ALSTON&BIRD LLP

Health Care Public Policy Group
Timeline of Key Health Reform Provisions

The chart below provides a timeline of the effective dates of key provisions in the "Patient Protection and Affordable Care Act" (H.R. 3590), signed into law on March 23, 2010, and the "Health Care and Education Reconciliation Act of 2010" (H.R. 4872), as reported by the House Rules Committee on March 21, 2010 and passed by the Senate on March 25, 2010. The reconciliation bill is expected to be signed this week. We have included implementation dates for which there are specific statutory deadlines.

DATE	PROVISION
Effective Upon Enactment	
Enactment	Labeling Changes. Amends the Federal Food, Drug, and Cosmetic Act with respect to requirements applicable to the labeling of generic drugs. (Sec. 10609 of H.R. 3590) Interagency Working Group on Health Care Quality. Creates an Interagency Working Group on Health Care Quality comprised of Federal agencies to collaborate on the development and dissemination of quality initiatives consistent with the national strategy. (Sec. 3012 of H.R. 3590) Quality Measure Development. Authorizes $75 million over 5 years for the development of quality measures at AHRQ and CMS. (Sec. 3013 of H.R. 3590) Clinical Practice Guidelines. Requires the Secretary to contract with the Institute of Medicine for the identification of existing and new clinical practice guidelines. (Sec. 10303 of H.R. 3590) Health Care Delivery System Research; Quality Improvement Technical Assistance. Enables the Director of AHRQ to identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices in health care quality, safety, and value. (Sec. 3501 of H.R. 3590) National Prevention, Health Promotion and Public Health Council. Establishes the National Prevention, Health Promotion and Public Health Council. (Sec. 4001 of H.R. 3590) Prevention and Public Health Fund. Establishes a Prevention and Public Health Investment Fund to provide for investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs. (Sec. 4002 of H.R. 3509) School-Based Health Centers. Establishes a grant program for eligible entities to support the operation of "school-based health centers. (Sec. 4101 of H.R. 3590) Immunizations. Authorizes the Secretary to negotiate and enter into contracts with manufacturers of vaccines for the purchase and delivery of vaccines to adults. (Sec. 4204 of H.R. 3590) Better Diabetes Care. Directs the Secretary of HHS to develop a national report card on diabetes to be updated every two years. (Sec. 10407 of H.R. 3590)

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DATE	PROVISION
Enactment	National Diabetes Prevention Program. Establishes a national diabetes prevention program targeted at adults at high risk for diabetes in order to eliminate the preventable burden of diabetes through community-based prevention services. (Sec. 10501(g)) of H.R. 3590) National Health Care Workforce Commission. Establishes a national commission tasked with reviewing health care workforce and projected workforce needs. (Sec. 5101 of H.R. 3590) Federally Supported Student Loan Funds. Eases current criteria for schools and students to qualify for loans, shorten payback periods, and decreases the non-compliance provision to make the primary care student loan program more attractive to medical students. (Sec. 5201 of H.R. 3590) Nursing Student Loan Program. Increases loan amounts and updates the years for nursing schools to establish and maintain student loan funds. (Sec. 5202 of H.R. 3590) Public Health Workforce Recruitment and Retention Program. Establishes the Public Health Workforce Loan Repayment Program to ensure an adequate supply of public health professionals to eliminate shortages in federal, state, local, or tribal public health agencies. (Sec. 5204 of H.R. 3590) Funding for National Health Service Corps. Increases and extends the authorization of appropriations for the National Health Service Corps scholarship and loan repayment program for 2010-2015. (Sec. 5207 of H.R. 3590) Nurse-Managed Health Clinics. Strengthens the health care safety-net by creating a $50 million grant program administered by HRSA to support nurse-managed health clinics. (Sec. 5208 of H.R. 3590) Training in Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantship. Provides grants and contracts to support and develop primary care training programs. (Sec. 5301 of H.R. 3590) Training in General, Pediatric, and Public Health Dentistry. Reinstates dental funding in Title VII of the Public Health Service Act. (Sec. 5303 of H.R. 3590) Advanced Nursing Education Grants. Strengthens language for accredited Nurse Midwifery programs to receive advanced nurse education grants in Title VIII of the Public Health Service Act. (Sec. 5308 of H.R. 3590) Nurse Education, Practice, and Retention Grants. Awards grants to nursing schools to strengthen nurse education and training programs and to improve nurse retention. Authorizes such sums as may be necessary for 2010-2012. (Sec. 5309 of H.R. 3590) Nurse Faculty Loan Program. Establishes a Federally-funded student loan repayment program for nurses with outstanding debt who pursue careers in nurse education. (Sec. 5311 of H.R. 3590) Fellowship Training in Public Health. Authorizes the Secretary to address workforce shortages in State and local health departments in applied public health epidemiology and public health laboratory science and informatics. (Sec. 5314 of H.R. 3590) Counting Resident Time in Outpatient Settings and Allowing Flexibility for Jointly Operated Residency Training Programs. Modifies rules governing when hospitals can receive indirect medical education (IME) and direct graduate medical education (DGME) funding for residents who train in a non-provider setting so that any time spent by the

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DATE	PROVISION
Enactment	resident in a non-provider setting shall be counted toward DGME and IME if the hospital incurs the costs of the stipends and fringe benefits. (Sec. 5504 of H.R. 3590) Preservation of Resident Cap Positions from Closed Hospitals. Directs the Secretary to redistribute medical residency slots from a hospital that closes on or after the date that is two years before enactment of the this legislation based on certain criteria. (Sec. 5506 of H.R. 3590) Increasing Teaching Capacity. Directs the Secretary to establish a grant program to support new or expanded primary care residency programs at teaching health centers. (Sec. 5508 of H.R. 3590) Negotiated Rulemaking for Development of Methodology and Criteria for Designating Medically Underserved Populations and Health Professions Shortage Areas. Directs the Secretary, in consultation with stakeholders, to establish a comprehensive methodology and criteria for designating medically underserved populations and Health Professional Shortage Areas. (Sec. 5602 of H.R. 3590) Provider Screening and Other Enrollment Requirements Under Medicare, Medicaid, and CHIP. Requires the Secretary to screen all providers and suppliers participating in Medicare, Medicaid, and CHIP. (Sec. 6401 of H.R. 3590) Medicare and Medicaid Program Integrity Provisions. Requires CMS to complete development of the Integrated Data Repository (IDR), which would expand existing program integrity data sources and data sharing across Federal agencies. (Sec. 6402 of H.R. 3509) Medicare Program Sanctions. Allows the Secretary to impose an appropriate administrative penalty if an individual knowingly participated in a Federal health care fraud offense or conspiracy to commit an offense. (Sec. 6402 of H.R. 3590) Medicare Prepayment Medical Review Limitations. Repeals Section 1847A(h) of the SSA that relates to the conduct of prepayment review to allow Medicare Administrative Contractors to perform additional reviews to limit fraud and abuse. (Sec. 1302 of H.R. 4872) Overpayments. Requires that any person who knows of an overpayment would be required to return the overpayment to the Secretary, the state, or a Medicare contractor. (Sec. 6402 of H.R. 3590) Medicaid Statistical Information System. Permits the withholding of federal matching payments for states that fail to report enrollee encounter data in the Medicaid Statistical Information System. (Sec. 6402 of H.R. 3590) Permissive Exclusions. Allows permissive exclusions for individuals or entities that knowingly make false statements or misrepresentations of material facts. (Sec. 6402 of H.R. 3590) Deterrence/Civil and Criminal Penalties. Amends CMP law in several respects. Amends the Anti-Kickback statute so that a claim that includes items or services violating the statute would also constitute a false or fraudulent claim. (Sec. 6402 of H.R. 3590) Subpoena Authority. Grants the Secretary subpoena authority in exclusion-only cases. (Sec. 6402 of H.R. 3590) Surety Bond Requirements. Allows the Secretary to determine surety bond requirements for DME and home health providers based on an amount commensurate with the volume of

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Enactment	the billing of the provider. (Sec. 6402 of H.R. 3590) Suspension of Payments. Secretary may suspend Medicare and Medicaid payments to a provider or supplier pending an investigation of fraud. (Sec. 6402 of H.R. 3590) Program Integrity Funding and Reporting Requirements. Health Care Fraud and Abuse Control (HCFAC) program funding would be increased by $10 million each year for 10 years, and would remain available until expended. Permanently applies the CPI adjustment to HCFAC and Medicare Integrity Program funding. (Sec. 6402 of H.R. 3590) Medicare and Medicaid Integrity Programs. Requires entities that are enrolled in Medicare and Medicaid to submit performance statistics on the number of fraud referrals, overpayments recovered, and return on investment. (Sec. 6402 of H.R. 3590) Transition from Healthcare Integrity and Protection Data Bank to the National Practitioner Data Bank. Requires Secretary to maintain a data collection program for the reporting of final adverse actions against health care providers. (Sec. 6403 of H.R. 3590) Medicare Payment. For services furnished before January 1, 2010 claims must be submitted no later than December 31, 2010. (Sec. 6404 of H.R. 3590) Termination of Provider Participation. Terminates a provider's participation in Medicaid if enrollment under Medicare or another state plan is terminated. (Sec. 6501 of H.R. 3590) Medicaid Exclusion from Participation. Requires State Medicaid agencies to exclude from Medicaid participation for a period any entity that owns, controls, or manages an entity or is owned, controlled, or managed by an individual or entity that has unpaid overpayments, is suspended or excluded from participation, or is affiliated with an entity that has been suspended or excluded. (Sec. 6502 of H.R. 3590) Required Registration under Medicaid. Requires agents, clearinghouses, and other alternate payees to register under Medicaid. (Sec. 6503 of H.R. 3590) Overpayments. Extends the period for collection of overpayments from 60 days to 1 year. (Sec. 6506 of H.R. 3590) Prohibition on False Statements and Representations. Prohibits any person, in connection with a plan or other arrangement that is a multiple employer welfare arrangement, from making a false statement in connection with the marketing or sale of such plan. (Sec. 6601 of H.R. 3590) Development of Model Uniform Report Form. Requires the Secretary to request that the National Association of Insurance Commissioners (NAIC) develop a model uniform report form for private health insurance issuers seeking to refer suspected fraud and abuse to state insurance departments. (Sec. 6603 of H.R. 3590) Applicability of State Law to Combat Fraud and Abuse. Allows the Secretary to adopt regulatory standards or issue an order establishing that a person engaged in the business of providing insurance through a multiple employer welfare arrangement is subject to the laws of the states in which such person operates which regulate insurance. (Sec. 6604 of H.R. 3590) Issue of Summary Cease and Desist Orders. Allows the Secretary of Labor to issue cease and desist orders and summary seizure orders against multiple employer welfare arrangements (MEWAs), if the Secretary determines the MEWA is in a financially hazardous condition. (Sec. 6605 of H.R. 3590) MEWA Plan Registration with the Department of Labor. MEWAs must register with the

