



# Health Law Update

April 28, 2010

## SUMMARY OF KEY MEDICARE, MEDICAID, PROGRAM INTEGRITY AND TAX-EXEMPT HOSPITAL PROVISIONS IN THE HEALTH CARE REFORM LAW

### I. Medicare

Section of Health Care Reform Law		Summary of Provision	Effective Date
1.	Medicare Advantage Payments § 3201 and 3203 of the Patient Protection and Affordable Care Act (PPACA) and § 1102 of the Health Care and Education Reconciliation Act of 2010 (HCERA)	<ul style="list-style-type: none"> <li>Reduces Medicare Advantage plans subsidy payments so that payments are more in line with Medicare fee-for-service payments.</li> <li>Freezes Medicare Advantage plan payments in 2011.</li> <li>Medicare Advantage benchmarks would be reduced relative to current levels in 2012.</li> <li>Benchmarks would vary from 95% of Medicare spending in high cost areas to 115% of Medicare spending in low-cost areas.</li> <li>Includes an incentive system to increase payments to high-quality plans by up to 5% by 2014.</li> </ul>	March 23, 2010
2.	Medicare Advantage Payments § 1103 of HCERA	<ul style="list-style-type: none"> <li>Beginning in 2014, Medicare Advantage plans must have a medical loss ratio of 85%, meaning that the plan must spend at least 85% of its revenue on medical costs or activities that improve quality of care, rather than on profit or overhead. Plans that fail to satisfy the spending requirement are subject to monetary penalties, membership enrollment postponement or termination from the Medicare program.</li> </ul>	2014 contract year
3.	Medicare Disproportionate Share Hospital Payments § 1104 of HCERA; § 3133 and § 10316 of PPACA	<ul style="list-style-type: none"> <li>Requires Secretary of HHS to update hospital payments to better account for uncompensated care costs. Beginning in fiscal year 2014, hospitals' Medicare DSH payments will be reduced to reflect lower uncompensated care costs relative to increases in the number of insured. The HCERA reduces the 10-year reduction in Medicare DSH payments by \$3 billion.</li> </ul>	October 1, 2013
4.	Revision of Market Basket Updates § 3401 and § 10319 of PPACA and § 1105 of HCERA	<ul style="list-style-type: none"> <li>The PPACA institutes market basket update adjustments for productivity, reducing reimbursement by \$103 billion over 10 years starting in 2010. The HCERA increases productivity adjustments for an additional \$9.9 billion reduction in reimbursements over 10 years. The hospital market basket reduction that is in addition to the productivity adjustment is as follows: -0.3 in fiscal year 2014 and -0.75 in fiscal year 2017, 2018 and 2019. Providers affected are inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals and outpatient hospitals.</li> </ul>	October 1, 2013

Section of Health Care Reform Law		Summary of Provision	Effective Date
5.	Payment for Imaging Services § 3135 of PPACA and § 1107 of HCERA	<ul style="list-style-type: none"> <li>Increases the assumed utilization rate to 75% for the practice expense portion of advanced diagnostic imaging services. Also adjusts the technical component discount on single session imaging studies on contiguous body parts from 25% to 50%.</li> </ul>	January 1, 2011
6.	Hospital Value-Based Purchasing Program §§ 3001 and 10335 of PPACA	<ul style="list-style-type: none"> <li>Requires the Secretary of HHS to establish a value-based purchasing program under which value-based incentive payments are made to hospitals that meet certain performance standards.</li> <li>Transitions the existing value-based purchasing program from payment for <i>reporting</i> quality data to payment for <i>meeting</i> standards established by the Secretary.</li> <li>Quality measures relate to common and high-cost conditions, including cardiac, surgical, and pneumonia care.</li> <li>Total amount available for value-based incentive payments in a fiscal year is equal to the amount of reduction to the base operating DRG payment for all hospitals in that fiscal year.</li> <li>Establishes a schedule for reducing the base operating DRG for all hospitals as follows:                             <ul style="list-style-type: none"> <li>In FY 2013, 1%</li> <li>In FY 2014, 1.25%</li> <li>In FY 2015, 1.5%</li> <li>In FY 2016, 1.75%</li> <li>In FY 2017 and succeeding fiscal years, 2%.</li> </ul> </li> <li>Does not include measures of hospital readmissions.</li> </ul>	Applicable to payments for discharges occurring on or after October 1, 2012
7.	Physician Quality Reporting System § 3002 and 10327 of PPACA	<ul style="list-style-type: none"> <li>Extends the Physician Quality Reporting System (previously scheduled to expire in 2010) through 2014.</li> <li>Establishes a physician incentive payment of 1% for 2011 and 0.5% for 2012, 2013 and 2014.</li> <li>Additional 0.5% bonus for physicians who successfully report quality measures to CMS via Maintenance of Certification program.</li> <li>Penalizes physicians who do not participate in the quality reporting period by reducing the fee schedule amount for that physician's professional services by 1.5% in 2015 and 2% thereafter.</li> <li>Requires the Secretary to develop a plan to integrate reporting under the Physician Quality Reporting System with reporting requirements under the meaningful use rule for electronic health records by January 1, 2012.</li> <li>Requires the Secretary to establish an informal appeals process by not later than January 1, 2011.</li> </ul>	Incentive payments effective 2011 – 2014; penalties effective 2015 and subsequent years

