Hospitals

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
Delivery System Reform			
Geographic Variation Recon. § 1109	**Additional payment:** Provides an additional payment for PPS hospitals located in a county with the lowest (25th percentile) levels of Medicare spending per beneficiary enrolled in Parts A or B, as adjusted by age, gender and race. **Informal agreement**: HHS Secretary agreed that Institute of Medicine (IOM) would conduct two studies. Under this informal agreement, the first study would evaluate hospital and physician geographic payment adjustments; validity of adjustment factors, measures and methodologies used in those factors; and sources of data used for such adjustments. HHS Secretary to implement study findings to Medicare physician payments and hospital wage index rates by December 31, 2012. Second study would examine geographic variation in volume and intensity of health care services. Study to consider availability of health services, health status, access to health care and insurance, and race, ethnicity, gender, age, income and educational status. Study will recommend ways to incorporate quality and value	Additional payments will be given in FFYs 2011 and 2012	Costs $400 million

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	metrics into Medicare reimbursement. Newly established Center for Medicare and Medicaid Innovation (CMI) to take into account recommendations of both studies to incentivize high-value care across provider spectrum. HHS Secretary to convene a national summit in late 2010 on geographic variation, cost, access and value in health care.		
Value-Based Purchasing PPACA §§ 3001, 10335	HHS Secretary must establish a hospital value-based purchasing program (VBP) for Medicare, under which value-based incentive payments would be made to hospitals that met specified performance standards. Program is budget neutral, and the total amount of payments available to hospitals for a fiscal year will equal the total amount of reduced payments to hospitals. Medicare payments will be reduced by 1 percent in FFY 2013, 1.25 percent in FFY 2014, 1.5 percent in FFY 2015, 1.75 percent in FFY 2016 and 2 percent in FFY 2017 and thereafter. Add-on payments (disproportionate share hospital (DSH), indirect medical education (IME), outliers) will not be affected; special rules apply for sole community hospitals (SCHs) and Medicare-dependent hospitals (MDHs). Beginning in FFY 2013, payments would be tied to hospital performance on quality measures related to common conditions, including, at a minimum, the following conditions: acute myocardial infarction, heart failure, pneumonia, surgeries and health care-associated infections. Beginning in FFY 2014, HHS Secretary will select measures (other than measures of readmissions) to calculate hospitals'	Applies to discharges occurring on or after October 1, 2012	$0 score

Provision	Description	Effective Date(s)	CBO 10-Year Score
	performance. These will include efficiency measures and measures of Medicare spending per beneficiary. HHS Secretary will also establish performance standards for these measures, including levels of achievement and improvement. Finally, HHS Secretary must ensure that application of methodology will result in appropriate distribution of VBP payments among hospitals. **Calculations:** The base operating diagnosis related group (DRG) payment amount of hospitals that meet or exceed the performance standards will increase for each discharge by the VBP amount. VBP incentive payment amount for each discharge will be the product of the base operating DRG payment amount for the discharge and the VBP percentage. The HHS Secretary will specify a VBP percentage each fiscal year for a hospital that is based on the hospital's performance score and the total amount of value-based incentive payments to all hospitals. Calculation of a hospital's performance assessment will be appealable by a process to be established by HHS Secretary. No judicial or administrative review regarding the methodology used to determine the amount of the VBP payment, the amount of funding available for such VBP incentive payments, the establishment of performance standards, or the methodology used to calculate hospital performance scores. **Reporting:** HHS Secretary must also make hospital- specific performance information available to the public on the Hospital Compare Web site. Hospitals may review and submit corrections to information before it is made publicly available. HHS Secretary will post information on number of hospitals receiving VBP payments (and amounts) and the number of hospitals receiving		

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	less than the maximum VBP payment (and amounts). HHS Secretary must promulgate regulations to develop methodology that will be used to calculate hospital performance scores and to determine the amount of value-based incentive payments. GAO must conduct study on performance of VBP, which will analyze the impact of the program on the following: (1) quality of care furnished to Medicare beneficiaries, including diverse Medicare beneficiary populations; (2) expenditures under the Medicare program, including any reduced expenditures that are attributable to the improvement in the delivery of inpatient hospital services; (3) quality performance among safety net hospitals and any barriers such hospitals face in meeting the performance standards; and (4) quality performance among small rural and small urban hospitals and any barriers such hospitals face in meeting the performance standards. GAO must submit an interim report to Congress by October 1, 2015, and a final report by July 1, 2017. HHS Secretary must conduct a study on performance of VBP, which will include an analysis of the following: (1) ways to improve the program and ways to address any unintended consequences; (2) whether VBP resulted in lower spending under the Medicare program or other financial savings to hospitals; (3) appropriateness of Medicare program sharing in any savings; and (4) any other area determined appropriate by HHS Secretary. HHS Secretary must submit a report to Congress no later than January 1, 2016 that contains study results and includes recommendations for legislation and administrative action.		

