Physician Provisions

Patient Protection and Affordable Care Act, Pub. L. No. 111-148 ("PPACA")
Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 ("Recon")

Provision	Description	Effective Date(s)	CBO 10-Year Score
Demonstration Projects/Delivery Reform			
Accountable Care Organizations (ACOs) PPACA §§ 3022, 10307, 2706	Establishes a shared savings program that allows ACOs to receive a share of savings achieved for the Medicare program. ACOs can include groups of health care providers, including physicians and hospitals, and must serve at least 5,000 beneficiaries. Methods of payments include shared savings, partial capitation and broad discretion to the Secretary of HHS to establish other payment models. Under a partial capitation model, an ACO would bear the financial risk for only some of the items and services provided to beneficiaries, while the shared savings model allows payments only if the average per capita costs fall under a benchmark established for each ACO. ACOs must use patient-centered processes of care, promote evidence-based medicine and report on clinical processes/outcomes, quality of patient care and utilization rates. Also establishes a separate pediatric ACO program.	Programs begin by January 1, 2012 and must last for at least three years; pediatric ACOs begin by January 1, 2012 and end December 31, 2016	Saves $4.9 billion

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Demonstration Projects/Delivery Reform			
National Pilot Program on Payment Bundling PPACA §§ 3023, 10308	Establishes a five-year pilot program to evaluate bundled payment schemes for episodes of care based on 10 conditions chosen by the Secretary of HHS. The 10 conditions must show an opportunity to improve quality of care, have significant variation in readmission, have high post-acute care expenditures and include a mix of chronic and acute, surgical and medical conditions. Hospitals, physicians, physician groups, skilled nursing facilities and home health agencies may apply to participate. The program may be expanded if it meets goals of improving quality and reducing costs. A report on the progress of the programs is due to Congress on January 1, 2016.	Programs begin by January 1, 2013	$0
Medical Homes PPACA §§ 2703, 3024	Medicare program that rewards providers for coordinating care for patients. Providers include physicians, nurse practitioners or a group of physicians and nurse practitioners that will act in teams with other providers to deliver care. Eligible patients must be enrolled in Medicare part B and entitled to benefits under part A (the program does not include Medicare Advantage beneficiaries). Patients must also have two or more chronic illnesses, have had a nonelective hospital admission, received acute or subacute rehabilitation services in the last year and have two or more functional dependencies requiring the assistance of another person (such as bathing, dressing, walking, etc.).	Programs begin by January 1, 2012	$0

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Demonstration Projects/Delivery Reform			
	The program tests whether the model reduces preventable hospitalizations, readmissions and emergency room visits and improves health outcomes, improves efficiency, reduces costs and achieves beneficiary and caregiver satisfaction. Providers will receive incentive payments if costs fall under an annual spending target set by the Secretary of HHS. The target reflects the anticipated costs that would have been incurred without the demonstration project. Also a Medicaid program that provides states with the option of establishing medical homes. States may receive planning grants for establishing such programs.		
Gainsharing Demonstration Project PPACA § 3027	Extends the Medicare gainsharing demonstration project established by the Deficit Reduction Act of 2005, which tests new payment methodologies and financial arrangements between hospitals and physicians. Provides $1.6 million in funding for the program for FY 2010. Physicians are rewarded with a share of the hospital savings.	Effective upon enactment through September 30, 2011; final report to Congress due March 31, 2013	$0

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Demonstration Projects/Delivery Reform			
Annual Wellness Visits and Personalized Prevention Plans PPACA §§ 4103, 10402	Requires Medicare to cover the creation of a personalized prevention plan and an annual wellness visit. The prevention plan must include a health risk assessment that identifies chronic diseases and injury risks. The plan may also include the individual's family and medical history, a list of current health providers that regularly provide care, routine measurements (such as blood pressure) and cognitive impairments. The plan may also establish a screening schedule for the next five to 10 years and include a list of risk factors and conditions along with associated prevention methods. The health risk assessment may be furnished over the telephone or Internet if the process meets certain standards established by the Secretary of HHS.	Effective for services furnished on or after January 1, 2011	Costs $3.6 billion
Improvements to the Physician Feedback Program PPACA § 3003	Voluntary program that allows the Secretary of HHS to provide confidential feedback reports to physicians and groups of physicians regarding the resources used in furnishing care. Reports will provide comparisons to patterns of other physicians' usage rates. Originally enacted as part of the Medicare Improvements for Patients and Providers Act (MIPPA).	First reports by January 1, 2012	$0