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DATE	PROVISION
Enactment	Secretary of Labor. (Sec. 6606 of H.R. 3590) Permitting Evidentiary Privilege and Confidential Communications. Secretary may provide for evidentiary privilege and confidential communications between certain federal agencies during investigations, audits, examinations, or inquiries. (Sec. 6607 of H.R. 3590) Health Care Fraud Enforcement. Increases the federal sentencing guidelines for health care fraud. Changes the intent requirement for fraud under the Anti-Kickback statute such that a person need not have actual knowledge of this section or specific intent to violate this section. (Sec. 10606 of H.R. 3590) Required Disclosure of Ownership and Additional Disclosable Parties Information. Requires that SNFs under Medicare and nursing facilities (NFs) under Medicaid make available on request by the Secretary, the Inspector General of the Department of Health and Human Services, the States, and the State long-term care ombudsman, information on ownership, including a description of the governing body and organizational structure of the facility and information regarding additional disclosable parties. (Sec. 6101 of H.R. 3590) Accountability Requirements for SNFs and NFs. Requires SNFs and NFs to implement a compliance and ethics program to be followed by the facility's employees and its agents within 36 months of enactment, and requires the Secretary to evaluate this program and report the results to Congress. (Sec. 6102 of H.R. 3590) Nursing Home Compare Medicare Website. Requires the Secretary to publish the certain information on the Nursing Home Compare Medicare website. (Sec. 6103 of H.R. 3590) Reporting of Expenditures. Requires the Secretary to modify cost reports for SNFs to require reporting of expenditures on wages and benefits for direct care staff, breaking out registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff. (Sec. 6104 of H.R. 3590) Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long Term Care Facilities and Providers. Requires the Secretary to establish a nationwide program for national and State background checks on direct patient access employees of certain long-term supports and services facilities or providers. (Sec. 6201 of H.R. 3590) Extension of Physician Fee Schedule Mental Health Add-On. Increases the payment rate for psychiatric services by 5 percent for two years, through the end of 2010. (Sec. 3107 of H.R. 3590) Pharmacy Benefit Managers Transparency Requirements. Requires Pharmaceutical Benefit Managers (PBMs) or a qualified health benefits plan offered through an exchange to provide to the Secretary, and in the case of a PBM, to the plan with which the PBM is under contract with certain information. (Sec. 6005 of H.R. 3590) Additional Requirements for Charitable Hospitals. Establishes additional requirements to quality as a section 501(c)(3) charitable hospital organization, including conducting community needs assessments. (Sec. 9007 of H.R. 3590) Exclusion for Assistance Provided to Participants in State Student Loan Repayment Programs for Certain Health Professionals. Excludes from gross income any amount received under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. (Sec. 10908 of H.R. 3590)

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Enactment	Implementation Funding. Creates a $1,000,000,000 Health Insurance Reform Implementation Fund within HHS for implementation on the Patient Protection and Affordable Care Act and the Reconciliation Act. (Sec. 1005 of H.R. 4872) Access to Therapies. Prevents the HHS Secretary from promulgating regulations that create unreasonable barriers to individuals obtaining medical care. (Sec. 1554 of H.R. 3590) Freedom Not to Participate in Federal Health Insurance Programs. Provides that no individual, company, business, nonprofit entity, or health insurance issuer shall be required to participate in any Federal health insurance program created under this Act. (Sec. 1555 of H.R. 3590) Improving Women's Health. Establishes an Office of Women's Health in the Office of the Secretary, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, and the Food and Drug Administration. (Sec. 3509 of H.R. 3590) Oversight. The Inspector General of the Department of HHS shall have oversight authority with respect to the administration and implementation of title I related to quality affordable health care for all Americans. (Sec. 1559 of H.R. 3590) Qualifying Therapeutic Discovery Project Credit. Creates a 2-year temporary tax credit to an overall cap of $1,000,000,000 to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases. (Sec. 9023 of H.R. 3590) Labeling Changes. Amends the Federal Food, Drug, and Cosmetic Act with respect to requirements applicable to the labeling of generic drugs. (Sec. 10609 of H.R. 3590) Health Care Fraud. Requires enhanced screening procedures for health care providers to eliminate fraud and waste in the health care system. (Sec. 6401 of H.R. 3590) Extension of LTCH MMSEA Provisions. Extends Sections 114 (c) and (d) of the Medicare, Medicaid and SCHIP Extension Act of 2007 by two years. (Sec. 3106 of H.R. 3590) Simplification of Annual Beneficiary Election Periods. Provides an annual 45 day period for beneficiaries to disenroll from MA plans and elect to enroll in FFS Medicare. Allows beneficiaries to disenroll from a MA plan and return to FFS Medicare from January 1 to March 15 of each year. (Sec. 3204 of H.R. 3590) Technical Correction to MA Private FFS plans. Extends applicability of the 2008 service area extension waver for MA coordinated care plans to employers that contract directly with MA. (Sec. 3207 of H.R. 3590) Making Senior Housing Facility Demonstration Permanent. Allows MA plans that operate in continuing care retirement communities and provide specified services to continue to operate under the MA program. (Sec. 3208 of H.R. 3590)
2010	
1/1/2010	Expanded Participation in the 340B Program. Expands list of covered entities eligible to receive discounted prices under the 340B Program to outpatient children's cancer, and critical access hospitals as well as certain sole community hospitals and rural referral centers. Exempts orphan drugs from expansion. (Sec. 7101 of H.R. 3590 and Sec. 2302 of H.R. 4872) Prescription Drug Rebates. Increases Medicaid rebate percentage for outpatient single source and innovator multiple source prescription drugs from 15.1% to 23.1% (except for

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1/1/2010	certain clotting factors and outpatient drugs for pediatric indications, for which the basic rebate would increase to 17.1%). (Sec. 2501 of H.R. 3590) Prescription Drug Rebates. Increases rebate for non-innovator, multiple source drugs to 13 percent of AMP. (Sec. 2501 of H.R. 3590) Prescription Drug Rebates. Applies additional rebate for new formulations of existing drugs to line extensions of a single source drug or an innovator multiple source drug that are an oral solid dosage form. (Sec. 2501 of H.R. 3590 and Sec. 1206 of H.R. 4872) Prescription Drug Rebates. Extends Medicaid rebates to Managed Care Organizations. (Sec. 2501 of H.R. 3590) Evidence-Based Coverage of Preventive Services in Medicare. Authorizes the Secretary to modify the coverage of certain preventive services covered by Medicare and the coverage of the services included in the initial preventive physical examination, to the extent that such modification is consistent with the recommendations of the U.S. Preventive Services Task Force. (Sec. 4105 of H.R. 3590) Medicare Payment. The maximum period for submission of Medicare claims on or after January 1, 2010 would be reduced to not more than 12 months. (Sec. 6404 of H.R. 3590) Requirements for Physicians to Provide Documentation on Referrals to Programs at High Risk of Waste and Abuse. Allows the Secretary to revoke enrollment for a period of not more than one year for each act for a physician or supplier who fails to maintain or does not provide access to documentation relating to written orders or requests for payment for DME, certifications for home health services, or referrals for other items or services specified by the Secretary. (Sec. 6406 of H.R. 3590) Face to Face Encounter with Patient Required before Physicians may Certify Eligibility for Home Health Services or Durable Medical Equipment Under Medicare. Requires physicians to have a face-to-face encounter with patients prior to certification or re-certification for home health services or DME under Medicare. (Sec. 6407 of H.R. 3590) Enhanced Penalties. Amends and enhances application of civil monetary penalties. (Sec. 6408 of H.R. 3590) Required Reporting Under Medicaid Management Information System (MMIS). Requires entities (including managed care organizations) to report additional data elements under MMIS as the Secretary determines necessary. (Sec. 6504 of H.R. 3590) Disclosure Requirements for In-Office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services. Amends requirement to the in-office ancillary exception of the Stark law. (Sec. 6003 of H.R. 3590) Limitation on Excessive Remuneration Paid by Certain Health Insurance Providers. Creates a special rule under section 162(m) regarding the deductibility of excessive remuneration (including deferred deduction remuneration) by an insurance provider. (Sec. 9014 of H.R. 3590) Modification of Section 833 Treatment of Certain Health Organizations. Requires that nonprofit Blue Cross Blue Shield organizations have a medical loss ratio of 85 percent or higher in order to take advantage of the special tax benefits provided to them under section 833 of the IRC. (Sec. 9016 of H.R. 3590) Expanded Participation in the 340B Program. Expands list of covered entities eligible to receive discounted prices under the 340B Program. Exempts orphan drugs from expansion. (Sec. 7101 of H.R. 3590 and Sec. 2302 of H.R. 4872)