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	HHS Secretary must develop plans to implement VBPs for skilled nursing facilities, home health agencies and ambulatory surgical centers and submit reports to Congress within 18 months of the completion of demonstration.		
Health Care-Acquired Conditions PPACA § 2702	HHS Secretary must adopt regulations effective July 1, 2011, to prohibit federal Medicaid payments to states for any amounts paid for providing medical assistance for health care-acquired conditions.	July 1, 2011	$0 score
Hospital-Acquired Conditions (HAC) PPACA § 3008	To provide an incentive for hospitals to reduce HACs, beginning in FFY 2015, hospitals in the top quartile of rates of HACs will have payments reduced by 1 percent. HAC is a condition, as determined by the HHS Secretary, that an individual acquires during a hospital stay. Prior to FFY 2015 and each subsequent fiscal year, HHS Secretary shall provide confidential reports to hospitals with respect to their HAC rates. Hospital-specific HAC information will be made available to the public on the Hospital Compare Web site. Hospitals will have opportunity to review and submit corrections to information before it is made publicly available. No judicial or administrative review regarding hospitals applicable to this subsection, the specification of HACs or the applicable periods or information within the hospital-specific reports. HHS Secretary will conduct a study on expanding this HAC policy to other institutions. The study will include an analysis of how such policies could impact quality of patient care, patient safety and spending under Medicare. HHS Secretary will submit a report to	Applies to discharges occurring on or after October 1, 2014	Saves $1.4 billion

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	Congress no later than January 1, 2012 that contains study results and includes recommendations for legislation and administrative action.		
Readmissions PPACA §§ 3025, 10309	HHS Secretary will impose financial penalties on hospitals for excess readmissions. The maximum amount that can be deducted in FFY 2013 is 1 percent but that will be increased by 1 percent each year to a cap of 3 percent for each DRG. Special rules for SCHs and MDHs will apply. Critical access hospitals (CAHs) and post-acute care providers are excluded. **Definitions:** Readmission is when, after a discharge from a hospital, an individual with certain conditions is admitted to the same or another applicable hospital within a time period specified by the Secretary. Three conditions (heart failure, pneumonia and acute myocardial infarction) will be used beginning in FFY 2013 and then expanded in FFY 2015 to all seven conditions identified by MedPAC in the June 2007 report to Congress. Payment reductions will apply to all admissions. Planned readmissions will be exempt. **Calculations:** Payments will be reduced to hospitals with excess readmissions by an amount equal to the product of the base operating DRG payment amount and the adjustment factor for the hospital for the fiscal year. Base operating payment amount is the payment amount that would otherwise be for a discharge. The adjustment factor is equal to the greater of: 1 minus the ratio of the aggregate payments for excess readmissions to a hospital for a period and the aggregate	Applies to discharges occurring on or after October 1, 2012	Saves $7.1 billion

Provision	Description	Effective Date(s)	CBO 10-Year Score
	payments for all discharges for such hospital for such period or the floor adjustment factor specified, which is 0.99 (FFY 2013), 0.98 (FFY 2014) or 0.97 (FFY 2015 and subsequent fiscal years). Aggregate payments for excess readmissions for applicable conditions will be calculated by the *product*, for each applicable condition, of the base operating DRG payment amount, the number of admissions for such condition and the excess readmissions ratio minus 1. Excess readmissions ratio for an applicable condition is the ratio (but not less than 1) of the risk-adjusted readmissions based on actual readmissions to the risk-adjusted expected readmissions. Excess readmissions will not include readmissions for an applicable condition for which there are fewer than a minimum number of discharges for such condition for a hospital in the applicable period. No administrative or judicial review of determination of base operating DRG payment amounts, methodology for determining the adjustment factor, excess readmissions ratio, aggregate payments for excess readmissions or aggregate payments for all discharges, or applicable periods and applicable conditions. **Reporting:** HHS Secretary will make hospital-specific readmissions information available to public on the Hospital Compare Web site. Hospitals will be able to review and submit corrections to information before it is made publicly available. All hospitals will submit to HHS Secretary, in a form, manner and		