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Payment Reforms			
Extension of Physician Quality Reporting Initiative (PQRI) PPACA §§ 3002, 10327	Extends Medicare PQRI through 2014 with 1 percent incentive payment in 2011 and 0.5 percent payments in 2012-14. Increases incentive payments by 0.5 percent if the eligible professional completes a certified learning program called a "Maintenance Certification Program." Beginning in 2015, physician payments will be reduced by 1.5 percent and 2 percent thereafter if quality data is not satisfactorily submitted.	Voluntary system through 2014; mandatory beginning 2015	Saves $200 million
Value-based Payment Modifier Under the Medicare Physician Fee Schedule PPACA § 3007	Physicians provided with differential payments based on the quality of care provided to Medicare beneficiaries relative to costs. The Secretary of HHS will establish methods to evaluate costs and quality measures that reflect health outcomes. Will initially only apply to specific physicians. Physicians in rural areas will be provided special consideration when applying the payment modifier.	Initial set of physicians – January 1, 2015; expansion to all physicians – by January 1, 2017	$0

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Payment Reforms			
Geographic Payment Adjustments PPACA §§ 3102, 10324; Recon § 1108	Extends the floor for the Medicare geographic practice cost index (GPCI) payment adjustment. Overall, the adjustment will help benefit physicians in rural and low-cost areas. Adjusts the practice expense portion of physicians' 2010 payments to reflect 3/4 of the difference between the relative costs of wages and rents in the different fee schedule areas and the national average. In 2011, the adjustment reflects 1/2 the difference. Makes an adjustment to GPCI that will benefit certain physicians located in frontier states (Montana, North Dakota, South Dakota, Utah and Wyoming) by increasing the practice expense GPCI adjustment to equal the national average. Modifies the calculation of the practice expense adjustment to include basing office rents and considering a representative range of professionals and nonprofessional personnel.	Floor is extended through December 31, 2010; reduction in rural and low-cost areas applied for services furnished in 2010 and 2011 and authorizes the Secretary of HHS to revise in later years; changes to frontier states begin January 1, 2011; adjustment to the practice expense by January 1, 2012	Costs $2.2 billion
Extension of Medicare Payment Add-ons PPACA § 3107	Extends the 5 percent Medicare payment increase for psychiatric therapeutic procedures in both inpatient and outpatient settings as originally provided under the Medicare Improvement for Patients and Providers Act (MIPPA).	Extended through December 31, 2010	$0

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Payment Reforms			
Medicaid Payments to Primary Physicians Recon § 1202	Increases Medicaid payments to primary care doctors to equal Medicare payment rates. This change takes into account potential losses due to the expansion of Medicaid program. The increased funding is financed by the federal government, not the states.	For services furnished in January 1, 2013 through December 31, 2014	Costs $8.3 billion
Medicare Bonus Payments to Certain Physicians PPACA § 5501	Provides 10 percent Medicare bonus payments for general surgeons who perform major procedures in health professional shortage areas; primary care physicians defined as physicians practicing in family, internal, geriatric or pediatric medicine; or a nurse practitioner, clinical nurse specialist or physician assistant for whom primary care services account for at least 60 percent of their allowed Medicare charges.	For services furnished on January 1, 2011 through December 31, 2015	Costs $3.5 billion
Cuts to Imaging Payments PPACA § 3135; Recon § 1107	Sets the utilization rate for diagnostic imaging equipment worth more than $1 million at 75 percent rather than 50 percent, which will result in negative reimbursements for such equipment. Low-tech imaging such as ultrasound, x-ray and EKG are excluded from this adjustment. Adjusts the technical component discount on single-session imaging studies on contiguous body parts from 25 percent to 50 percent for services. The chief actuary of the Centers for Medicare & Medicaid Services (CMS) will publish an analysis of the expenditure reductions that result from the imaging reforms.	Utilization rate– January 1, 2011; technical component adjustment– July 1, 2010; analysis– January 1, 2013	Saves $2.3 billion

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Payment Reforms			
Expansion of the Recovery Audit Contractor (RAC) Program PPACA § 6411	Expands to Medicaid and Medicare Parts C and D the demonstration program originally established in the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) that uses Recovery Audit Contractors to detect and fix incorrect Medicare FFS payments. States will contract with RACs to conduct the Medicaid payment review. RACs are then paid through the recouped overpayments. For Medicare Parts C and D, RACs will ensure that each Medicare Advantage and prescription drug plan has an antifraud strategy. RAC will also examine part D claims to determine if costs are in excess of allowable reinsurance costs and review estimates of the enrollment of high cost beneficiaries.	Programs begin by December 31, 2010	$0
Medical Device Tax Recon § 1405	Imposes a 2.3 percent excise tax on the sale of medical devices. Excludes eyeglasses, contact lenses, hearing aids and other devices the Secretary of HHS determines are generally purchased by the public at retail for individual use.	Effective for sales after December 31, 2012	Saves $20.0 billion