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DATE	PROVISION
1/1/2010	Prescription Drug Rebates. Increases Medicaid rebate percentage for outpatient single source and innovator multiple source prescription drugs from 15.1% to 23.1% (except for certain clotting factors and outpatient drugs for pediatric indications, for which the basic rebate would increase to 17.1%). (Sec. 2501 of H.R. 3590) Prescription Drug Rebates. Increases rebate for non-innovator, multiple source drugs to 13 percent of AMP. (Sec. 2501 of H.R. 3590) Prescription Drug Rebates. Applies additional rebate for line extensions of a single source drug or an innovator multiple source drug that are an oral sold dosage form. (Sec. 1206 of H.R. 4872) Prescription Drug Rebates. Extends Medicaid rebates to Managed Care Organizations. (Sec. 2501 of H.R. 3590) Part B Premium Adjustment. Freezes income thresholds at 2010 levels through 2019 for income-related premium for Part B Medicare. (Sec. 3402 of H.R. 3590) Small Business Tax Credit. Initiates first phase of the small business tax credit for qualified small employers for contributions to purchase health insurance for employees. The credit is up to 35% of the employer's contribution to provide health insurance for employees. There is also up to a 25 percent credit for small nonprofit organizations. Effective calendar year 2010. (Later, when Exchanges are operational, tax credits will be up to 50% of premiums.) (Sec. 1421 of H.R. 3590) Medicaid Global Payments Demonstration. Requires the Secretary, in coordination with the CMS Innovation Center, to establish a demonstration project in up to five states from 2010 to 2012, under which a large, safety net hospital system participating in Medicaid would be permitted to alter its provider payment system from a fee-for-service structure to a capitated, global payment structure. (Sec. 2705 of H.R. 3590) Medicaid and CHIP Payment and Access Commission (MACPAC) Assessment of Policies Affecting All Medicaid Beneficiaries. Authorizes $11 million for MACPAC for FY2010, of which $9 million would come from Medicaid funds and $2 million would come from CHIP funds. (Sec. 2801 of H.R. 3590) Funding to Expand State Aging and Disability Resource Centers. Appropriates, to the Secretary of HHS, $10 million for each of FYs 2010 through 2014 to carry out Aging and Disability Resource Center (ADRC) initiatives. (Sec. 2405 of H.R. 3590) Extension of the Work Geographic Index Floor. Extends the 1.0 floor for the geographic index for physician work through 2010. (Sec. 3102 of H.R. 3590) Extension of Payment for Technical Component of Certain Physician Pathology Services. Extends a provision that directly reimburses qualified rural hospitals for certain clinical laboratory services through the end of 2010. (Sec. 3104 of H.R. 3590) Modification of Equipment Utilization Factor for Advanced Imaging Services. Increases the utilization rate assumption for advanced diagnostic imaging equipment from 50 percent to 65 percent for 2010-2012; to 70 percent for 2013; and to 75 percent for 2014 and subsequent years. (Sec. 3135 of H.R. 3590) Payment for Bone Density Tests. Restores payment for dual-energy x-ray absorptiometry (DXA) services furnished during 2010 and 2011 to 70 percent of the Medicare rate paid in 2006. (Sec. 3111 of H.R. 3590) Extension of Outpatient Hold Harmless Provision. Extends the existing outpatient hold

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DATE	PROVISION
1/1/2010	harmless provision through the end of FY2010 and would allow Sole Community Hospitals with more than 100 beds to also be eligible to receive this adjustment through the end of FY2010. (Sec. 3121 of H.R. 3590) Rural Physician Training Grants. Directs the Secretary, acting through HRSA, to establish a grant program for purposes of assisting eligible entities in recruiting students mostly likely to practice in underserved rural communities, providing rural-focused training and experience, and increasing the number of recent allopathic and osteopathic medical school graduates who practice in rural communities. Appropriates $4,000,000 for each of the FYs 2010 through 2013. (Sec. 10501 of H.R. 3590)
3/1/2010	Providing Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries. Establishes the Federal Coordinated Health Care Office (CHCO) within CMS no later than March 1, 2010. (Sec. 2602 of H.R. 3590)
4/1/2010	Home Health Rural Add-On Payment. Reinstates a 3 percent per episode add-on payment for rural home health providers from April 1, 2010 through 2015. (Sec. 3131 of H.R. 3590) Ensuring Medicaid Flexibility for States. Allows States to cover parents and childless adults up to 133 percent of FPL and receive current law Federal Medical Assistance Percentage (FMAP). Effective April 1, 2010. (Sec. 2001 of H.R. 3590). Hospital Wage Index Improvement. Extends reclassifications under section 508 of the Medicare Modernization Act (P.L 108-173) through the end of FY2010. Beginning on April 1, 2010, the Secretary shall include the average hourly wage data of hospitals whose reclassification was extended only if including such data results in a higher applicable reclassified wage index. (Sec. 3137 of H.R. 3590) Payment Update: LTCH. Requires market basket minus 0.25%. (Sec. 3401 of H.R. 3590) Payment Update: Hospitals (Inpatient and Outpatient), Inpatient Psych. and IRFs. Requires market basket minus 0.25%. (Sec. 3401 of H.R. 3590)
4/23/2010	Transparency in Government. Not later than 30 days after the date of enactment of this Act, the Secretary shall publish on the HHS website a list of all of the authorities provided to the Secretary under this Act. (Sec. 1552 of H.R. 3590)
5/1/2010	Medication Management Services in Treatment of Chronic Disease. Establishes a program to provide grants or contracts to eligible entities to implement medication management ("MTM") services provided by licensed pharmacists. (Sec. 3503 of H.R. 3509)
5/23/2010	Immediate Access to Insurance for Uninsured Individuals with a Pre-Existing Condition. Requires the Secretary to create a temporary insurance high-risk pool program within 90 days of enactment to provide insurance to people who have been uninsured for 6 months and have a pre-existing condition. The program terminates in 2014 when the Exchanges are operational. (Sec. 1101 of H.R. 3590) Reducing Cost of Covering Early Retirees. Requires the Secretary to establish a temporary reinsurance program to provide reimbursement to participating employment-based plans for part of the cost of providing health benefits to retirees (age 55-64) and their families (until Jan. 1, 2014). (Sec. 1102 of H.R. 3590)
7/1/2010	Requirements Related to Durable Medical Equipment and Home Health. Requires physicians, who order durable medical equipment or home health services that are billable to Medicare, to be Medicare participating physicians or eligible professionals, as determined by the Secretary. (Sec. 6405 of H.R. 3590) Improving Consumer Information through the Web. Requires the Secretary of HHS to

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7/1/2010	establish an Internet website through which residents of any State may identify affordable health insurance coverage options in that State. (Sec. 1003 of H.R. 3590).
9/23/2010	Improvements to the 340B Program Integrity. Not later than 180 days after the Act's enactment, Secretary is required to make certain improvements to the 340B Program. (Sec. 7102 of H.R. 3590) Demonstration Project to Provide Access to Affordable Care. Not later than 6 months after the Act's enactment, the Secretary, acting through HRSA, shall establish a 3-year demonstration in 10 states to provide access to comprehensive health care services to the uninsured at reduced fees. (Sec. 10504 of H.R. 3590) Provider Self-Disclosure Protocol. Within 180 days, the Secretary would be required to develop a mechanism for providers to voluntarily disclose specific information regarding actual and potential violations of the physician self-referral law. (Sec. 6409 of H.R. 3590) Improvements to the 340B Program Integrity. Requires the Secretary to make certain improvements to the 340B Program. (Sec. 7102 of H.R. 3590) Health Insurance Standards. Requires the Secretary to develop standards for use by health insurers in compiling and providing an accurate summary of benefits and explanation of coverage to be provided to applicants, enrollees, and policyholders. (Sec. 1001, adding Sec. 2715, of H.R. 3590) Prohibiting Rescissions. Prohibits individual and group plans from rescinding coverage except in instances of fraud or intentional misrepresentation of material fact and with prior notice given to enrollees. (Sec. 1001, adding Sec. 2712, of H.R. 3590) Eliminating Lifetime Limits. Prohibits insurers from imposing lifetime limits on benefits. (Sec. 1001, adding Sec. 2711, of H.R. 3590) Regulating Use of Annual Limits. Regulates plans use of annual limits to ensure access to needed care in all group plans and all new individual plans. Effective six month after enactment and applying to new plans in the individual market and all employer plans. (When the Exchanges are operational in 2014, the use of annual limits will be banned for new plans in the individual market and all employer plans.) (Sec. 1001, adding Sec. 2711, of H.R. 3590) Preventive Health Services. Requires individual and group plans to cover and not impose cost-sharing on preventive services and immunizations. (Sec. 1001, adding Sec. 2713, of H.R. 3590) Appeals Process. Requires insurers to implement an effective process for appeals of coverage determinations and claims. Requires plans to maintain both internal and external appeals processes. (Sec. 1001, Sec. 2719, of H.R. 3590) Extending Coverage for Young Adults. Requires individual and group plans offering dependent coverage to allow unmarried individuals up to age 26 to remain covered as dependents. (Sec. 1001, adding Sec. 2714, of H.R. 3590) Grants to Collect Reimbursement Data. Provides grants to States to establish academic or non-profit medical reimbursement data centers to collect medical reimbursement information from health insurers to analyze, and to make such information available to issuers, providers, researchers, policymakers, and the general public; and to develop fee schedules and other database tools that reflect market rates for medical services and the geographic difference in those rates and would also make information available to the public through a website. (Sec. 1003 of H.R. 3590)