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8.	Physician Feedback Program § 3003 of PPACA	<ul style="list-style-type: none"> <li>Expands program to permit development of individualized physician reports comparing physicians' and physician groups' per capita utilization to other physicians who see similar patients.</li> <li>Reports will be risk-adjusted and standardized to take into account local health care costs.</li> </ul>	January 1, 2012
9.	Quality Reporting for LTCHs, Inpatient Rehabilitation Hospitals, Hospice Programs, and Inpatient Psychiatric Hospitals §§ 3004 and 10322 of PPACA	<ul style="list-style-type: none"> <li>Requires Secretary of HHS to implement quality reporting measures for LTCHs, inpatient rehabilitation facilities and hospice providers.</li> <li>Establishes 2% reduction in annual market basket update for providers who fail to participate in reporting program; may result in update of less than 0.0 for a rate year.</li> </ul>	Program becomes effective in rate year 2014; Secretary must publish measures by October 1, 2012
10.	Value-Based Purchasing Program for SNFs, HHAs and ASCs §§ 3006 and 10301 of PPACA	<ul style="list-style-type: none"> <li>Requires Secretary of HHS to submit to Congress a plan for value-based purchasing payment system for SNFs, HHAs, and ASCs.</li> </ul>	Deadline for submission of plans to Congress is October 1, 2011 for SNFs and HHAs; January 1, 2011 for ASCs
11.	Value-Based Payment Modifier under the Physician Fee Schedule § 3007 of PPACA	<ul style="list-style-type: none"> <li>Requires Secretary of HHS to develop budget-neutral payment system to adjust Medicare physician payments based upon quality and cost of care.</li> <li>Requires quality and cost measures to be risk-adjusted and geographically standardized.</li> <li>Secretary required to take into account special circumstances of physicians in rural areas and other underserved communities.</li> <li>No administrative or judicial review.</li> </ul>	Quality and cost measures and implementation dates must be published by January 1, 2012  Two-year phase-in of modifier begins January 1, 2015
12.	Payment Adjustment for Conditions Acquired in Hospitals § 3008 of PPACA	<ul style="list-style-type: none"> <li>Establishes 1% payment penalties for hospitals in the top 25<sup>th</sup> percentile of rates of hospital acquired conditions.</li> <li>Information posted on Hospital Compare website.</li> <li>No judicial or administrative review.</li> <li>Requires Secretary of HHS to report to Congress appropriateness of similar policy for other health care providers, including nursing homes, inpatient rehabilitation facilities, LTCHs, outpatient hospital departments, ASCs and health clinics.</li> </ul>	Penalties applicable FY 2015  Report to Secretary due January 1, 2012
13.	Establishment of Center for Medicare and Medicaid Innovation within CMS §§ 3021 and 10321 of PPACA	<ul style="list-style-type: none"> <li>Establishes Center for Medicare and Medicaid Innovation to research, develop, test and expand innovative payment and delivery arrangements.</li> <li>Requires Secretary to focus on measures that will both improve quality and reduce cost of care to Medicare and Medicaid patients.</li> <li>Funding dedicated to test models that require benefits not currently covered by Medicare, including payment reform models such as rural telehealth expansions and development of rapid learning network.</li> </ul>	January 1, 2011