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	time specified by HHS Secretary, data and information determined necessary to calculate patient readmission rates. States may collect this information in lieu of HHS Secretary. HHS Secretary shall calculate readmission rates for all patients for a hospital for an applicable condition in same manner as used to calculate such readmission rates for hospitals and make this information publicly available. A quality improvement program for hospitals with high severity adjusted readmission rates will be established.		
Payment Changes			
Medicaid DSH PPACA § 2551; Recon. § 1203 **Medicare DSH** PPACA §§ 3133, 10316; Recon. § 1104	**Medicaid:** Beginning in FFY 2014, Medicaid DSH payments will be reduced $500 million for 2014, $600 million for 2015, $600 million for 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019 and $4 billion in 2020. HHS Secretary must develop a methodology to distribute DSH reductions in a manner that imposes the largest percentage reduction on the states with the lowest percentage of uninsured or those that do not target DSH payments on hospitals with high volumes of Medicaid inpatients or hospitals that have high levels of uncompensated care. Methodology must account for the extent to which DSH allotment for a state was used for section 1115 waivers. States that have a $0 DSH allotment for FFY 2012 or FFY 2013 will have federal DSH allotments extended through FFY 2013. **Medicare:** Beginning in FFY 2014, Medicare DSH payments will be reduced initially by 75 percent. Medicare DSH payments will	Payments will be reduced starting October 1, 2013	Saves $14 billion in Medicaid DSH and $22.1 billion in Medicare DSH

Provision	Description	Effective Date(s)	CBO 10-Year Score
	then subsequently increase based on factors including the percentage of the population that is uninsured and the amount of uncompensated care that the hospital provided. Therefore, some of the 75 percent reduction will then be returned to hospitals based on the following calculations: Beginning in FFY 2014, hospitals will be paid an additional amount equal to the product of the following three factors: (a) the amount equal to the difference between the aggregate amount of payments that would be made to hospitals if the reduction did not yet apply and the aggregate amount of payments that are made to hospitals for that fiscal year; and (b) [for FFYs 2014-2017] a factor equal to minus [0.1 percentage points for FFY 2014 and 0.2 percentage points for FFYs 2015-2017] from the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals who were uninsured in 2012—the last year before the coverage expansion—and who are uninsured in the most recent period for which data is available or [for FFY 2018 and subsequent years] a factor equal to minus 0.2 percentage points for FFYs 2018 and 2019 from the percent of individuals who are uninsured, as determined by comparing the percent of individuals who are uninsured in 2012 and who are uninsured in the most recent period for which data is available; and (c) a factor equal to the percent for each hospital representing the quotient of the amount of uncompensated care provided by the hospital for a period selected by the Secretary and the aggregate amount of uncompensated care provided by all		

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	hospitals that receive a DSH payment. No administrative or judicial review regarding any estimate that HHS Secretary makes for purposes of determining the factors or any period selected for determining factors.		
GME/IME PPACA §§ 5503, 5504, 5505, 5506 and 10501(j)	**Redistribution of Residents:** There will be a redistribution of unused residency training positions as a way to encourage increased training of primary care physicians and general surgeons. If a hospital's reference resident level is less than its otherwise applicable resident limit or full-time equivalent (FTE) cap, effective for portions of cost reporting periods occurring on or after July 1, 2011, the FTE cap will be reduced by 65 percent of the difference between the FTE cap and the reference resident level. However, this will not apply to rural hospitals with fewer than 250 beds or a hospital that was part of the voluntary residency reduction plan, if the hospital demonstrates it has a plan to fill the unused positions within two years of enactment (March 23, 2012). Hospitals can apply to increase their FTE cap—and qualified hospitals may request up to 75 new FTE slots. Hospitals receiving an increase in their FTE cap will be paid for these additional slots beginning on or after July 1, 2011. At least 75 percent of the slots received through this redistribution program must be used for primary care or general surgery residents for at least five years. In addition, for five years the number of primary care resident FTEs must not be less than the average number of such FTEs at the hospital during the last three	Various (see description)	Costs $1.1 billion

Provision	Description	Effective Date(s)	CBO 10-Year Score
	cost reporting periods prior to enactment (March 23, 2010). If the Secretary determines that a hospital does not meet these requirements, the additional resident slots will be redistributed. HHS Secretary must take into account whether a hospital has an accredited rural training track and the likelihood that the hospital will fill the new positions within the first three cost reporting periods beginning on or after July 1, 2011 when determining the redistribution. HHS Secretary must reserve 70 percent of the redistributed slots for hospitals in states with resident-to-population ratios in lowest quartile. The Secretary will reserve 30 percent of the redistributed slots for hospitals in the 10 states with highest proportion of population living in a health professional shortage area (HPSA) and for rural hospitals. The current IME adjustment factor will be used for redistributed slots. **Counting Resident Time in Non-Provider Settings:** For both direct graduate medical education (GME) and IME purposes, effective July 1, 2010, resident time spent in non-provider settings will be counted, as long as the teaching hospital incurs the costs of the residents' stipends and fringe benefits. If more than one hospital incurs these costs, hospital can count a proportional share of the time as determined by a written agreement. Hospitals must maintain and keep records of the amount of time residents spend in non-provider settings. **Resident Didactic Time:** All time spent by residents in non-provider settings for didactic conferences and seminars shall be		