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DATE	PROVISION
9/23/2010	Patient Protections. Requires insurers to allow enrollees to designate any participating primary care provider (or pediatrician for children) who is available to accept the individual as the enrollee's primary care provider. Requires covered benefits for emergency department services to be covered without prior authorization requirements and without regard to whether the provider furnishing services is a participating provider. Prohibits plans from requiring authorization or referral for female patients seeking obstetrical or gynecologic care. (Sec. 1001, Sec. 2719A, of H.R. 3590) Bringing Down the Cost of Health Care Coverage (Standard Hospital Charges Reporting). Requires hospitals to publicize a list of standard charges for items and services provided by the hospitals, including DRGs. (Sec. 1001, adding Sec. 2718, of H.R. 3590) Health Information Technology Enrollment Standards and Protocols. Requires, within 180 days after enactment, the Secretary to develop standards and protocols, in consultation with the HIT Policy and Standards Committees, to promote the interoperability of systems for enrollment of individuals in Federal and State health and human services programs. (Sec. 1561, of H.R. 3590)
10/1/2010	Approval Pathways for Biosimilar Biological Products. Requires Secretary to develop recommendations to Congress with respect to user fees. (Sec. 7002 of H.R. 3590) Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid. Requires states to cover diagnostic, therapy, and counseling services and pharmacotherapy (including prescription and nonprescription tobacco cessation agents) for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use by or under the supervision of a physician or any other authorized health care professional. (Sec. 4107 of H.R. 3590) Primary Care Extension Program. Creates a Primary Care Extension Program to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. (Sec. 5405 of H.R. 3590) National Correct Coding Initiative. Requires states to use the National Correct Coding Initiative. (Sec. 6507 of H.R. 3590) Revisions to SNF Provisions. Requires the Secretary to implement the concurrent therapy change and changes to the "look-back" period to ensure that only those services furnished after admission are included in determining case mix classification. (Sec. 10325 of H.R. 3590) State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation. Authorizes states to conduct demonstration programs to evaluate alternatives to current medical tort litigation. (Sec. 10607 of H.R. 3590) Approval Pathways for Biosimilar Biological Products. Requires Secretary to develop recommendations to Congress with respect to user fees. (Sec. 7002 of H.R. 3590) Strengthening Community Health Centers. Provides funds to build new and expand existing community health centers. (Sec. 3502 of H.R. 3590) Application of Budget Neutrality on a National Basis in the Calculation of the Medicare Hospital Wage Index Floor. Starting on October 1, 2010, the provision would require application of budget neutrality associated with the effect of the imputed rural and rural floor to be applied on a national, rather than State-specific basis through a uniform, national adjustment to the area wage index. (Sec. 3141 of H.R. 3590)

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DATE	PROVISION
12/31/2010	Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals. Prohibits physician-owned hospitals that do not have a provider agreement prior to December 31, 2010 from participating in Medicare. (Sec. 6001 of H.R. 3590 and Sec. 1106 of H.R. 4872) Extension of Exceptions Process for Medicare Therapy Caps. Extends the process allowing exceptions to limitations on medically necessary therapy until December 31, 2010. (Sec. 3103 of H.R. 3590) Expansion of the Recovery Audit Contractor (RAC) Program. Not later than December 31, 2010, expands RAC program to Medicaid and Medicare Parts C and D. Requires RACs to ensure that MA and PDPs implement anti-fraud plans. (Sec. 6411 of H.R. 3590)
2011	
1/1/2011	Providing Adequate Pharmacy Reimbursement Limits. Changes the FUL to no less than 175 of the weighted average of the most recent AMPs for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies. Clarifies definition of AMP. (Sec. 2503 of H.R. 3590 and 1101 of H.R. 4872) Community-Based Care Transitions Program. Requires the Secretary to establish a 5-year program under which the Secretary would provide funding to hospitals and community-based entities that furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission. (Sec. 3026 of H.R. 3590) National Strategy. Establishes a Federal health care quality internet website. (Sec. 3011 of H.R. 3590) State Option to Provide Health Homes for Enrollees with Chronic Conditions. Creates a new Medicaid state plan option under which enrollees with at least two chronic conditions, or with one chronic condition and at risk of developing another, or with at least one serious and persistent mental health condition, could designate a provider, a team of health care professionals, or a health team as their health home. (Sec. 2703 of H.R. 3590) Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan. Provides coverage under Medicare for an annual wellness visit where individuals are provided a personalized prevention plan services. (Sec. 4103 of H.R. 3590) Removal of Barriers to Preventive Services in Medicare/Amendment Relating to Waiving Coinsurance for Preventive Services. Waives coinsurance in all settings (co-payment and deductible) for certain preventive and screening services, an initial preventive physical examination, and personalized prevention plan services. (Sec. 4104 and 10406 of H.R. 3590) Training Opportunities for Direct Care Workers. Provides grants for entities to provide new training opportunities for direct care workers employed in long-term care settings. (Sec 5302 of H.R. 3590) 90-Day Period of Enhanced Oversight for Initial Claims of DME Suppliers. Permits the Secretary to withhold payment to DME suppliers initially enrolling in the Medicare program who are within a category or geographic area deemed to be at significant risk of fraudulent activity for 90 days. (Sec. 1304 of H.R. 4872). National Provider Identifier. Requires the Secretary to promulgate a regulation no later than January 1, 2011 requiring all providers and suppliers that qualify for a national provider identifier to include this identifier on all applications for enrollment. (Sec. 6402 of H.R. 3590) Expanding Access to Primary Care Services and General Surgery Services. Provides

A&B Health Care Public Policy Group Health Care Reform Chart

DATE	PROVISION
1/1/2011	primary care practitioners, as well as general surgeons practicing in health professional shortage areas, with a 10 percent Medicare payment bonus for five years. (Sec. 5501 of H.R. 3590) Productivity Adjustment. Implements a full productivity adjustment for laboratories, DME, and ambulatory surgical centers. (Sec. 3401 of H.R. 3590) Fee schedule reduction for Clinical Laboratories. For 2011-2015, reduces the annual fee schedule update by 1.75 percent after the productivity adjustment. (Sec. 3401(l) of H.R. 3590) Inclusion of Cost of Employer-Sponsored Health Coverage on W-2. An employer would be required to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2. (Sec. 9002 of H.R. 3590) Distribution for Medicine Qualified Only if for Prescribed Drug or Insulin. Provides that nontaxable reimbursements from health flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), and health savings accounts (HSAs) do not include a medicine or drug unless the medicine or drug is prescribed or is insulin. (Sec. 9003 of H.R. 3590) Increase in Additional Tax on Distributions from HSAs and Archer MSAs not Used for Qualified Medical Expenses. Increases the additional tax for HSA withdrawal prior to 65 that are used for purposes other than qualified medical expenses from 10 to 20 percent. (Sec. 9004 of H.R. 3590) Imposition of Annual Fee on Branded Prescription Pharmaceutical Manufacturers and Importers. Imposes a $2,300,000,000 aggregate fee on all manufacturers and importers with gross receipts from branded prescription drug sales to be paid to the Secretary of the Treasury. (Sec. 9008 of H.R. 3590 and Sec. 1404 of H.R. 4872) Establishment of Simple Cafeteria Plans for Small Business. Provides a safe harbor from the nondiscrimination requirements for eligible small employers that maintain "simple cafeteria plans." (Sec. 9022 of H.R. 3590) Providing Adequate Pharmacy Reimbursement Limits. Changes the FUL to no less than 175 of the weighted average of the most recent AMPs for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies. Clarifies definition of AMP. (Sec. 2503 of H.R. 3590) Providing New, Voluntary Options for Long-Term Care Insurance ("CLASS" Program). Creates a long-term care insurance program to be financed by voluntary payroll deductions to provide benefits to adults who become disabled. (Sec. 8002 of H.R. 3590) Reporting on Premium Dollars. Health plans, including grandfathered plans, must annually report on the share of premium dollars spent on medical care and provide consumer rebates for excessive medical loss ratios. (Sec. 1103 of H.R. 3590) Medical Loss Ratio Requirements. Health insurers must begin providing a rebate to each enrollee if the amount the insurer spends on clinical services provided to enrollees and activities that improves health care quality does not exceed 85% of premium revenue for large groups (80% for small groups). (Sec. 1001, adding Sec. 2718, of H.R. 3590) Home Health Outlier Cap. Provider-specific annual cap of 10% of revenues on Home Health agency outlier reimbursements. (Sec. 3131 of H.R. 3590) Payment Update: LTCH. Requires market basket minus 0.5%. (Sec. 3401 of H.R. 3590) Payment Update: Home Health. Requires market basket minus 1%. (Sec. 3401 of H.R.