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14.	Medicare Shared Savings Program §§ 3022 and 10307 of PPACA	<ul style="list-style-type: none"> <li>Requires the Secretary to establish a shared savings program that promotes accountability for a patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.</li> <li>Groups of providers and suppliers may work together to manage and coordinate care for Medicare fee-for-service beneficiaries ("Accountable Care Organizations" or "ACOs").</li> <li>ACOs that meet quality performance standards will be eligible to receive payments for shared savings.</li> <li>Gives the Secretary of HHS flexibility to implement innovative payment models for participating ACOs, including models currently used in the private sector.</li> </ul>	January 1, 2012
15.	National Pilot Program on Payment Bundling §§ 3023 and 10308 of PPACA	<ul style="list-style-type: none"> <li>Requires the Secretary of HHS to establish a pilot program for integrated care during an episode of care provided to a beneficiary around a hospitalization in order to improve the coordination, quality and efficiency of health care services.</li> <li>Program will apply to one or more of ten conditions selected by the Secretary of HHS.</li> <li>Program may be expanded after January 1, 2016 if the Secretary of HHS determines that doing so will improve patient care and reduce costs.</li> </ul>	January 1, 2013
16.	Hospital Readmissions Reduction Program § 3025 of PPACA	<ul style="list-style-type: none"> <li>Reduces payments for hospitals based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for three conditions.</li> <li>Permits the Secretary of HHS to expand the number of conditions covered in future years.</li> <li>Requires the Secretary of HHS to make information on all hospital readmission rates for certain conditions available to the public.</li> </ul>	Applies to discharges occurring during a fiscal year beginning on or after October 1, 2012
17.	Extension of Exceptions Process for Medicare Therapy Caps § 3103 of PPACA	<ul style="list-style-type: none"> <li>Extends the process allowing exceptions to limitations on medically necessary therapy until December 31, 2010.</li> </ul>	March 23, 2010
18.	Extension of Payment for Technical Component of Certain Physician Pathology Services § 3104 of PPACA	<ul style="list-style-type: none"> <li>Extends a provision for direct reimbursement of qualified rural hospitals for certain clinical laboratory services through December 31, 2010.</li> </ul>	March 23, 2010
19.	Extension of Certain Payment Rules for LTCH Services and of Moratorium on Establishment of Certain Hospitals and Facilities § 3106 and 10312 of PPACA	<ul style="list-style-type: none"> <li>Extends the delay in application of the 25% patient threshold payment adjustment applicable to LTCHs for an additional two years, ending June 30, 2012.</li> <li>Extends the delay in application of the very short stay outlier policy for LTCHS for an additional two years, ending December 28, 2012.</li> <li>Extends the delay of one-time adjustment to standard amount for LTCHs for two additional years, ending December 28, 2012.</li> <li>Extends the moratorium on establishment of LTCHs, LTCH satellite facilities and increase of LTCH beds in existing LTCHs or satellite facilities.</li> </ul>	March 23, 2010

Section of Health Care Reform Law		Summary of Provision	Effective Date
20.	Extension of Physician Fee Schedule Mental Health Add-On § 3107 of PPACA	<ul style="list-style-type: none"> <li>Extends 5% increase in payment rate for psychiatric services through December 31, 2010.</li> </ul>	March 23, 2010
21.	Treatment of Certain Complex Diagnostic Laboratory Tests § 3113 of PPACA	<ul style="list-style-type: none"> <li>Requires the Secretary of HHS to conduct a demonstration project under Part B in which separate payments are made for complex diagnostic laboratory tests performed after a period of hospitalization.</li> <li>Demonstration project will test impact of direct payments on Medicare quality and costs.</li> <li>Applies to hospital-based and independent laboratories.</li> </ul>	Two-year period beginning July 1, 2011
22.	Payment Adjustments for Home Health Care §§ 3131 and 10315 of PPACA	<ul style="list-style-type: none"> <li>Requires Secretary of HHS to rebase home health payments based on analysis of current mix of services and intensity of care provided to home health patients.</li> <li>Four year phase-in of payment adjustments, with cap of 3.5% adjustment in any one year of the phase-in period.</li> <li>Sets 10% cap on reimbursement to home health provider from outlier payments.</li> <li>Reinstates 3% add-on payment for rural home health providers from April 1, 2010 through December 31, 2015.</li> <li>Requires Secretary to recommend payment reforms for home health services by March 1, 2011.</li> <li>Requires Secretary to study improving access to home health care for patients with high-severity levels of illness, low-income patients, patients living in underserved area, and authorizes demonstration program based on results of study.</li> </ul>	Payment changes and cap effective 2014
23.	Hospice Reform § 3132 of PPACA	<ul style="list-style-type: none"> <li>Requires the Secretary to update hospice claims forms to gather data as appropriate to revise payments for hospice care.</li> <li>Requires Secretary to implement revisions to methodology for determining payment rates for routine home care and other services included in hospice care.</li> <li>Requires hospice physician or nurse practitioner to have a face-to-face encounter with the individual to determine continued eligibility prior to recertification.</li> <li>Requires medical review of hospice care provided to an individual for more than 180 days by a hospice program with a high number of patients receiving care for more than 180 days.</li> </ul>	<p>Secretary must begin collecting data by January 1, 2011</p> <p>Secretary must implement new payment methodology by October 1, 2013</p> <p>Accountability provisions effective January 1, 2011</p>
24.	Hospital Wage Index Improvement §§ 3137 and 10317 of PPACA	<ul style="list-style-type: none"> <li>For hospitals who received wage index re classification under Section 508 of the Medicare Modernization Act of 2003, such reclassification is extended through September 30, 2010.</li> <li>Requires the Secretary of HHS to recommend to Congress changes to the Medicare wage index system by December 31, 2011.</li> <li>Sets the lower thresholds for reclassification at 82% for rural hospitals and 84% for urban hospitals until the first fiscal year that begins on or after the date that the Secretary submits her recommendations to Congress.</li> </ul>	<p>§ 508 reclassification extension effective retroactively to October 1, 2009</p> <p>Report to Congress due by December 31, 2011</p> <p>Lower threshold requirements effective for reclassifications for FY 2011</p>