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	counted for GME purposes for cost reporting periods occurring on or after July 1, 2009. All resident vacation time, sick leave or other approved leave will be counted for IME and GME purposes in determining a hospital's FTE count for cost reporting periods occurring on or after July 1, 1983. All time spent by residents for didactic conferences shall be counted for IME purposes for cost reporting periods occurring on or after July 1, 1983. Resident research time that is not associated with the treatment or diagnosis of a particular patient shall not be counted for IME purposes for cost reporting periods occurring on or after October 1, 2001. However, this does not give rise to any inference of how resident research time should be treated prior to that date. **Preservation of Resident Cap Positions:** The Secretary will establish a process for how residency slots will be redistributed for hospitals that have closed in the two years prior to enactment. The Secretary will prioritize hospitals within the same geographic area in redistributing these slots.		
Market Basket and Productivity Adjustments PPACA §§ 3401, 10319; Recon. § 1105	**IPPS**: Prospective payment system (PPS) hospitals' inpatient market basket update reductions as follows— ▪ FFYs 2010 and 2011: reduced by 0.25 percent. ▪ FFYs 2012 and 2013: reduced by 0.1 percent. ▪ FFYs 2014: reduced by 0.3 percent. ▪ FFYs 2015 and 2016: reduced by 0.2 percent.	Reductions begin in FFY 2010 and continue through FFY 2019	$156.6 billion

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	▪ FFYs 2017, 2018 and 2019: reduced by 0.75 percent. Beginning in 2012 and subsequent years, PPS hospitals market basket update also to be reduced by productivity adjustment, which is equal to 10-year moving average of productivity gains in general economy. In 2010, MedPAC estimated 1.3 percent productivity adjustment. **OPPS**: PPS hospitals' outpatient department (OPD) fee schedule factor reductions as follows— ▪ FYs 2010 and 2011: reduced by 0.25 percent. ▪ FYs 2012 and 2013: reduced by 0.1 percent. ▪ FYs 2014: reduced by 0.3 percent. ▪ FYs 2015 and 2016: reduced by 0.2 percent. ▪ FYs 2017, 2018, and 2019: reduced by 0.75 percent. Beginning in 2012 and subsequent years, OPD fee schedule factor to be reduced by productivity adjustment. Application of IPPS and OPPS market basket reductions and productivity adjustments could result in a negative update.		
Independent Payment Advisory Board (IPAB) PPACA §§ 3403, 10320	Establishes IPAB to implement proposals to reduce per capita rate of growth in Medicare spending if spending exceeds target growth rate. **Background:** 15 members appointed to six-year terms; appointed by the President and confirmed by Senate. Board would continue indefinitely unless Congress acts to eliminate it by August 15, 2017.	First report due January 15, 2014	Saves $15.5 billion

06.14.10 v12
18286862 v13

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	Actuary projections: By April 30, 2013, the Centers for Medicare & Medicaid Services (CMS) actuary must project whether Medicare per capita spending exceeds average consumer price index for all urban consumers (CPI-U) and CPI-M (medical expenditure) based on a five-year period ending with such year. If such spending exceeds thresholds, beginning January 15, 2014, IPAB must submit recommendations to the President and HHS Secretary to achieve reductions in spending; the CMS actuary would calculate an applicable savings target. **Proposal requirements/restrictions**: Proposals must meet the following requirements: (1) must result in a net reduction in total Medicare spending that is at least equal to applicable savings target. Savings target equal to the product of the total amount of projected Medicare spending for the year and the applicable percent for the implementation year: (i.e., 2015 (0.5 percent); 2016 (1 percent); 2017 (1.25 percent); 2018 and subsequent years (1.5 percent)); (2) may not ration care, raise taxes or Part B premiums or change Medicare eligibility, benefit or cost-sharing; (3) proposals submitted prior to 2019 would not be able to reduce payment rates for "providers" (i.e., a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program or a fund) that are scheduled to receive a reduction in their annual updates; (4) must reduce Medicare payments under Medicare Parts C and D "as appropriate"; (5) must include recommendations regarding administrative funding; (6) must only include recommendations related to Medicare. To extent feasible, IPAB must do the following: (1) give priority to recommendations that extend Medicare solvency; (2) include		