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DATE	PROVISION
1/1/2011	3590) Long-Term Care Ombudsman Program Grants and Training. Appropriates $5 million for FY 2011, $7.5 million for FY 2012, and $10 million for each of FYs 2013 and 2014 for grants to eligible entities to support the long-term care ombudsman program. Appropriates $10 million for each of FYs 2011 through 2014 for the Secretary to establish programs to provide and improve ombudsman training related to elder abuse. (Sec. 6703 adding Sec. 2043, of H.R. 3590) Hospice Reform. This provision would require the Secretary to update Medicare hospice claims forms and cost reports by 2011. Based on this information, the Secretary would be required to implement changes to the hospice payment system to improve payment accuracy in FY2013. (Sec. 3132 of H.R. 3590) Permitting Physician Assistants to order Post-Hospital Extended Care Services. Authorizes physician assistants to order skilled nursing care services in the Medicare program beginning in 2011. (Sec. 3108 of H.R. 3590) Payment for Imaging Services. Sets the utilization rate assumption for expensive diagnostic imaging equipment (equipment priced over $1 million) at 75 percent for 2011 and subsequent years. (Sec. 1107 of H.R. 4872) Public Reporting of Performance Information. Requires the Secretary of HHS to develop by January 1, 2011 a "Physician Compare" website with information on physicians enrolled in the Medicare program and other eligible professionals who participate in the PQRI program. (Sec. 10331 of H.R. 3590) Payment Update: Clinical Labs. Reduces update for clinical laboratories by 1.75 percent in each of 2011-2015. (Sec. 3401 of H.R. 3590) Payment Update: DME. For covered items of durable medical equipment and prosthetic devices and orthotics and prosthetics, sets the annual update at CPI for 2011 and subsequent years (subject to the productivity adjustment below). (Sec. 3401 of H.R. 3590) Benefit Protection and Simplification. Prohibits MA plans from charging beneficiaries cost sharing for chemotherapy, dialysis services, skilled nursing care, and other designated service that is greater than that charged under FFS Medicare. Effective in 2011. (Sec. 3202 of H.R. 3590) Authority to Deny Plan Bids. Beginning in 2011, authorizes the Secretary to deny bids submitted by MA plans that propose to significantly increase beneficiary cost sharing or decrease benefits. (Sec. 3209 of H.R. 3590) Protections for Frontier States. Starting in FY 2011, for hospitals and physicians located in states in which at least 50% of the counties in the state are frontier (i.e. less than 6 people per square mile), establishes a hospital wage index floor of 1.00, a hospital outpatient department wage adjustment factor floor of 1.00, and a geographic practice expense floor for physician services of 1.00. The 1.00 floor would not apply to hospitals or services in a state that receives a non-labor related adjustment (Alaska and Hawaii). (Sec. 10324 of H.R. 3590) Subsidy-Eligible Individuals under PDPs and MA–PD plans. Allows Part D plans that bid a nominal amount above the regional low-income subsidy (LIS) benchmark to absorb the cost of the difference between their bid and the LIS benchmark in order to remain a $0 premium LIS plan. Authorizes the Secretary to auto-enroll subsidy eligible individuals in plans that waive de minimis premiums. Effective date January 1, 2011. (Sec. 3303 of H.R. 3590)

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DATE	PROVISION
1/1/2011	Establishment of Center for Medicare and Medicaid Innovation within CMS. Establishes within the Centers for Medicare and Medicaid Services (CMS) a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements (models) to improve the quality and reduce the cost of care provided to patients in each program. Appropriates $5 million from the Treasury not otherwise appropriated for the design, implementation, and evaluation of models for DY 2010; and appropriates $10 billion for Center activities over 10 years. (Sec. 3021 of H.R. 3590)
3/23/2011	Advancing Research and Treatment for Pain Care Management. Not later than 1 year after funds are appropriated to carry out this section, the Secretary shall seek to enter into an agreement with Institute of Medicine to convene a conference on pain management. (Sec. 4305 of H.R. 3590) Advancing Research and Treatment for Pain Care Management. Not later than 1 year after the Act's enactment establishes an Interagency Pain Research Coordinating Committee to coordinate all efforts within HHS and other federal agencies that relate to pain research. (Sec. 4305 of H.R. 3590) GAO Study and Report on Medicare Beneficiary Access to High-Quality Dialysis Services. Directs the Comptroller General to submit to Congress, within one year of enactment, a study on the impact on Medicare beneficiary access to high-quality dialysis services of the end stage renal disease prospective payment system. (Sec. 10336 of H.R. 3590)
7/1/2011	Payment Adjustment for Health Care-Acquired Conditions (HACs). Prohibits Federal payments to states for Medicaid services related to HACs. (Sec. 2702 of H.R. 3590) Distribution of Additional Residency Positions. Directs the Secretary to redistribute residency positions that have been unfilled for the prior three cost reports and directs those slots for training of primary care physicians. (Sec. 5503 of H.R. 3590) Treatment of Certain Complex Diagnostic Laboratory Tests. Creates a 2-year demonstration program to test the impact of direct payments for certain complex laboratory tests on Medicare quality and costs. (Sec. 3113 of H.R. 3590) Payment Adjustment for Health Care-Acquired Conditions (HACs). Effective July 1, 2011, prohibits Federal payments to states for Medicaid services related to health care acquired conditions. (Sec. 2702 of H.R. 3590)
9/23/2011	GAO Study to Make Recommendations on Improving the 340B Program. Requires GAO to make recommendations on improvements to the Program with 18 months of the Act's enactment. (Sec. 7103 of H.R. 3590)
9/30/2011	Extension of Gainsharing Demonstration. The Deficit Reduction Act of 2005 authorized a demonstration to evaluate arrangements between hospitals and physicians designed to improve the quality and efficiency of care provided to beneficiaries. This provision would extend the demonstration through September 30, 2011. (Sec. 3027 of H.R. 3590)
10/1/2011	Graduate Nurse Education Demonstration Program. This provision directs the Secretary to establish a demonstration program for up to 5 eligible hospitals to increase graduate nurse education training under Medicare. (Sec. 5509 of H.R. 3590) Revisions to SNF Provisions. Delays the implementation of certain SNF "RUGs-IV" payment system changes by one year. (Sec. 10325 of H.R. 3590) Community First Choice Option. Establishes an optional Medicaid benefit through which States could offer community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require the level of care offered in a hospital, nursing facility, or intermediate care facility for the mentally retarded. (Sec. 2401 and Sec. 1205 of H.R. 3590)

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DATE	PROVISION
10/1/2011	Home Health and SNF Value-Based Purchasing Plan. Due date for consideration. (Sec. 3006 of H.R. 3590)
	2012
1/1/2012	Demonstration Project to Evaluate Integrated Care Around a Hospitalization. Establishes a bundled payment demonstration project under Medicaid in up to 8 states, which will begin on January 1, 2012 and end on December 31, 2016. (Sec. 2704 of H.R. 3590) Independence at Home Demonstration Program. Not later than January 1, 2012, creates a new demonstration program for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system that utilizes physician and nurse practitioner directed home-based primary care teams aimed at reducing expenditures and improving health outcomes. (Sec. 3024 of H.R. 3590) Community Mental Health Centers. Requires community mental health centers that provide at least 40 percent of their services to individuals not eligible for Medicare to meet new requirements for receiving Medicare billing privileges. Effective for items and services furnished on or after the first day of the first calendar quarter that is at least 12 months from the date of enactment. (Sec. 1301 of H.R. 4872) Pediatric ACO Demonstration Project. Establishes a demonstration project from January 1, 2012 to December 31, 2016 for states, which would allow pediatric medical providers who meet certain criteria to be recognized as accountable care organizations (ACOs). (Sec. 2706 of H.R. 3590) Medicare Shared Savings Program. Not later than January 1, 2012, requires the Secretary to establish a shared savings program that would reward ACOs that take responsibility for the costs and quality of care received by their patient panel over time. (Sec. 3022 of H.R. 3590) Productivity Adjustment. Beginning in 2012, implements a full productivity adjustment for inpatient and outpatient hospital services, inpatient psychiatric facilities, inpatient rehabilitation, long term care hospital services, ESRD, and SNFs. (Sec. 3401 of H.R. 3590) Transparency Reports and Reporting of Physician Ownership or Investment Interests. Preempts state law, unless state law is beyond the scope of this section. (Sec. 6002 of H.R. 3590) Prescription Drug Sample Transparency. Not later than April of each year, each drug manufacturer and authorized distributer of record shall submit to the Secretary information with respect to the preceding year on the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed during that year. (Sec. 6004 of H.R. 3590) Demonstration Project to Evaluate Integrated Care Around a Hospitalization. Establishes a bundled payment demonstration project under Medicaid in up to 8 states, which will begin on January 1, 2012 and end on December 31, 2016. (Sec. 2704 of H.R. 3590) Payment Update: Home Health. Requires market basket minus 1%. (Sec. 3401 of H.R. 3590) Payment Update: Hospitals (Inpatient and Outpatient), Inpatient Psychiatric, IRFs, and LTCHs. Requires market basket minus 0.1%. (Sec. 3401 of H.R. 3590) Full Productivity Adjustment. Hospitals (Inpatient and Outpatient), Inpatient Psychiatric, IRFs, LTCHs, SNFs, and ESRD will receive an annual full productivity adjustments (equal to the 10-year moving average of changes in annual economy-wide private nonfarm

A&B Health Care Public Policy Group Health Care Reform Chart

DATE	PROVISION
1/1/2012	business multifactor productivity. (Sec. 3401 of H.R. 3590) Payments to Primary Care Physicians. Requires Medicaid payment for primary care services (including payments for office visits and immunizations) furnished by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine to be reimbursed at 100 percent of the payment rate that applies to such services and physician under Part B in 2013 and 2014. Provides a 100 percent FMAP to states for meeting this requirement. (Sec. 1202 of H.R. 3590) Revisions to the Practice Expense Geographic Adjustment Factor Under the Medicare Physician Fee Schedule. Requires, the Secretary shall, no later than January 1, 2012, to make appropriate adjustments to the practice expense geographic adjustment to ensure accurate geographic adjustments across payment areas. Adjustments made in 2012 would be made without regard to the adjustments made in 2010 and 2011 and in a budget neutral manner. (Sec. 3102 of H.R. 3590) Physician Feedback Program. Requires the Secretary, beginning in 2012, to provide reports to physicians comparing their resource use with that of other physicians or groups of physicians caring for patients with similar conditions. (Sec. 3003 of H.R. 3590) Value-Based Payment Modifier Under the Physician Fee Schedule. Requires the Secretary to establish a value-based payment modifier that provides for differential payment to a physician or a group of physicians under the fee schedule based upon the quality of care furnished compared to cost during a performance period. Not later than January 1, 2012, requires that the Secretary publish the measures of quality of care and costs, the dates of implementation of the payment modifier, and the initial performance period. The Secretary will apply the payment modifier beginning on January 1, 2015. (Sec. 3007 of H.R. 3590) Payment Update: Clinical Labs. Reduces update for clinical laboratories by 1.75 percent in each of 2011-2015. (Sec. 3401 of H.R. 3590) Medicare Advantage Payment. Freezes Medicare Advantage payments. (Sec. 1102 of H.R. 4872) Temporary Improvements to the Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals. Expands the program providing a temporary adjustment to inpatient hospital payments for certain low-volume hospitals (threshold of 1,600 Medicare Part A discharges) through FY2012 and would modify eligibility requirements regarding distance from another facility and number of eligible discharges. (Sec. 3125 of H.R. 3590) Extension of and Revisions to Medicare Rural Hospital Flexibility Program. This provision extends the Flex Grant program through 2012 and will allow Flex Grant funding to be used to support rural hospitals' efforts to implement delivery system reform programs, such as value-based purchasing programs, bundling, and other quality programs. (Sec. 3129 of H.R. 3590) Availability of Medicare Data for Performance Measurement. Effective January 1, 2012, authorizes the release and use of standardized extracts of Medicare Parts A, B and D claims data to qualified entities to measure the performance of providers and suppliers. Requires qualified entities to pay a fee equal to the cost of making the data available, which would be deposited in the Federal Supplementary Medical Insurance Trust Fund. (Sec. 10332 of H.R. 3590)
1/15/2012	Approval Pathway for Biosimilar Biological Products. Not later than January 15, 2012,