Section of Health Care Reform Law		Summary of Provision	Effective Date
25.	Temporary Adjustment to the Calculation of Part B Premiums § 3402 of PPACA	<ul style="list-style-type: none"> <li>Freezes income thresholds for higher income beneficiaries who pay a higher Part B premium rate at 2010 levels.</li> </ul>	Effective for the period of January 1, 2011-December 31, 2019
26.	Independent Payment Advisory Board §§ 3403 and 10320 of PPACA	<ul style="list-style-type: none"> <li>Creates a 15-member Independent Payment Advisory Board (IPAB).</li> <li>Purpose is to provide Congress comprehensive proposals to reduce cost growth and improve quality of care for Medicare beneficiaries.</li> <li>In years in which Medicare costs are projected by CMS's Chief Actuary to be unsustainable, IPAB's proposals are effective unless Congress passes alternative measures.</li> <li>Alternative measures must achieve same level of savings as IPAB's proposal, and may be considered on a fast-track basis.</li> <li>IPAB cannot ration care, raise taxes, raise Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards.</li> <li>IPAB to make annual recommendations to President, Congress and private entities concerning actions to improve quality and reduce rate of cost growth in private sector.</li> <li>In years in which Medicare growth is below targeted growth rate, requires IPAB to make non-binding Medicare recommendations to Congress.</li> <li>Prohibits IPAB recommendations to reduce premium supports for low-income beneficiaries.</li> <li>Beginning in 2015, requires IPAB recommendations every two years concerning slowing overall health expenditures.</li> </ul>	Funding for IPAB is appropriated for FY 2012 and subsequent years

**II. Medicaid**

Section of Health Care Reform Law		Summary of Provision	Effective Date
1.	Medicaid Coverage for the Lowest Income Populations § 2001 of PPACA and § 1201 of HCERA	<ul style="list-style-type: none"> <li>Requires states to provide coverage to individuals and families whose income does not exceed 133% of the poverty line.</li> <li>Provides for an increase in the federal medical assistance percentage (FMAP) for amounts expended to provide medical assistance to newly eligible individuals. The FMAP with respect to newly eligible individuals will be 100% in 2014, 2015 and 2016; 95% in 2017; 94% in 2018; 93% in 2019 and 90% in 2020 and subsequent years.</li> </ul>	January 1, 2014
2.	Determination of Income Eligibility for the Nonelderly § 2002 of PPACA	<ul style="list-style-type: none"> <li>Requires states to use the modified gross income of individuals and the household income of families to determine income eligibility for medical assistance under Medicaid.</li> <li>Exceptions include, but are not limited to, individuals eligible for coverage on a basis that does not require a determination of income, individuals who are age 65 or older, individuals who qualify for coverage on the basis of being blind or disabled, and individuals seeking long term care.</li> </ul>	January 1, 2014
3.	Additional Federal Financial Participation for CHIP § 2101 of PPACA	<ul style="list-style-type: none"> <li>Provides that for FY 2014 through FY 2019, states will receive an enhanced CHIP FMAP increased by 23%, but not to exceed 100%.</li> <li>Requires states to maintain eligibility standards for CHIP as they were on the date of enactment through September 30, 2019.</li> </ul>	March 23, 2010
4.	Presumptive Eligibility Determinations by Hospitals § 2202 of PPACA	<ul style="list-style-type: none"> <li>Permits hospitals participating in Medicaid to elect to be qualified entities for purposes of determining, on the basis of preliminary information, whether an individual is eligible for medical assistance under the state Medicaid plan for purposes of providing the individual with medical assistance during a presumptive eligibility period.</li> </ul>	January 1, 2014
5.	Medicaid Prescription Drug Rebates § 2501 of PPACA	<ul style="list-style-type: none"> <li>Increases the Medicaid prescription drug rebate from 15.1% to 23.1% of the Average Manufacturer Price (AMP).</li> <li>Increases the prescription drug rebate for certain clotting factors and drugs exclusively for pediatric indications to 17.1% of the AMP.</li> <li>Increases the Medicaid prescription drug rebate amount for generic drugs from 11% to 13% of the AMP.</li> <li>Extends prescription drug rebates to Medicaid managed care organizations.</li> </ul>	January 1, 2010
6.	Disproportionate Share Hospital Payments § 2551 of PPACA and § 1203 of HCERA	<ul style="list-style-type: none"> <li>Lowers the reduction in federal Medicaid DSH allotments to states from \$18.1 billion to \$14.1 billion.</li> <li>States that have the lowest percentage of uninsured individuals will experience the largest percentage reduction in DSH payments.</li> </ul>	Reduction in DSH payments beginning in FY 2014
7.	Health Care–Acquired Conditions § 2702 of PPACA	<ul style="list-style-type: none"> <li>Prohibits Medicaid payments to states for services related to health care acquired conditions.</li> </ul>	July 1, 2011