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	recommendations that improve health care delivery system and health outcomes (including promoting integrated care, care coordination, prevention and wellness) and protect and improve beneficiary access to necessary evidence-based items and services; (3) include recommendations that target reductions in Medicare program spending to sources of excess cost growth; (4) consider effects on Medicare beneficiaries of changes in payments to providers and suppliers; (5) consider effects on providers and suppliers with actual or projected negative cost margins or payment updates; and (6) consider unique needs of duals (i.e., beneficiaries that are eligible for both Medicare and Medicaid). President must submit IPAB proposals to Congress. IPAB's proposals would take effect (implemented by HHS Secretary), unless Congress passes alternative that achieves same level of required savings. Beginning on January 15, 2014, IPAB may also submit advisory reports (regardless of whether excess cost growth is projected) to reform payments, including payments to providers that are not subject to IPAB recommendations until 2019 (see above). Over a 10-year period, proposals may not result in any increase in total amount of net Medicare program spending relative to total amount of net Medicare program spending that would have occurred absent such implementation.		

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
340B Drug Pricing Program Expansion PPACA § 7101; Recon. § 2302	Expands types of covered entities that may be eligible to participate in existing 340B program. New covered entities include: children's hospitals and PPS-exempt cancer hospitals with greater than 11.75 percent DSH adjustment percentage; rural referral centers and sole community hospitals with equal to or greater than 8 percent DSH; and critical access hospitals. Newly covered entities would not be able to receive 340B discounts on orphan drugs, and children's and cancer hospitals may not purchase covered drugs through group purchasing organizations.	Effective upon enactment and applies to drugs purchased on or after January 1, 2010	Score bundled under Medicaid Prescription Drug Coverage—which saves a total of $38.1 billion; same provision includes Medicaid drug rebate and pharmacy reimbursement changes
Wage Index PPACA § 3137	Section 508 hospital reclassifications for purpose of adjusting payment rates based on difference in hospital wage levels extended until September 30, 2010. HHS Secretary must use hospital wage index that was promulgated by the Secretary in *Federal Register* on August 27, 2009 (74 Fed. Reg. 43,754) and any subsequent corrections for FFY 2010. Beginning on April 1, 2010, in addition to determining wage index applicable to hospitals that qualify for wage index reclassification, HHS Secretary will include the hourly wage data of hospitals whose reclassification was extended, but only if including such data results in higher applicable reclassified wage index. HHS Secretary must submit to Congress by December 31, 2011, a report that includes a plan to reform the hospital wage index system. HHS Secretary must take into account goals for reform in June 2007 MedPAC Report, which included the following—	Various (see description)	Costs $300 million over 10 years

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	▪ establishing a new hospital compensation index system that uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved ▪ minimizes wage index adjustments between and within metropolitan statistical areas and statewide rural areas ▪ includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments ▪ takes into account effect that implementation of the system would have on health care providers and on each region of country ▪ addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on effect on quality of care or patient safety as a result of implementation of the system ▪ provides for a transition to the new system. HHS Secretary must consult with relevant affected parties in creating its plan. In making decisions on applications for reclassifications for FFY 2011 and subsequent years (until the first fiscal year beginning on or after the date that is one year after the Secretary submits the report to Congress), Geographic Medicare Classification Review Board must use the average hourly wage comparison criteria used in making such decisions as of September 30, 2008.		

06.14.10 v12
18286862 v13

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Demonstration Projects			
National Pilot Program on Payment Bundling PPACA §§ 3023, 10308	Establishes pilot program that would allow "entities" to provide integrated care during an "episode of care" provided to a beneficiary around a hospitalization for an "applicable condition" to improve coordination, quality and efficiency of health services. **Definitions:** 1. Entities: An "entity" composed of providers—including hospital, physician group, skilled nursing facility (SNF), home health agency (HHA)—may submit application to participate in pilot. 2. Episode of care: The period three days prior to admission, the length of stay and 30 days following discharge from hospital. 3. Applicable beneficiaries: Those in Medicare Parts A or B and admitted to a hospital for an applicable condition. 4. Applicable conditions: One or more of 10 conditions to be selected by HHS Secretary. In selecting conditions, HHS Secretary must take into account following factors: (1) mix of chronic and acute conditions; (2) mix of surgical and medical conditions; (3) evidence of an opportunity to improve quality of care while reducing total expenditures; (4) significant variation in number of readmissions and amount of expenditures for post-acute care spending; (5) high-volume and high post-acute care expenditures; and (6) most amenable to bundling across spectrum of care. 5. Bundled services: Services that would be bundled include the	No later than January 1, 2013	$0 score