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DATE	PROVISION
1/15/2012	Secretary shall revise recommendations to Congress relating to user fees. (Sec. 7002 of H.R. 3590)
3/23/2012	Understanding Health Disparities: Data Collection and Analysis. By not later than 2 years after the Act's enactment, the Secretary shall ensure that any federally conducted or supported health care or public health program, activity or survey collects and reports, to the extent practicable, data on race, ethnicity, primary language, data at the smallest geographic level, and any data deemed appropriate by the Secretary regarding health disparities. (Sec. 4302 of H.R. of 3590) GAO Study and Report on Causes of Action. Within two years of enactment, requires the Comptroller General to submit a study on whether certain provisions of the bill create new causes of action or claims. (Sec. 3512 of H.R. 3590)
5/1/2012	Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals. Not later than May 1, 2012, Secretary is required to audit hospitals to determine whether there are violations of this prohibition. (Sec. 6001 of H.R. 3590 and Sec. 1106 of 4872)
10/1/2012	Hospital Readmissions Reduction Program. Adjusts payments for hospitals paid under the inpatient prospective payment system based upon exceeding certain readmission thresholds. (Sec. 3025 of H.R. 3590) Productivity Adjustment. Implement a full productivity adjustment for hospice providers beginning FY 2013. (Sec. 3401 of H.R. 3590) Approval Pathway for Biosimilar Biological Products. Congress should authorize the collection of user fees. (Sec. 7002 of H.R. 3590) Extension of the Medicare-dependent hospital (MDH) program. Extends the Medicare-dependent hospital program by one year through October 1, 2012. It would also require HHS to study whether certain urban hospitals should qualify for the MDH program. (Sec. 3124 of H.R. 3590) Patient-Centered Outcomes Research Trust Fund. Establishes the Patient-Centered Outcomes Research Trust Fund (PCORTF) to fund the Patient-Centered Outcomes Research Institute and its activities. Transfers from the general funds in the Treasury to the PCORTF the following amounts: $10 million in FY 2010, $50 million in FY 2011, $150 million in FY 2012, and $150 million for FYs 2013 through 2019. From the Medicare Federal Hospital Insurance and the Federal Supplemental Medical Trust Funds and from health insurance and self-insured health plans the following: (1) $1 multiplied by the average number of individuals enrolled in the plans (Medicare, health insurance policies, and self-insured policies) for FY 2013, and; (2) $2 (increased by annual medical inflation after FY 2014) multiplied by the average number of individuals enrolled in the plans for FY 2014 through FY 2019. Fees for health insurance and self-insurance policies would sunset after 2019. (Sec. 6301 of H.R. 3590)
12/31/2012	Study and Report of Effect on Veterans Health Care. Not later than December 31, 2012, directs Secretary of Veterans Affairs to conduct a study on the effect (if any) of the provisions relating to the fees on branded pharmaceutical manufacturers and importers, medical device manufacturers and importers, and health insurance providers on the cost of medical care provided to veterans and veterans' access to medical devices and branded prescription drugs. (Sec. 9011 of H.R. 3590)
2013	
1/1/2013	National Pilot Program on Payment Bundling. Establishes 5-year national voluntary pilot program on payment bundling for hospitals, physicians, and post-acute care providers. (Sec. 3023 of H.R. 3590)

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DATE	PROVISION
1/1/2013	Improving Access to Preventive Services for Eligible Adults in Medicaid. Amends the current Medicaid state option to provide "other diagnostic, screening, preventive, and rehabilitative services." (Sec. 4106 of H.R. 3590) Unearned Income Medicare Contribution. Amends the IRC to include net investment income in the taxable base. (Sec.1402 of H.R. 4872) Imposition of Annual Fee on Medical Device Manufacturers and Importers. Imposes a fee on any person that manufacturers or imports medical devices offered for sale in the U.S. (Sec. 9009 of H.R. 3590 and Sec. 1405 of H.R. 4872) Modification of Itemized Deduction for Medical Expenses. Increases the threshold for the deduction from 7.5 percent of adjusted gross income (AGI) to 10 percent of AGI for regular income tax purposes. (Sec. 9013 of H.R. 3590) Additional Hospital Insurance Tax on High-Income Taxpayers. Increases hospital insurance tax (FICA and SECA) rate by 0.9 percent on individual taxpayers earning over $200,000 and for taxpayers filing jointly that earn over $250,000. (Sec. 9015 of H.R. 3590) Limitation on Health Flexible Spending Arrangements Under Cafeteria Plans. Limits the amount of salary contributions to Health FSAs under a cafeteria plan to $2,500. (Sec. 9005 of H.R. 3590 and Sec. 1403 of H.R. 4872) Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy. Eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees. (Sec. 9012 of H.R. 3590 and Sec. 1407 of H.R. 4872) Offering of Plans in More than One State. By July 1, 2013, requires the Secretary, in consultation with NAIC, to issue regulations on health care choice compacts under which 2 or more States may agree to have 1 or more qualified plans offered in both (or all) States. (Sec. 1333 of H.R. 3590) National Pilot Program on Payment Bundling. Establishes 5-year national voluntary pilot program on payment bundling for hospitals, physicians, and post-acute care providers. (Sec. 3023 of H.R. 3590) Payment Update: Home Health. Requires market basket minus 1%. (Sec. 3401 of H.R. 3590) Payment Update: Hospitals (Inpatient and Outpatient), Inpatient Psychiatric, IRFs, and LTCHs. Requires market basket minus 0.1%. (Sec. 3401 of H.R. 3590) Increasing Medicaid Payment for Primary Care. Requires states to pay primary care physicians the same rate Medicare pays, and fully federally funds any additional state costs. (Sec. 1202 of H.R. 4872) Payment Update: Hospice. Requires market basket minus 0.3%. (Sec. 3401 of H.R. 3590) Full Productivity Adjustment. Hospice, ambulatory services, ambulatory surgical center services, laboratory services and certain DME, will receive an annual full productivity adjustment (equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity. (Sec. 3401 of H.R. 3590) "Give Back" Based on Level of Insured: Hospice. For fiscal years 2013-2019 for hospice, the market basket reduction would be contingent on the level of non-elderly insured population relative to the projection of non-elderly insured at the time of enactment. (Sec. 3401 of H.R. 3590)

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DATE	PROVISION
1/1/2013	Value-Based Purchasing. Creates a value-based purchasing program for Physicians, Hospitals, and Ambulatory Surgical Centers starting in FY 2013 (Sec. 3001 of H.R. 3590) Payments to Primary Care Physicians. Requires Medicaid payment for primary care services (including payments for office visits and immunizations) furnished by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine to be reimbursed at 100 percent of the payment rate that applies to such services and physician under Part B in 2013 and 2014. Provides a 100 percent FMAP to states for meeting this requirement. (Sec. 1202 of H.R. 3590) Physician Compare Website. Requires the Secretary to implement by January 1, 2013 a plan for making available through the Physician Compare website information on physician performance. (Sec. 10331 of H.R. 3590) CMS Actuary Report on Advanced Imaging Services. Requires the CMS Actuary to publish by January 1, 2013 an analysis of whether the total Medicare savings to be produced by these policies over the 2010-2019 period will exceed $3 billion. (Sec. 3135 of H.R. 3590) Payment Update: Clinical Labs. Reduces update for clinical laboratories by 1.75 percent in each of 2011-2015. (Sec. 3401 of H.R. 3590) Medicare Advantage Payment. Medicare Advantage benchmarks based on plan bids and bonus payments for meeting benchmarks (Sec. 1102 of H.R. 4872) Extension of Reasonable Cost Contracts. Extends reasonable cost contracts to January 1, 2013. (Sec. 3206 of H.R. 3590)
3/31/2013	Transparency Reports and Reporting of Physician Ownership or Investment Interests. On the 90th day of each calendar year beginning thereafter, any covered drug, device, biological, or medical supply manufacturer that provides a payment or other transfer of value to a physician or teaching hospital shall submit to the Secretary certain information with respect to the preceding year. (Sec. 6002 of H.R. 3590)
7/1/2013	CO-Ops. Prior to July 1, 2013, requires the Secretary to establish a Consumer Operated and Oriented Plan (CO-OP) program to foster creation of qualified nonprofit health insurance issuers to offer insurance in the individual and small group markets in States where licensed; and to provide grants and loans to assist with start up costs and solvency requirements. (Sec. 1322 of H.R. 3590) Health Care Choice Compacts. By July 1, 2013, requires the Secretary, in consultation with NAIC, to issue regulations on health care choice compacts which will allow multiple States to enter into an agreement under which one or more qualified health plans could be offered in the markets in all such States, but only be subject to the laws of the State in which the plan was written. (Sec. 1333 of H.R. 3590)
2014	
1/1/2014	Elimination of Exclusion of Coverage of Certain Drugs. Removes smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid's excluded drug list. (Sec. 2502 of H.R. 3590) Imposition of Annual Fee on Health Insurance Providers. Imposes an annual fee to any U.S. health insurance provider with respect to health insurance. (Sec. 9010 of H.R. 3590 and Sec. 1406 of H.R. 4872) Establishing Health Insurance Exchanges. Opens health insurance Exchanges in each State to the individual and small group markets. (Sec. 1321 of H.R. 3590)