Section of Health Care Reform Law		Summary of Provision	Effective Date
8.	Medicaid Termination § 6501 of PPACA	<ul style="list-style-type: none"> <li>Provides that individuals or entities terminated under Medicare or another state's Medicaid plan must also be terminated under the State Medicaid plan.</li> </ul>	March 23, 2010
9.	Medicaid Exclusion Related to Ownership, Control and Management Affiliations § 6502 of PPACA	<ul style="list-style-type: none"> <li>Requires the exclusion of individuals or entities that own, control or manage an entity that has unpaid overpayments determined to be delinquent; is suspended, excluded or terminated from participation in any Medicaid program; or is affiliated with an individual or entity that has been suspended, excluded or terminated from participation in Medicaid.</li> </ul>	March 23, 2010
10.	Payees Required to Register under Medicaid § 6503 of PPACA	<ul style="list-style-type: none"> <li>Requires agents, clearinghouses or other alternate payees that submit claims on behalf of a health care provider to register with the State and Secretary of HHS.</li> </ul>	March 23, 2010
11.	Overpayments § 6506 of PPACA	<ul style="list-style-type: none"> <li>Extends the period for repayment of overpayments due to fraud to one (1) year when there is not a final determination of the amount of the overpayment under an administrative or judicial process.</li> <li>States will have 30 days after the date of the final judgment to repay the overpayment.</li> </ul>	March 23, 2010
12.	Payments to Primary Care Physicians § 1202 of HCERA	<ul style="list-style-type: none"> <li>Provides that, for 2013 and 2014, physicians with a primary specialty designation of family medicine, general internal medicine or pediatric medicine will receive Medicaid payments no less than 100% of the Medicare payment rate that applies to the primary care services furnished by the physicians.</li> </ul>	Payments for primary care services begin in 2013.

**III. Program Integrity Provisions**

Section of Health Care Reform Law		Summary of Provision	Effective Date
1.	Restrictions to Stark Exception for Physician Ownership of Hospitals § 6001 of PPACA; § 1106 of HCERA	<p>Makes substantial restrictions to the Stark exception for physician ownership of hospitals, including:</p> <ul style="list-style-type: none"> <li>• Requires physician-owned hospitals to have a Medicare provider agreement in effect as of December 31, 2010.</li> <li>• Prohibits any increase in the number of operating rooms, procedure rooms or beds after March 23, 2010.                             <ul style="list-style-type: none"> <li>• Permitted increase for hospitals that have a high Medicaid volume and meet other criteria.</li> </ul> </li> <li>• Prohibits any increase in the total value of physician ownership after March 23, 2010.</li> <li>• Requires disclosure of physician ownership to HHS in annual report, to patients being referred to the hospital, on any public website of hospital and in any public advertising by hospital.</li> <li>• Provides for HHS audits of physician-owned hospitals.</li> </ul>	<p>March 23, 2010, except as otherwise noted</p> <p>May 1, 2012</p>
2.	Transparency Reports and Reporting of Physician Ownership or Investment Interests § 6002 of PPACA	<ul style="list-style-type: none"> <li>• Requires manufacturers of covered drugs, devices, biologicals and medical supplies to report payments or transfers of anything of value to physicians and teaching hospitals.</li> <li>• Requires manufacturers of covered drugs, devices, biologicals and medical supplies and group purchasing organizations to report ownership interests held by physicians (and immediate family members of physicians).</li> </ul>	March 31, 2013
3.	Revisions to In-Office Ancillary Services Exception Related to Imaging Services § 6003 of PPACA	<ul style="list-style-type: none"> <li>• Revises the Stark in-office ancillary services exception to require a physician referring a Medicare patient to the physician's office for an MRI, CT scan, PET scan or other designated service (to be determined later by HHS) to inform the patient in writing that the patient may obtain the service elsewhere and provide a written list of suppliers who furnish the service in the area where the patient resides.</li> </ul>	January 1, 2010
4.	Prescription Drug Sample Transparency § 6004 of PPACA	<ul style="list-style-type: none"> <li>• Requires drug manufacturers and distributors to report to HHS the identity and quantity of drug samples provided to practitioners.</li> </ul>	April 1, 2012
5.	Required Disclosure of Ownership and Additional Disclosable Parties' Information Related to Skilled Nursing Facilities (SNF) and Nursing Facilities § 6101 of PPACA	<ul style="list-style-type: none"> <li>• Requires skilled nursing facilities and nursing homes to report to HHS information on direct and indirect ownership, members of the governing body, officers, directors, managing employees, lenders with secured obligation interest in 5% or more of the total assets.</li> <li>• Requires facilities to have such information available, even though reporting is not required for at least 2 years.</li> </ul>	<p>Effective 90 days after effective date of final regulations</p> <p>March 23, 2010</p>
6.	Adoption of Compliance and Ethics Program for SNFs and Nursing Facilities	<ul style="list-style-type: none"> <li>• Requires skilled nursing facilities and nursing homes to have in operation a compliance and ethics program.</li> </ul>	March 23, 2013