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	following: (1) acute care inpatient services; (2) physician services delivered in and out of an acute care hospital setting; (3) outpatient hospital services (including emergency); (4) post-acute care services (including HHA, SNF, inpatient rehabilitation facility (IRF), long-term care hospital (LTCH)); and (5) others as determined appropriate by HHS Secretary. Bundling to include other "appropriate services," such as care coordination, medication reconciliation, discharge planning, transitional care services and other patient-centered activities. HHS Secretary to ensure that beneficiaries have adequate choice of providers. Services must be furnished by the entity or directed by the entity. **Duration and expansion:** Pilot program must be conducted for five-year period. At any point after January 1, 2016, HHS Secretary may expand duration and scope of pilot program for period determined appropriate if: (1) HHS Secretary determines that expansion is expected to reduce spending without reducing quality of care or improves quality of care and reduces spending; (2) CMS actuary certifies expansion would reduce spending; and (3) HHS Secretary determines that expansion would not deny or limit coverage or provision of benefits. HHS Secretary must develop payment methods for pilot program. Bundled payment must: (1) be comprehensive and cover the costs of services listed above and (2) be made to an entity participating in the pilot. Payments to entities cannot be more than payments in a year for applicable services absent pilot. **Quality:** HHS Secretary must establish quality measures (in consultation with Agency for Healthcare Research and Quality		

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	(AHRQ) and National Quality Forum (NQF)) for entities participating in pilot program to report on the following: (1) functional status improvement; (2) reduction in rates of avoidable hospital readmissions; (3) rates of discharge to community; (4) rates of admission to emergency room after hospitalization; (5) incidence of health care acquired infections; (6) efficiency measures; (7) measures of patient-centered care; (8) measures of patient perception of care; and (9) other measures determined by HHS Secretary, including patient outcomes. **Evaluation:** HHS Secretary must conduct an "independent" evaluation of pilot that will focus on whether the pilot improved health outcomes and beneficiary access to care and reduced spending. HHS Secretary must provide interim and final evaluation reports to Congress two and three years after implementation, respectively.		
Center for Medicare and Medicaid Innovation (CMI) PPACA §§ 3021, 10306	The CMI will be established within CMS to test innovative payment and service delivery models to reduce program expenditures, while preserving or enhancing the quality of care for beneficiaries (Medicare, Medicaid, duals and Children's Health Insurance Program (CHIP)). Models that also improve coordination, quality and efficiency of health care services to beneficiaries will be given preference. In carrying out its duties, CMI must consult with other federal agencies, clinical and analytical experts and other interested parties. **Phase I: Model Testing:** HHS Secretary must select models where there is evidence that they address a defined population where there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. HHS Secretary must focus on	No later than January 1, 2011	Saves $1.3 billion

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	models expected to reduce program costs while preserving or enhancing quality of care to beneficiaries. Selected models may include those with one or more of 20 characteristics that are specifically enumerated in the Act. In selecting models, CMI may consider whether the model does the following: (1) includes regular processes for monitoring and updating patient care plans; (2) places family members and other informal caregivers at center of care team; (3) provides for in-person contact with beneficiaries; (4) utilizes technology to coordinate care over time and across settings (e.g., electronic health record (EHR) and patient-based remote monitoring systems); (5) provides for maintenance of close relationship between care coordinators, primary care practitioners, specialists and community-based organizations; (6) relies on a team-based approach to interventions (e.g., comprehensive care assessments, care planning, self-management coaching); (7) allows providers and suppliers to share information on real-time basis with other patients, caregivers, suppliers or other providers; and (8) demonstrates effective linkage with other public sector or private sector payers. HHS Secretary may not "initially" require that the model be budget neutral. HHS Secretary must terminate or modify design and implementation of model unless it is expected to achieve the following: (1) improve quality of care without increasing spending; (2) reduce spending without reducing quality of care; or (3) improve quality and reduce spending. HHS Secretary must evaluate each model with regard to the quality		