A&B Health Care Public Policy Group Health Care Reform Chart

DATE	PROVISION
1/1/2014	Reforming Health Insurance Regulations. Implements reforms that prohibit insurance companies from engaging in discriminatory practices that enable them to refuse to sell or renew policies due to an individual's health status. Insurers can no longer exclude coverage for treatments based on pre-existing health conditions. Additionally, limits the ability of insurance companies to charge higher rates due to heath status, gender, or other factors. Premiums can vary only on age (no more than 3:1), geography, family size, and tobacco use. (Sec. 1201, adding Sec. 1254, of H.R. 3590) Individual Tax Credits. Affordability tax credits for individuals and families between 100-400% of poverty (Sec. 1401 and Sec. 1001 of H.R. 4872) Cost-Sharing Subsidies. Cost-sharing subsidies for individuals and families between 100-200% of poverty. (Sec. 1402 of H.R. 3590) Ensuring Coverage for Individuals Participating in Clinical Trials. Requires group and individual plans to cover routine costs of participation in certain clinical trials by qualified individuals. Applies to all clinical trials that treat cancer or other life-threatening diseases. (Sec. 1201, adding Sec. 2709, of H.R. 3590) Plan Certification in Exchange. Health plans seeking certification must submit to the Exchange, State, and Secretary, and make publicly available: claims payment policies; periodic financial disclosures; enrollment and disenrollment data; among other information. (Sec. 1311, of H.R. 3590) No Lifetime or Annual Limits. Prohibits individual and group plans that are required to provide essential health benefits from establishing lifetime or annual limits on the dollar value of benefits for any participant or beneficiary, but for plan years beginning prior to January 1, 2014, allows a plan to establish a restricted annual limit, as defined by the Secretary, on essential benefits. Allows annual or lifetime limits on non-essential benefits. (Sec. 1001, adding Sec. 2711, of H.R. 3590) Promoting Individual Responsibility (Individual Mandate). Requires most individuals to obtain acceptable health insurance coverage or pay a penalty of $95 for 2014, $325 for 2015, $695 for 2016 (or, up to 2.5% of income in 2016), up to a cap of the national average bronze plan premium. Families will pay half the amount for children, up to a cap of up to a cap of $2,250 per family. After 2016, dollar amounts are indexed. If affordable coverage is not available to an individual, they will not be penalized. (Sec. 1501 of H.R. 3590, and Sec. 1002 of H.R. 4872) Elimination of Exclusion of Coverage of Certain Drugs. Removes smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid's excluded drug list. (Sec. 2502 of H.R. 3590) Ensuring Choice through a Multi-State Option. Provides a choice of coverage through a multi-State plan, available nationwide, and offered by private insurance carriers under the supervision of the Office of Personnel Management. (Sec. 1334 of H.R. 3590) Promoting Employer Responsibility (Employer Mandate). Requires employers with 50 or more employees who do not offer coverage to their employees to pay $2,000 annually for each full-time employee over the first 30 as long as one of their employees receives a tax credit. Precludes waiting periods over 90 days. Requires employers who offer coverage but whose employees receive tax credits to pay $3,000 for each worker receiving a tax credit up to an aggregate cap of $2,000 per full-time employee. (Sec. 1512 of H.R. 3590, and Sec. 1003 of H.R. 4872) Requirement to Offer Premium Assistance for Employer-Sponsored Insurance. Effective January 1, 2014, states may offer premium assistance and subsidies to Medicaid

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DATE	PROVISION
1/1/2014	beneficiaries who are offered employer-sponsored insurance if it is cost effective to do so, consistent with current law requirements. (Sec. 2003 of H.R. 3590) Permitting Hospitals to Make Presumptive Eligibility Determinations for All Medicaid Eligible Populations. Effective January 1, 2014, permits all hospitals that participate in Medicaid to make presumptive eligibility determinations in addition to providers currently eligible to do so. (Sec. 2202 of H.R. 3590) Medicaid Coverage for Former Foster Care Children. As of January 1, 2014, requires all individuals under age 26, who have aged out of foster care as of the date of enactment, to receive Medicaid. (Sec. 2004 of H.R. 3590) Providing Health Care Tax Credits. Makes premium tax credits available through the Exchange to ensure people can obtain affordable coverage. Credits are available for people with incomes above Medicaid eligibility and below 400% of poverty who are not eligible for or offered other acceptable coverage. (Sec. 1001 of H.R. 3590) Ensuring Choice through Free Choice Vouchers. Workers who qualify for an affordability exemption to the individual responsibility policy but do not qualify for tax credits can take their employer contribution and join an Exchange plan. (Sec. 10108 of H.R. 3590) Increasing Access to Medicaid. Medicaid eligibility will increase to 133 percent of poverty for all non-elderly individuals to ensure that people obtain affordable health care in the most efficient and appropriate manner. (Sec. 2001 of H.R. 3590) Federal Support for Medicaid. Increases federal support for the Medicaid expansion by requiring the Federal government to pay 100 percent of the cost of covering newly-eligible individuals in 2014, 2015, and 2016 (Sec. 1201 of H.R. 4872). Permitting Hospitals to Make Presumptive Eligibility Determinations. Permits all hospitals that participate in Medicaid to make presumptive eligibility determinations. (Sec. 2202 of H.R. 3590) Medicaid Improvement Fund Recession. Rescinds funds available in the Medicaid Improvement Fund for FY 2014-2018 (Sec. 2007 of H.R. 3590) Standards for Exchange. Requires the Secretary to set standards for establishment and operation of Exchanges, qualified health plans, and reinsurance and risk adjustment programs as soon as practicable, no later than January 1, 2014. (Sec. 1321 of H.R. 3590) Small Business Tax Credit. Implements the second phase of the small business tax credit for qualified small employers. (Sec. 1421 of H.R. 3590) Quality Reporting. Requires quality reporting for LTCHs, IRFs, PPS-Exempt Cancer Hospitals, and Hospice. (Sec. 3004 and 3005 of H.R. 3590) Health Insurance Provider Fee. Imposes an annual, non-deductible fee on the health insurance sector allocated across the industry according to market share. The fee does not apply to companies whose net premiums written are $25 million or less. (Sec. 9010 of H.R. 3590) Payments for FQHCs. Requires qualified health plans to pay for services at FQHCs at rates that are at least as high as rates under Medicaid. (Sec. 1302 of H.R. 3590) Contracting Health Plans. Office of Personnel Management (OPM) must contract with health insurers to offer at least two multi-state qualified health plans (at least one non-profit) through Exchanges in each State. (Sec. 1311 of H.R. 3590)

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DATE	PROVISION
1/1/2014	Rebasing Home Health Payments. Directs the Secretary to improve payment accuracy through rebasing home health payments starting in 2014 and phased in over four years with a 3.5 percent per year limitation on reductions based on an analysis of the current mix of services and intensity of care provided to home health patients. (Sec. 3131 of H.R. 3590) Payment Update: Hospitals (Inpatient and Outpatient), Inpatient Psychiatric, IRFs, and LTCHs. Requires market basket minus 0.3%. (Sec. 1105 of H.R. 4872) "Give Back" Based on Level of Insured. For fiscal years 2014-2019, the market basket reduction would be contingent on the level of non-elderly insured population relative to the projection of non-elderly insured at the time of enactment. (Sec. 3401) Payment Update: Hospice. Requires market basket minus 0.3%. (Sec. 3401 of H.R. 3590) Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment. Requires States to apply spousal impoverishment rules to beneficiaries who receive HCBS. This provision would apply for a five-year period beginning on January 1, 2014. (Sec. 2404 of H.R. 3590) Transitional Reinsurance Program for Individual Market. For 2014, 2015, and 2016, requires each State to contract with a nonprofit reinsurance entity that collects payments from insurers in the individual and group markets and makes payments to such insurers in the individual market that cover high-risk individuals (based on medical condition). (Sec. 1341 of H.R. 3590) Establishment of Risk Corridors for Plans in Individual and Small Group Markets. Requires the Secretary to establish risk corridors for qualified health plans in 2014, 2015, and 2016. (Sec. 1342 of H.R. 3590) Medicaid Disproportionate Share Hospital Payments (DSH) Payments. Applies DSH payment reductions to states beginning in FY 2014. (Sec. 1203 of H.R. 4872) Improvements to the Physician Quality Reporting Initiative. Extends the PQRI program through 2014. For 2011, incentive payments would equal 1.0 percent and 0.5 percent for 2012, 2013, and 2014. (Sec. 3002 of H.R. 3590) Payment Update: Clinical Labs. Reduces update for clinical laboratories by 1.75 percent in each of 2011-2015. (Sec. 3401 of H.R. 3590) Extension for Specialized MA Plans for Special Needs Individuals. Extends the SNP program until 2014. (Sec. 3205 of H.R. 3590) Savings from Limits on MA Plan Administrative Costs. Beginning with contract year 2014, requires MA plans that do not have a medical loss ratio (MLR) of at least 85 percent for a contract year to remit to the Secretary the difference between the plan's MLR and 85 percent; for plans that do not have an 85 percent MLR for 3 consecutive contract years, prevents new enrollment in the plan; requires the Secretary to terminate the plan contract if the plan fails to have an 85 percent MLR for 5 consecutive contract years. (Sec. 1103 of H.R. 3590) Medicare Disproportionate Share Hospital (DSH) Payments. Reduces Medicare DSH payments as the number of uninsured patients is reduced, effective FY 2014. (Sec. 1104 of H.R. 4872)
1/15/2014	Independent Payment Advisory Board. Creates a 15-member Independent Payment Advisory Board (IPAB) tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. The