Section of Health Care Reform Law	Summary of Provision	Effective Date
§ 6102 of PPACA		
7. CMPs applicable to SNFs and Nursing Facilities § 6111 of PPACA	<ul style="list-style-type: none"> <li>Provides for reduction of civil monetary penalties imposed on skilled nursing facilities and nursing homes that self-report and promptly correct a deficiency.</li> </ul>	March 23, 2011
8. Provider Screening and Other Enrollment Requirements Under Medicare, Medicaid and CHIP § 6401 of PPACA	<ul style="list-style-type: none"> <li>Requires screening of Medicare, Medicaid and CHIP providers, which may include criminal background checks and unannounced site visits; effective for new providers March 23, 2011, current providers March 23, 2012 and revalidating enrolled providers March 23, 2010.</li> <li>Provides for a provisional period of enhanced oversight of new providers, such as prepayment review and payment caps.</li> <li>Provides for increased disclosure requirements for providers submitting applications for enrollment or revalidation, such as disclosure of current or previous affiliation with an excluded provider.</li> <li>Provides for adjustment of payments to providers to satisfy past-due obligations of a provider with the same tax identification number.</li> <li>Permits HHS to impose a temporary moratorium on enrollment of new Medicare, Medicaid or CHIP providers, or categories of providers, as HHS determines necessary to prevent fraud and abuse; states not required to comply if possible adverse effect on access to care.</li> </ul>	<p>March 23, 2010, except as otherwise noted</p> <p>When HHS develops procedures</p> <p>March 23, 2011</p>

	Section of Health Care Reform Law	Summary of Provision	Effective Date
9.	Enhanced Medicare and Medicaid Integrity Provisions § 6402 of PPACA	<ul style="list-style-type: none"> <li>• Requires any provider, supplier or Medicaid managed care organization to report and return an overpayment to HHS, the state, an intermediary, a carrier or a contractor, as appropriate, within 60 days of identification of the overpayment or the date any corresponding cost report is due; provides that an overpayment retained after the deadline is an "obligation" as defined in the False Claims Act.</li> <li>• Expands civil monetary penalties liability for any person that (i) orders a service or item during a period in which the person was excluded from a federal health care program; (ii) knowingly makes or causes to be made any false statement, omission or misrepresentation of a material fact in any application or contract to participate as a provider or supplier under a federal health care program; or (iii) knowingly retains, and does not report and return, an overpayment.</li> <li>• Excludes from the prohibition against patient inducements: (i) any remuneration that promotes access to care and poses a low risk of harm to patients and federal health care programs; (ii) the offer or transfer of items or services for free or less than fair market value by a retailer, subject to certain conditions; (iii) the offer or transfer of items or services for free or less than fair market value to a person in financial need, subject to certain conditions; or (iv) effective sometime after January 1, 2011, a prescription drug plan's waiver of an enrollee's copayment for the first fill of a covered generic drug.</li> <li>• Revises the Anti-Kickback Statute to (i) provide that a violation of the Anti-Kickback Statute is a false claim under the False Claims Act; and (ii) revises the intent requirement such that a person need not have actual knowledge of the Anti-Kickback Statute to commit a violation.</li> <li>• Provides that surety bonds required for DME suppliers and home health agencies must be commensurate with the volume of their billing; HHS may require surety bonds for other providers and suppliers in an amount not less than \$50,000 and commensurate with the volume or their billing.</li> <li>• Provides for the suspension of Medicare and Medicaid payments to a provider or supplier pending an investigation of a credible allegation of fraud.</li> </ul>	March 23, 2010, except as otherwise noted

