physician Quality Reporting Initiative; an assessment of patient health outcomes and the functional status of patients; an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use; an assessment of efficiency; an assessment of patient experience and patient, caregiver, and family engagement; an assessment of the safety, effectiveness, and timeliness of care; and other information as determined appropriate by the Secretary.

Medicaid Quality Measurement and Reporting: No later than January 1, 2011, the Secretary must identify and publish priorities for the development and advancement of quality measures for adults in the Medicaid program. These measures are to be reported and used by providers, State Medicaid programs, and health insurers (including managed care entities) that contract with State entities.

By January 1, 2012, the Secretary must publish an initial core set of adult health quality measures that are applicable to Medicaid eligible adults. By January 1, 2013, the Secretary, in consultation with states, must develop a standardized format for reporting information based on the initial core set of adult health quality measures and create procedures to encourage states to use those measures to voluntarily report information regarding the quality of health care for Medicaid eligible adults.

No later than 12 months after the release of the recommended core set of adult health quality measures (January 1, 2013), the Secretary is to establish a Medicaid Quality Measurement Program. Beginning not later than 24 months after the establishment of the Medicaid Quality Measurement Program, and annually thereafter, the Secretary shall publish recommended changes to the initial core set of adult health quality measures.

A similar program for Medicaid/CHIP eligible children was enacted under the Child Health Insurance Program Reauthorization Act (CHIPRA) of 2009.

CMS Center for Medicare and Medicaid Innovation (CMI) (PPACA Section 3021)

Savings: U.S.—\$1.3 billion over ten years.

Establishes, by 2011, the Center for Medicare and Medicaid Innovation (CMI) to test innovative payment and service delivery models to improve the coordination, quality, and efficiency of health care services provided to Medicare and Medicaid beneficiaries. Gives preference to models for which there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.

The Secretary may expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested or a demonstration project to the extent determined appropriate, if the Secretary determines that such expansion is expected to reduce spending under the Medicare and/or Medicaid program without reducing the quality of care; or improve the quality of care and reduce spending; and the Chief Actuary of CMS certifies that such expansion would reduce the Medicare and/or Medicaid program.

Requires that the Secretary, every other year beginning in 2012, report to Congress on the model tested under the CMI and make recommendations for legislative action to facilitate the development and expansion of successful payment models. Funding is set at \$5 million in FFY 2010, \$10 billion for the period FFY 2011 through 2019, and an additional \$10 billion for each subsequent ten-year period.

Additional Provider Issues

Medicare Graduate Medical Education (GME) (PPACA Sections 5503, 5504, and 5506)

Spending: U.S.—\$1.1 billion over ten years.

GME payments to hospitals are protected, maintaining current levels of funding for Indirect Medical Education and Direct Medical Education in perpetuity.

Redistribution of Unused Resident Slots: Effective July 1, 2011, redistributes 65% of the currently unused training slots. Unused slots will be based on each hospital's highest resident level in any of the three most recent cost reporting periods prior to July 1, 2011. Rural hospitals with less than 250 beds and hospitals that participated in voluntary reduction programs are exempt from reductions. Hospitals may apply to receive up to 75 additional

residency positions. In return, the hospital will be required to use at least 75% of the increase for primary care or general surgery residency and to maintain its quantity of primary care residents. Priority will be given to hospitals located in states with low resident-to-population ratios; hospitals in one of the top ten states for the ratio of the total population living in a Health Professional Shortage Area (HPSA); and hospitals located in rural areas.

Preservation of Resident Slots from Closed Hospitals: Resident slots from closed hospitals will be redistributed using a process to be determined by the Secretary. Priority will be given to other hospitals within the same Core-based Statistical Area (CBSA), followed by hospitals within the same state. This includes hospitals that have closed up to two years prior to enactment.

Resident Time in Non-Provider Settings: Allows hospitals to be paid for resident training in non-hospital settings if the hospital incurs the costs of the stipends and fringe benefits for the resident. Further, hospitals are now allowed to count time spent by a resident in non-patient care activities such as didactic conferences and seminars.