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Payment Reforms			
Independent Payment Advisory Board (IPAB) PPACA §§ 3403, 10320	Establishes an independent board that would submit proposals to the President and Congress to reduce Medicare costs and improve quality of care. Generally, HHS is required to implement IPAB's recommendations unless Congress enacts alternative measures that achieve the same cost savings. IPAB must submit proposals when Medicare per capita growth rate exceeds a target growth rate. IPAB includes 15 members appointed by the President and confirmed by the Senate. Membership is intended to reflect a broad geographic and professional representation and will include officials from government agencies, representatives from health plans, physicians and health care providers. GAO will conduct a study on how the IPAB's proposals affect payment and coverage practices.	First possible recommendation–January 15, 2014; recommendations cannot reduce payment rates for items and services furnished by providers prior to December 31, 2019.	Saves $15.5 billion
Comparative Effectiveness Research (CER) PPACA §§ 6301-02, 10602	Establishes a new nonprofit institute, the Patient-Centered Outcomes Research Institute, to identify research priorities and conduct CER. Although, CER findings cannot be used as mandates; they may influence coverage decisions if the research process allows stakeholder involvement and includes peer-review procedures. The Institute is funded through appropriations, the Medicare trust fund and a fee on health plans.	FFY 2010	Saves $300 million (Medicare) Costs $2.5 billion (Non-Medicare)

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Workforce Reforms			
Loan Repayment Program PPACA § 5203	Establishes a pediatric loan repayment program for individuals who agree to be employed for at least two years in a pediatric medical subspecialty, pediatric surgical specialty or mental and behavioral health care position, including substance abuse prevention and treatment. Payments on the principal and interest of the loans will not exceed more than $35,000 a year for a maximum of three years. Individuals must work in or for a provider serving a health professional shortage area or medically underserved area.	First appropriations FFY 2010	$0 (as scored for entire Subtitle C of Title V)
National Health Care Workforce Commission and Development Grants PPACA §§ 5101-3, 10501	Establishes a commission of health care professionals, employers, consumers and others to evaluate, among other topics, the supply, education and training of the current health care workforce. The commission will submit recommendations and reports on its findings to Congress. Provides grants to states to develop coherent health care workforce planning and development strategies. Grants are awarded for one year and are limited to a maximum award of $150,000.	First reports by the commission due in 2011; appropriations for grants provided in FFY 2010	$0 (as scored for entire Subtitle C of Title V)

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Program Integrity			
Medical Liability Reform Grants PPACA § 10607	Authorizes the Secretary of HHS to award a total of $50 million in grants to states to develop alternatives to the current tort system. States must apply for grants through an application process and develop programs that will enhance patient safety by collecting and analyzing data on medical errors. States must also fully inform patients about the differences in the tort litigation process. States are required to report on the effectiveness of alternative systems and the impact on patient safety. HHS, MedPAC and MACPAC will also conduct a review of the alternative programs to evaluate their effectiveness. Reports will later be submitted to Congress.	Grants awarded for five years beginning in FFY 2011; MedPAC and MACPAC reporting due by December 31, 2016	$0
Misvalued Codes Under the Physician Fee Schedule PPACA § 3134	Authorizes the Secretary of HHS to review codes and make appropriate adjustments to misvalued services. The Secretary will identify potentially misvalued codes by reviewing those that experienced substantial changes, are frequently billed multiple times and have not undergone a recent review.	March 23, 2010	$0
Compliance Programs Now a Condition of Enrollment PPACA § 6401(a)	Requires Medicare and Medicaid participating providers and suppliers to establish a compliance program as a condition of enrollment. Programs must contain certain core elements to be developed by the Secretary and the HHS Office of Inspector General (OIG) for each industry sector or category of provider or supplier.	Implementation timeline to be developed by HHS Secretary	Saves $100 million (as scored for entire § 6401)

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Program Integrity			
Provider Screening and Other Enrollment Requirements PPACA § 6401(a), (b)	Requires HHS Secretary to establish screening procedures for new Medicare, Medicaid and CHIP providers. Must include licensure checks and may, as the Secretary deems appropriate (based on the risk of fraud, waste and abuse), include criminal background checks, fingerprinting and site visits. Imposes application fees on providers to cover the cost of screening. Requires new providers and suppliers to disclose affiliations within the past 10 years with any provider or supplier with uncollected debt, suspended payments or exclusion or revoked billing privileges from a federal health care program; grants HHS the option of denying enrollment due to "undue risk." Authorizes CMS to match data with the Internal Revenue Service to identify providers with seriously delinquent tax debt. Requires HHS Secretary to establish procedures to provide for a provisional period of between 30 days and one year during which new providers and suppliers, as the Secretary deems appropriate, would be subject to enhanced oversight such as prepayment review and payment caps. Requires states to establish and enforce Medicaid provider and supplier screening, oversight and reporting requirements similar to those required of Medicare providers and suppliers.	Secretary to establish procedures for screening–180 days after enactment; newly enrolled and existing providers and suppliers screening–March 23, 2010	Saves $100 million (as scored for entire § 6401)