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10.	Elimination of Duplication between HIPDB and NPDB § 6403 of PPACA	<ul style="list-style-type: none"> <li>• Dissolves the Healthcare Integrity and Protection Data Bank (HIPDB) and provides for transfer of its data to the National Practitioner Data Bank (NPDB).</li> <li>• Provides for a national health care fraud and abuse data collection program and reporting of the data to the NPDB.</li> <li>• Requires states to have a system for reporting information about formal licensing proceedings, civil and criminal judgments related to the delivery of health care and other final adverse actions taken against health care providers.</li> </ul>	Effective on the later of March 23, 2011, or the effective date of regulations implementing these provisions
11.	12-Month Time Limit for Submission of Medicare Claims § 6404 of PPACA	<ul style="list-style-type: none"> <li>• Reduces the time period for submission of Medicare claims from 3 calendar years following the year in which the services were provided to 1 calendar year after the date of service; claims for services provided before January 1, 2010 must be submitted by December 31, 2010.</li> </ul>	January 1, 2010
12.	Required Enrollment in Medicare to Order Items or Services § 6405 of PPACA	<ul style="list-style-type: none"> <li>• Requires orders for DME and orders and certifications for home health services for Medicare patients to be provided only by physicians or eligible professionals enrolled in the Medicare program.</li> </ul>	July 1, 2010
13.	Requirement for Physicians to Provide Documentation on Referrals to Programs at High Risk of Waste and Abuse § 6406 of PPACA	<ul style="list-style-type: none"> <li>• Provides for revocation of Medicare enrollment, for a period of not more than 1 year per act, of a physician or supplier that fails to maintain or provide HHS with access to documentation relating to written orders or requests for payment for DME, certifications for home health service or referrals for other items or services written or ordered by the physician or supplier for Medicare patients.</li> </ul>	January 1, 2010
14.	Required Face-to-Face Encounter before Physician May Certify Eligibility for Home Health or DME § 6407 of PPACA	<ul style="list-style-type: none"> <li>• Requires a physician or other permitted practitioner to have had a face-to-face encounter with a Medicare or Medicaid patient during the 6-month time period prior to making a certification for home health services or writing an order for DME; allows HHS to apply this encounter requirement to other services if it would reduce fraud and abuse.</li> </ul>	Effective for home health certifications after January 1, 2010; effective for DME orders after March 23, 2010
15.	Enhanced Civil Money Penalties for Failure to Grant Access § 6408 of PPACA	<ul style="list-style-type: none"> <li>• Provides for enhanced civil monetary penalties for false statements and for failure to grant timely access to the Office of Inspector General ("OIG") for the purpose of audits, investigations, evaluations or other OIG statutory functions.</li> </ul>	January 1, 2010
16.	Development of Stark Disclosure Protocol § 6409 of PPACA	<ul style="list-style-type: none"> <li>• Requires HHS and the OIG to establish a protocol to enable health care providers to self-disclose an actual or potential Stark violation; permits HHS to reduce the amount due for violations when certain factors, such as timeliness of self-disclosure, are considered.</li> </ul>	Effective when protocol established – not later than September 23, 2010
17.	Expansion of RAC Program to Medicaid and Medicare Parts C and D § 6411 of PPACA	<ul style="list-style-type: none"> <li>• Expands the RAC program to Medicaid and Medicare Parts C and D; requires the states to contract with RACs by December 31, 2010 for their Medicaid plans and HHS to contract with RACs by December 31, 2010 for Medicare Parts C and D.</li> </ul>	March 23, 2010