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	of care under the model, including patient-level outcomes and patient-centeredness criteria, and changes in spending. Each evaluation must be made publicly available. **Phase II: Expansion of Models:** Taking the evaluation (described above) into account, HHS Secretary may expand duration and scope of model (via rulemaking), if (1) Secretary determines that expansion is expected to reduce spending without reducing quality of care or improve the quality of care without increasing spending; (2) the CMS Actuary certifies that expansion would reduce net program spending; and (3) Secretary determines that expansion would not deny or limit coverage or provision of benefits. HHS Secretary may waive requirements that: (1) state Medicaid plans must be in effect statewide; (2) provide for a public process for determining payment rates for hospital services, nursing facility services and services of intermediate care facilities for the mentally disabled; and (3) provide for payments for Medicaid managed care plans. **Report to Congress:** Beginning in 2012, and not less than every other year thereafter, HHS Secretary must report to Congress on these activities.		
Accountable Care Organizations (ACOs) PPACA §§ 3022, 10307 (Medicare	**Overview:** Establishes Medicare Shared Savings Program that provides payments to qualifying ACOs; ACOs must participate in program for at least three years. **Eligible providers:** Groups of certain providers would work together to form an ACO. ACOs must include sufficient numbers of primary care physicians to serve the ACO's beneficiaries (at least 5,000 beneficiaries); HHS Secretary to determine how to assign	No later than January 1, 2012	Saves $4.9 billion

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Shared Savings Program)	beneficiaries to ACOs based on utilization of primary care services. ACOs may include the following: professionals in group practices; networks of individual practices; partnerships or joint venture arrangements between hospitals and practitioners; hospitals employing practitioners; and other groups of providers that HHS Secretary deems appropriate. **ACO Responsibilities:** ACOs would be accountable for, and report on, quality, cost and overall care of fee for service (FFS) beneficiaries. *Quality*. ACOs required to meet quality performance standards established by HHS Secretary to receive incentive payments. Quality standards would be based on measures such as clinical processes and outcomes, patient and caregiver experience, and utilization rates. ACOs may be required to report on physician quality reporting initiative measures. HHS Secretary may adopt new measures or higher quality standards over time to ensure improvement in quality of care. *Coordinated care*. ACOs required to define methods to promote patient engagement and evidence-based medicine, such as utilizing telehealth, remote patient monitoring and patient assessments. To further demonstrate coordinated care, ACOs may be required to report on discharge planning, post-discharge follow-up, electronic prescribing performance and electronic health records adoption performance. **Payment methods:** ACOs would be able to choose from one of the following payment methods (but HHS Secretary has discretion to establish other payment models)—		

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	Shared savings model. ACO eligible to share in portion of savings if average per capita costs are a specified percentage below a benchmark established for each ACO. Benchmark defined according to per-beneficiary Medicare expenditures as compiled from the three most recent years of available data. That amount can be adjusted for beneficiary characteristics or other relevant factors as determined by HHS Secretary. Benchmark is reset at start of each agreement year. HHS Secretary determines portion of difference between expenditures and benchmark that is retained by the ACO. *Partial capitation model*. ACO bears the financial risk for some, but not all, of the items and services covered under Medicare Parts A and B. HHS Secretary retains authority to limit this model to ACOs that are "highly integrated systems of care and capable of bearing risk." Model may not result in higher spending for beneficiaries than would otherwise be expended as if the model were not implemented. ▪ No payments will be made if savings are solely due to natural variations in expenses rather than actual reductions in costs. ▪ ACOs are required to have a formal legal structure that allows organization to receive and distribute payments for shared savings. **Encouraging adoption:** Allows HHS Secretary to give preference to ACOs that are already participating in similar arrangements with other payers. Permits existing physician group practice demonstration participants to qualify as ACOs. Prevents providers from receiving funds through other delivery reform pilot projects,		

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	such as those for medical homes. **Medicaid:** Establishes pediatric ACO demonstration project that authorizes states to provide ACO incentive payments to pediatricians who achieve state-established minimum saving levels.		
Extension of Gainsharing Demonstration PPACA § 3027	Extends existing gainsharing demonstration projects (as established by Deficit Reduction Act of 2005 (Pub. L. No. 109-171)) from December 31, 2009 through September 30, 2011.	Upon enactment	No score
Compliance			
Compliance Programs as 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 HHS 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 Secretary	$0 score
Provider Screening and Other Enrollment Requirements PPACA § 6401(a) and (b)	Requires HHS Secretary to establish screening procedures for Medicare, Medicaid and CHIP providers that 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 providers and suppliers to disclose on their application for	Provider screening procedures to be developed 180 days after enactment (September 19, 2010); Screening will apply one year after enactment (March 23, 2011) for new providers and suppliers and two years after enactment (March 23, 2012) for current	Savings of $100 million bundled into score for Provider Screening and Other Enrollment Requirements in PPACA § 6401