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Program Integrity			
Limits on Physicians Who Order Durable Medical Equipment (DME) or Home Health Services PPACA § 6405	Physicians who order DME or home health services are required to be enrolled in Medicare. Allows Secretary of HHS to extend this requirement to orders for any other Medicare items or services, including covered Part D drugs.	July 1, 2010	Saves $400 million
Requirement for Physicians Who Order DME and Home Health Services PPACA §§ 6406, 6407	Requires physicians and suppliers to maintain and provide to the Secretary of HHS, upon request, documentation relating to written orders or requests for payment for DME or certifications for home health services. Allows Secretary of HHS to revoke enrollment for up to one year for failure to maintain and provide such documentation. Requires as a condition of payment for home health services and DME that a physician document that the physician (or a physician assistant or nurse) had a face-to-face encounter with the beneficiary. Allows Secretary of HHS to apply the face-to-face encounter requirement to other items and services if doing so would reduce the risk of waste, fraud or abuse.	January 1, 2010	Saves $100 million

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Program Integrity			
90-Day Period of Enhanced Oversight for Initial Claims of DME Suppliers Recon § 1304	Allows Secretary of HHS to withhold payment to a newly enrolled DME supplier for 90 days following the supplier's first claim submission if there is a significant risk of fraud.	January 1, 2011	Saves $900 million bundled into score of Medicare prepayment review limitations, community mental health centers and 90-day period of enhanced oversight
Physician-Owned Hospitals and Referrals PPACA §§ 6001, 10601; Recon § 1106	Prohibits physician-owned hospitals without a provider agreement as of December 31, 2010 from participating in Medicare. Allows physician-owned hospitals with a provider agreement in place as of December 31, 2010 to continue to qualify under the whole hospital exception so long as those hospitals limit expansion, prevent conflicts of interest, ensure bona fide investments and ensure patient safety. Beginning November 1, 2011, HHS will audit physician-owned hospitals to determine compliance.	Provider agreements in place by December 31, 2010	Saves $500 million

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Program Integrity			
Transparency Reports and Reporting Physician Ownership and Investment PPACA § 6002	Requires manufacturers that make a payment or another transfer of value to a physician or teaching hospital to report annually specific information to the Secretary of HHS. Certain payments are excluded, including, among others: transfers of less than $10 of value unless the aggregate annual amount transferred exceeds $100; product samples not intended to be sold; educational materials that directly benefit or are used by patients; and discounts (including rebates), dividends or other profit distribution from, or an ownership or investment interest in, a publicly traded security or mutual fund. Information submitted by manufacturers must be made publicly available by HHS on a Web site, in searchable form, no later than September 30, 2013. Requires manufacturers and group purchasing organizations to report information regarding physician ownership and investment in their companies. Failure to report could result in civil monetary penalties between $1,000 and $10,000 for each payment or other transfer of value or ownership or investment interest not reported, not to exceed $150,000. A knowing failure to report could result in penalties between $10,000 and $100,000 for each payment or transfer of value or ownership or investment interest, not to exceed $1 million.	First reporting required March 31, 2013	$0

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Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Program Integrity			
	Reports are required on March 31, 2013, and on the 90th day of each calendar year thereafter. State laws that require reporting of the same types of information are preempted, but this explicitly does not preempt laws that require the disclosure or reporting of information not of the type required to be disclosed under this law, laws that require disclosure of information exempted from disclosure under this law, laws that require disclosure by any person or entity other than the entities covered by this law, or laws that require reporting of information for public health purposes.		
Prescription Drug Sample Transparency PPACA § 6004	Requires drug manufacturers and distributors to report to HHS information about drug samples distributed that year, including the identity and quantity of drug samples requested and distributed and the name, address, professional designation and signature of the practitioner making the request. Reports required on April 1 of each year.	First reporting required April 1, 2012	$0

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Program Integrity			
Changes to In-Office Ancillary Self-Referral Exception PPACA § 6003	Requires referring physician to inform patient in writing of the patient's right to obtain the proposed service from someone other than the referring physician or affiliate.	For services furnished on or after January 1, 2010	$0
Physician Self-Referral Protocol PPACA § 6409	Requires HHS Secretary to establish a self-disclosure protocol for actual or potential violations of the Stark Law. The protocol must direct health care providers to the specific person, official or office to whom such disclosures shall be made and the implication of the protocol on corporate integrity agreements and compliance agreements.	Protocol established no later than September 23, 2010	$0
Additional Fraud and Abuse Provisions	Please see the Akin Gump Summary Chart outlining additional fraud and abuse provisions		