Hospital Reporting of Charges (PPACA Section 1001)

Effective for FFY 2011, requires hospitals to publicize a list of standard charges for items and services provided by the hospital, including DRGs.

New Requirements Applicable to Tax-Exempt Status (PPACA Section 9007)

Establishes the following additional criteria for hospitals to maintain their Section 501(c)(3) tax-exempt status:

- implementation of strategies to meet community needs-based on the findings of periodic health needs assessments;
- adoption of a financial assistance policy with criteria to qualify, basis for payment and defined collection policies;
- limitation of charges for those who qualify for financial assistance to no more than the amounts generally billed to those with insurance, and prohibits the use of gross charges; and
- requirement that 501(c)(3) hospitals not engage in extraordinary collection actions.

In addition to meeting all four reporting requirements to maintain tax-exempt status, a \$50,000 excise tax will apply for hospitals that fail to meet the community health plan requirements. Requires the Internal Revenue Service to review information about a hospital's community benefit activities at least once every three years.

Requires the Secretary to report to Congress on the levels of charity care, bad debt, unreimbursed costs of non means-tested government programs, and the cost of community benefit activities incurred by tax-exempt, taxable, and government hospitals.

340B Drug Discount Program (PPACA Section 7101; HCEARA Section 2302)

Extension of 340B Program: Beginning January 1, 2010, extends access to the 340B program to certain children's and cancer hospitals, CAHs, Sole Community Hospitals (SCHs), and Rural Referral Centers (RRCs). SCHs and RRC must have a DSH adjustment percentage equal to or greater than 8 percent; children's and cancer hospitals must meet the same DSH requirements as other subsection (d) hospitals – a minimum DSH percentage of 11.75%; CAHs are exempted from the DSH requirement. The program is not extended to Medicare Dependent Hospitals.

Medical Liability Reform (PPACA Section 6801)

Authorizes the Secretary to award \$50 million in demonstration grants to states over a period of five years, beginning FFY 2011, for the development, implementation, and evaluation of alternatives to the existing civil litigation system. Each state desiring a grant is required to develop an alternative to current tort litigation that allows for the resolution of disputes over injuries allegedly caused by health care providers or health care organizations, and promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes resolved by organizations that engage in efforts to improve patient safety and the quality of health care.

Nursing Home Reporting Requirements (PPACA Sections 6102 through 6107)

Requires skilled nursing facilities to provide information on the ownership and governing body of the facility, staffing, and wages and benefits. Requires CMS to publically report data on staffing, number of substantiated complaints, and criminal violations by a facility or its employees. Requires that nursing homes operate a compliance and ethics program.

Medically Underserved Populations and Health Professions Shortage Areas (PPACA Section 5602)

Requires the Secretary to initiate a negotiated rulemaking process to establish a methodology and criteria for designation of medically underserved populations and health professions shortage areas.

Health Insurance Market Reforms

(PPACA Sections 1001, 1002, 1003, 1005, 1201, 1251 – 1253, and 1301 - 1304)

No Lifetime or Annual Limits: Six months after enactment, health plans must eliminate lifetime, annual, or unreasonable limits on coverage. The law, however, does not prevent a plan that does not provide essential health benefits, as defined by the Secretary, from placing per beneficiary limits on specific covered benefits.

Prohibition of Rescissions: Six months after enactment, the ban on the practice where insurers retroactively cancel health coverage will be extended to employer-based group policies, except in the case of fraud.

Medical Loss Ratio (MLR): Six months after enactment, the minimum required MLR for the group market will be 80%. The minimum MLR required for the individual market will be 75%. State law that requires a higher MLR will preempt this new federal standard, unless the Secretary determines the State's minimum MLR may destabilize the individual market.

Each year, health plans must submit a report detailing the percent of total premium revenue that is spent on provider reimbursement, activities that improve health care quality, and all other non-claim costs, excluding taxes. The report will be made public on the Health and Human Services (HHS) website.