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	enrollment or revalidation of enrollment 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" of fraud, waste or abuse. Authorizes CMS to match data with IRS 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 that are similar to those required of Medicare providers and suppliers.	providers and suppliers	
Expansion of Recovery Audit Contractor (RAC) Program PPACA § 6411	Expands RAC program to Medicaid and Medicare Parts C and D to identify underpayments and overpayments and recoup overpayments. Medicaid RAC audits will be separate from Medicaid Integrity Program (MIP) audits.	States required to establish program no later than December 31, 2010	$0 score

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
Reducing Maximum Period for Submission of Medicare Claims PPACA § 6404	Reduces maximum period of submission for claims from three years to one year and allows HHS Secretary to make certain exceptions. Claims with dates of service prior to October 1, 2009 fall under the old filing requirements. However, claims from October 1, 2009 through December 31, 2009 must be submitted by December 31, 2010.	January 1, 2010	$0 score
Disclosure of Hospital Charges PPACA § 1001	Every hospital must annually create and make public a list of the hospital's standard charges for items and services provided by hospital, including DRGs.	Beginning January 1, 2011	Negligible revenue effect
Specific Requirements for Tax-Exempt Hospitals PPACA § 9007	**Basic requirements:** Each 501(c)(3) hospital would be required to meet following requirements: (1) conduct community health needs assessment at least once every three years, make assessment publicly available and adopt implementation plan to meet community needs identified through the assessment; (2) establish (written) financial assistance policy that includes eligibility criteria for financial assistance (and whether the assistance includes free or discounted care), basis for calculating amounts charged to patients, method for applying for financial assistance, actions the hospital may take in event of nonpayment and measures to publicize policy widely within community to be served by hospital; (3) limit amounts charged for emergency or other medically necessary care to individuals eligible for assistance to not more than lowest amounts charged to individuals with insurance; and (4) cannot engage in "extraordinary collection actions" before hospital has made reasonable efforts to determine whether individual is eligible for assistance under financial assistance policy.	Community health needs assessment required for taxable years beginning two years after date of enactment (March 23, 2012) Remaining requirements will apply to taxable years beginning after date of enactment	Negligible revenue effect

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	Penalties: Penalty of up to $50,000 for failures to conduct assessment and/or adopt implementation plan occurring after date of enactment. **Reporting:** At least once every three years, Treasury Secretary must review the community benefit activities of each 501(c)(3) hospital. Hospitals required to report annually how they are meeting community needs and provide audited financial statements. Treasury Secretary, in consultation with HHS Secretary, required to report annually to Congress on hospitals' charity care, bad debt expenses and unreimbursed costs of non-means tested government programs. Treasury Secretary, in consultation with HHS Secretary, must also conduct study on trends in information required above and, no later than five years after enactment (March 23, 1015), must submit a report on such study to Congress.		
Health Care Workforce			
Workforce PPACA Title V	Health care workforce provision to improve access to, and delivery of, health care services for all individuals, particularly low-income, underserved, uninsured, minority, health disparity and rural populations. These goals will be met in the following ways: by promoting research on the supply, demand, distribution, diversity and skills needs of the health care workforce; by increasing the supply of a qualified health care workforce; by enhancing health care workforce education and training; and by providing support to the existing	Various (see description)	$17.1 billion (excluding the IME/GME provisions and the United States Public Health provisions)

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	health care workforce. Establishes a multi-stakeholder National Health Care Workforce Commission to develop a national health care workforce strategy whose first report to Congress is due on April 1, 2011. Other provisions include— ▪ establishing a program to award grants beginning in FFY 2011 to accredited higher education institutions that create training opportunities for direct care workers ▪ creating a graduate nurse education demonstration program from FFY 2012 through FFY 2015 in Medicare for advance practice nurses (thus, eligible hospitals would receive Medicare reimbursement for the clinical training costs attributable to the training of advance practice nurses) ▪ creating a demonstration through which grants will be available to federally qualified health centers (FQHCs) and nurse-managed health clinics training family nurse practitioners beginning in FFY 2010 ▪ establishing Teaching Health Centers that will be community-based, ambulatory patient care centers that will be eligible for GME payments for primary care residency programs starting in FFY 2011 ▪ creating scholarships and loans for the training of health professionals beginning in FFY 2010 ▪ establishing a public health care workforce loan repayment program beginning in FFY 2010		

Health Care Reform Legislation Summary

Provision	Description	Effective Date(s)	CBO 10-Year Score
	▪ increasing the capacity for education, supporting training programs, providing loan repayment and retention grants and creating a career ladder to nursing.		