**IV. Health Care Workforce**

Section of Health Care Reform Law	Summary of Provision	Effective Date
1. Training in Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantship § 5301 of PPACA	<ul style="list-style-type: none"> <li>• Permits the Secretary to make grants to or enter into contracts with accredited public or nonprofit private hospitals, medical schools, academically affiliated physician assistant training programs, and public or private nonprofit entities designated by the Secretary for the following purposes:                             <ul style="list-style-type: none"> <li>• to plan, develop, operate or participate in training programs, including residency and internship programs, in the fields of family medicine, general internal medicine, and general pediatrics, as well as physician assistant training programs;</li> <li>• to provide need-based financial assistance in the form of traineeships and fellowships to students planning to specialize in such fields;</li> <li>• to plan, develop and operate training programs for, and to provide financial assistance for, physicians who plan to teach in such fields; and</li> <li>• to plan, develop and operate a demonstration program that provides training in new competencies recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission, with a focus on team-based approaches to care, including the patient-centered medical home.</li> </ul> </li> </ul>	Funds are appropriated for FYs 2010 – 2014
2. Primary Care Extension Program § 5405 of PPACA	<ul style="list-style-type: none"> <li>• Requires the Secretary to establish a Primary Care Extension Program under the direction of the Agency for Healthcare Research to provide support and assistance to primary care providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based and evidence-informed therapies and techniques.</li> <li>• Also requires the Secretary to award competitive grants to states for the establishment of state- or multistate- level Primary Care Extension Program State Hubs, which will include, at a minimum state health departments, entities administering the Medicare and Medicaid programs, to coordinate Primary Care Extension Program activities at the local level.</li> </ul>	Funds are appropriated for FYs 2011 – 2014
3. Expanding Access to Primary Care Services and General Surgery Services §§ 5501 and 10501 of PPACA	<ul style="list-style-type: none"> <li>• Provides a 10% bonus payment for Medicare services provided by a primary care practitioner during the period of January 1, 2011 - December 31, 2015.                             <ul style="list-style-type: none"> <li>• "Primary Care Practitioners" include physicians specializing in family medicine, internal medicine, geriatric medicine, or pediatric medicine and nurse practitioners, clinical nurse specialists, and physician assistants, if at least 60% of such physician's or practitioner's allowed charges are primary care services, defined as HCPCS codes 99201 - 99215, 99304 - 99340, and 99341 – 99350.</li> </ul> </li> <li>• Also provides a 10% bonus payment for major surgical procedures furnished by a general surgeon in an area designated as a Health Professional Shortage Area during the period of January 1, 2011 - December 31, 2015.</li> </ul>	Bonus payments are effective for the period January 1, 2011 - December 31, 2015

Section of Health Care Reform Law		Summary of Provision	Effective Date
		<ul style="list-style-type: none"> <li>No budget neutrality adjustment</li> </ul>	
4.	Negotiated Rulemaking for Development of Methodology and Criteria for Designating Medically Underserved Populations and Health Professional Shortage Areas § 5602 of PPACA	<ul style="list-style-type: none"> <li>Requires the Secretary to establish a comprehensive methodology and criteria for designating medically underserved populations and health professional shortage areas</li> </ul>	Interim final rule due July 1, 2010; final rule due July 1, 2011
5.	Grant Program to Support Nurse Managed Health Clinics § 5208 of PPACA	<ul style="list-style-type: none"> <li>Provides for a \$50,000,000 grant program to assist in the operation of nurse-managed health clinics that provide primary care or wellness services to underserved or vulnerable populations and are associated with a school of nursing, a federally qualified health center or an independent nonprofit health or social services agency.</li> </ul>	March 23, 2010

**V. More Affordable Medicines for Children and Underserved Communities**

Section of Health Care Reform Law		Summary of Provision	Effective Date
1.	Expanded Participation in 340B Program § 7101 of PPACA	<ul style="list-style-type: none"> <li>Extends participation in the 340B program to children's hospitals, freestanding cancer hospitals, critical access hospitals, rural referral centers and sole community hospitals that meet certain criteria; provides for improvements in compliance by manufacturers to prevent overcharges and other violations of the pricing requirements of the program; provides for improvements in compliance by covered entities to prevent diversion and violation of the duplicate discount and other requirements of the 340B program.</li> </ul>	January 1, 2010

**VI. Tax-Exempt Hospital Provisions**

Section of Health Care Reform Law	Summary of Provision	Effective Date
1. 501(c)(3) Charitable Hospitals § 9007 and § 10903 of PPACA	<ul style="list-style-type: none"> <li>• Requires charitable hospitals to perform a community health needs assessment every 3 years and implement a strategy to meet the community health needs identified through this assessment.</li> <li>• Requires charitable hospitals to establish a written financial assistance policy including:                             <ul style="list-style-type: none"> <li>• Criteria for financial assistance;</li> <li>• Basis for calculating amounts charged to patients;</li> <li>• Method for applying for financial assistance;</li> <li>• Actions the organization may take in the event of nonpayment;</li> <li>• Measures to publicize the policy within the community.</li> </ul> </li> <li>• Requires charitable hospitals to adopt a written policy requiring the hospital to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital's financial assistance policy.</li> <li>• Requires charitable hospitals to limit their charges for emergency or medical necessary care to individuals eligible under the hospital's financial assistance policy to not more than the amounts generally billed to individuals who have insurance coverage.</li> <li>• Prohibits the charitable hospital from engaging in aggressive collection actions before it has determined whether the individual is eligible for assistance under the hospital's financial assistance policy.</li> <li>• Allows the IRS to assess an excise tax equal to \$50,000 for any taxable year against any hospital that fails to meet the community health needs assessment requirements.</li> </ul>	<p>Taxable year beginning after March 23, 2012</p> <p>Taxable year beginning after March 23, 2010</p> <p>Taxable year beginning after March 23, 2010</p> <p>Taxable year beginning after March 23, 2010</p> <p>Taxable year beginning after March 23, 2010</p> <p>March 23, 2010</p>

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