Appeals Process: Six months after enactment, health plans must have in place an effective process for appeals of coverage determinations and claims. At a minimum a plan must:

- Have in effect an internal claim appeal process;
- Provide notice to enrollees of available internal and external appeals processes;
- Allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of an appeal; and
- Provide an external review process that includes the consumer protections set forth in the Uniform Review Model Act. The Act, promulgated by National Association of Insurance Commissioners (NAIC), establishes standardized protocols for external review to ensure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination regarding benefits for specific procedures or services.

Annual Review of Premiums: Six months after enactment, the Secretary, in cooperation with States, will establish a process for the annual review of unreasonable increases in premiums. The process will require health plans to submit a justification for an unreasonable premium increase prior to the implementation of the increase. The plan must also prominently post the justification on its website.

In 2014, the Secretary and the states will begin monitoring premium increases offered through and outside of an exchange. When determining whether to offer a health plan in the large group market through an exchange the state must take into account excess premium growth outside of the exchange compared to the rate of premium growth inside the exchange.

Mandated Coverage for Preventive Health Services: Six months after enactment, a health plan must provide coverage without cost-sharing requirements for certain preventive care services.

Extension of Non-discrimination Rules: Six months after enactment, health plans may not discriminate in favor of highly compensated employees in terms of eligibility to participate and the level of benefits under a plan.

Uniform Coverage Documents: Plans must provide a summary explanation that accurately describes benefits and coverage to participants prior to enrollment. The Secretary will provide standards for developing the summary by 2011 and plans will be required to distribute the new summary by 2013.

Ensuring Quality of Care: By 2012 the Secretary will develop reporting requirements for use by health plans aimed at improving health outcomes. These reporting requirements may affect provider reimbursement. The Secretary will also promulgate regulations that will provide criteria for determining a reimbursement structure aimed at improving health outcomes.

Guaranteed Availability and Renewability of Coverage: Beginning in 2014, health plans that offer coverage must accept every employer and individual that applies for coverage. The plan must also renew or continue to offer coverage for all members.

Waiting Period Restrictions: Beginning in 2014, Health plans may not impose any waiting period in excess of 90 days.

No Discrimination Based on Health Status: Beginning in 2014, health plans may not establish rules for eligibility to enroll based on the individual's health status.

Mandated Coverage for Clinical Trials: Beginning in 2014, health plans cannot deny participation of a qualified individual in a clinical trial, deny coverage of routine costs in connection with the clinical trial, or discriminate on the basis of participation in a clinical trial.

Fair Health Insurance Premiums: Beginning in 2014, premium rates may only vary by:

- Whether the plan covers an individual or family;
- Rating area (to be established by the State);
- Age – may not vary more than 3:1 for adults; and/or
- Tobacco use – may not vary more than 15:1

Mandated Cost-Sharing Limits: Beginning in 2014, health plans must limit cost-sharing amounts to the limits applicable to high deductible health plans. Group health plans cannot have deductibles that exceed \$2,000 for single coverage or \$4,000 for any other coverage. These amounts are subject to cost-of-living adjustments after 2014.

Administrative Simplification

(PPACA Section 1104)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has been amended to ensure the establishment of uniform standards and requirements for electronic transmission of health information and to reduce the clerical burden on patients, healthcare providers, and health plans.

All standards and associated operating rules for Health Information Technology (HIT) adopted by the Secretary will:

- Enable determination of individual's eligibility and financial responsibility for services prior to or at the point of care;
- Require minimal augmentation by paper or other communications;
- Provide for timely acknowledgement, response, and status reporting that supports a transparent claims and denial management process, including adjudication and appeals; and
- Describe all data elements, including reason and remark codes, in unambiguous terms and all data elements will be required.

The Secretary will adopt a single set of operating rules for each HIT transaction with the goal of creating as much uniformity in the implementation of the electronic standards as possible.

Eligibility and claim status - may include the use of machine readable ID cards

- Rules will be adopted July 1, 2011
- Rules must be in effect January 1, 2013