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DATE	PROVISION
1/15/2014	IPAB would be tasked with presenting proposals to the President by January 15 of each year (beginning with 2014) except in years in which the CMS Actuary determines that the Medicare per capita growth rate does not exceed the target per capita growth rate, or the projected percentage increase in the medical care category of the CPI is less than the projected increase in CPI-U, or (for 2019 or subsequent years) the per capita growth rate for national health expenditures exceeds the Medicare per capita growth rate. The manager's amendment requires the board to send proposals to the Congress at the same time they are sent to the President. Proposals submitted prior to December 31, 2018 shall not include any recommendation that would reduce payment rates for items and services furnished before December 31, 2019 by providers of services and suppliers scheduled under the PPACA to receive a reduction to the inflationary payment updates in excess of a reduction due to productivity. (Sec. 3403 of H.R. 3590)
2015	
1/1/2015	Productivity Adjustment. Implements a full productivity adjustment for home health providers. (Sec. 3401 of H.R. 3590) Payment Update: Hospice. Requires market basket minus 0.3%. (Sec. 3401 of H.R. 3590) Payment Update: Hospitals (Inpatient and Outpatient), Inpatient Psychiatric, IRFs, and LTCHs. Requires market basket minus 0.2% (Sec. 3401 of H.R. 3590) Full Productivity Adjustment. Home Health. (Sec. 3401 of H.R. 3590) Payment Adjustment for Conditions Acquired in Hospitals. Starting in FY 2015, hospitals in the top 25th percentile of rates of hospital acquired conditions for certain high-cost and common conditions would be subject to a payment penalty under Medicare. (Sec. 3008 of H.R. 3590) Physician Compare Website. Requires the Secretary to report to Congress on the Physician Compare website by January 1, 2015. (Sec. 10331 of H.R. 3590) Payment Update: Clinical Labs. Reduces update for clinical laboratories by 1.75 percent in each of 2011-2015. (Sec. 3401 of H.R. 3590) Independent Payment Advisory Board. Requires the GAO, by July 1, 2015, to conduct a study on the effect of the IPAB's proposals. Specifically, the study would assess the effect of the IPAB's proposal on Medicare beneficiaries' access to providers, affordability of premiums and cost-sharing, and quality of care provided. Subsequent studies would be required. (Sec. 3403 of H.R. 3590)
9/30/2015	CHIP-Related Provisions. Extends the current reauthorization period of CHIP for two years, through September 30, 2015. (Sec. 10203 of H.R. 3590)
10/1/2015	CHIP Federal Financial Participation. CHIP Federal Matching Rate increased through FY 2019. (Sec. 2101 of H.R. 3590).
12/31/2015	Medicaid Payments. Changes the date through which states that have already undertaken a Medicaid expansion (i.e., an "expansion state"), will not receive any payments for newly eligible individuals, and have not been approved by the Secretary to divert DSH payments to the costs of providing medical assistance or other health benefits under a waiver in effect as of July 2009, will receive an increased FMAP of 2.2 percent from September 30, 2019 to December 31, 2015. (Sec. 1201 of H.R. 4872)
2016	
1/1/2016	National Pilot Program on Payment Bundling. Secretary may expand scope and duration of national voluntary pilot program. (Sec. 3023 of H.R. 3590) Payment Update: Hospice. Requires market basket minus 0.3%. (Sec. 3401 of H.R. 3590).

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DATE	PROVISION
1/1/2016	Payment Update: Hospitals (Inpatient and Outpatient), Inpatient Psychiatric, IRFs, and LTCHs. Requires market basket minus 0.2% . (Sec. 3401 of H.R. 3590) Pilot Programs for Value-Based Purchasing for IRFs, Psychiatric Hospitals, LTCHs, Cancer Hospitals, and Hospice The manager's amendment contains a new provision that would implement VBP pilot programs, beginning in 2016, for IRFs, LTCHs, psychiatric hospitals, cancer hospitals, and hospice providers. The HHS Secretary could expand the duration and scope of the pilot programs beginning in 2018. (Sec. 10326 of H.R. 3590). Employer Size for Small Group. Allows states to cap small employers at 50 employees for years prior to 2016. (Sec. 1304 of H.R. 3590) Additional Federal Financial Participation for CHIP. For the period beginning FY 2016 through FY 2019, increases the FMAP for each state by 23 percent, but in no case will the state match exceed 100 percent. State CHIP MOE must continue from the date of enactment through September 30, 2019. (Sec. 2101 of H.R. 3590) DMEPOS Competitive Acquisition Program. Expands round 2 of the DME Competitive Bidding program to the next 21 largest metropolitan statistical areas. For competitively bid covered items furnished on or after January 1, 2016, areas must either competitively bid or use competitive bid prices. (Sec. 6410 of H.R. 3590)
9/30/2016	Money Follows the Person Rebalancing Demonstration. Extends the Money Follows the Person Rebalancing Demonstration through September 30, 2016 and changes the eligibility rules for individuals to participate in the demonstration project by requiring that individuals reside in an inpatient facility for not less than 90 consecutive days. (Sec. 2403 of H.R. 3590)
12/31/2016	State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation. MedPAC and MACPAC shall conduct independent reviews of the alternatives to current tort litigation implemented by the states and submit reports to Congress not later than December 31, 2016. (Sec. 10607 of H.R. 3590)
2017	
1/1/2017	Waiver for State Innovation. Allows States to apply for a waiver of certain requirements for plans offered within the State for plan years beginning on or after January 1, 2017. Waivers could be for up to 5 years for requirements relating to qualified health plans, Exchanges, cost-sharing reductions, tax credits, the individual responsibility requirement, and shared responsibility for employers. (Sec. 1332 of H.R. 3590) Payment Update: Hospice. Requires market basket minus 0.3% (Sec. 3401 of H.R. 3590). Payment Update: Hospitals (Inpatient and Outpatient), Inpatient Psychiatric, IRFs, and LTCHs. Requires market basket minus 0.75%. (Sec. 3401 of H.R. 3590). Large Group Coverage. Allows States to allow large group coverage to be offered through the Exchange beginning in 2017. (Sec. 1312 of H.R. 3590) Medicaid. Increases federal support for the Medicaid expansion by requiring the Federal government to pay 95 percent in 2017. (Sec. 1201 of H.R. 3590)
10/17/2017	Graduate Nurse Education Demonstration Program. Secretary shall report on the nurse education demonstration program. (Sec. 5509 of H.R. 3590)
2018	
1/1/2018	Excise Tax on High Cost Employer-Sponsored Health Insurance. Imposes an excise tax on insurers if aggregate value of employer-sponsored health coverage for an employee exceeds a threshold amount. (Sec. 9001 of H.R. 3590 and Sec. 1401 of H.R. 4872)

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DATE	PROVISION
1/1/2018	Payment Update: Hospice. Requires market basket minus 0.3% (Sec. 3401 of H.R. 3590). Payment Update: Hospitals (Inpatient and Outpatient), Inpatient Psychiatric, IRFs, and LTCHs. Requires market basket minus 0.75% . (Sec. 3401 of H.R. 3590). Medicaid. Increases federal support for the Medicaid expansion by requiring the Federal government to pay 94 percent in 2018. (Sec. 1201 of H.R. 3590)
2019	
1/1/2019	Payment Update: Hospice. Requires market basket minus 0.3%. (Sec. 3401 of H.R. 3590). Payment Update: Hospitals (Inpatient and Outpatient), Inpatient Psychiatric, IRFs, and LTCHs. Requires market basket minus 0.75%. (Sec. 3401 of H.R. 3590). Medicaid. Increases federal support for the Medicaid expansion by requiring the Federal government to pay 93 percent in 2019. (Sec. 1201 of H.R. 3590) Physician Compare Website. Allows the Secretary to establish a demonstration program and, by January 1, 2019, to provide financial incentives to beneficiaries who are furnished services by high-quality physicians (determined based on the above performance measures). (Sec. 10331 of H.R. 3590)
2020	
1/1/2020	Independent Payment Advisory Board. Beginning in 2020, the manager's amendment requires the board to make binding biennial recommendations to Congress if the growth in overall health spending exceeds growth in Medicare spending; such recommendations would focus on slowing overall health spending while maintaining or enhancing beneficiary access to quality care under Medicare. (Sec. 3403 of H.R. 3590)

Acronyms used in the above chart are defined as follows:

ACO - Accountable Care Organization
AHRQ - Agency for Healthcare Research and Quality
AMP - Average Manufacturer Price
CDC - Centers for Disease Control and Prevention
CHIP – Children's Health Insurance Program
CMP - Civil Money Penalty
CO-OP - Consumer Operated and Oriented Plan
CPI - Consumer Price Index
DMEPOS - DME, Prosthetics, and Supplies
ERISA - Employee Retirement Income Security Act
Early and Periodic Screening, Diagnostic, and Testing
FDA - Food and Drug Administration
FEHBP - Federal Employees Health Benefits Program
FMAP - Federal Medical Assistance Percentage
FPL – Federal Poverty Level
GAO - Government Accountability Office
HSA - Health Savings Account
HHS - Health and Human Services
HCFAC- Health Care Fraud and Abuse Control Account
HRSA - Health Resources and Services Administration
HIT – Health Information Technology
IRS - Internal Revenue Service
LIS - Low-Income Subsidy
MCO - Managed Care Organizations
MCC - Minimum Creditable Coverage

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MSA - Metropolitan Statistical Areas
NIH - National Institutes of Health
PAC – Post-Acute Care
PQRI - Physician Quality Reporting Initiative
PHSA - Public Health Service Act
RHQDAPU - Reporting Hospital Quality Data for Annual Payment Update
SAMHSA - Substance Abuse and Mental Health Services Administration
SNPs - Special Needs Plans
VBP - Value-Based Purchasing