Timeline for Health Care Reform Implementation

Patient Protection and Affordable Care Act (H.R. 3590) and the Reconciliation Bill (H.R. 4872)

April 8, 2010

Color Code: Hospitals Insurance Coverage Other/Workforce Delivery System

2010

Expands the RAC program to include audits of Medicare Parts C and D, and by Dec. 31, 2010, audits of Medicaid.

Eliminates the exception for physician-owned hospitals under the Stark law. Grandfathers in providers with Medicare agreements in place before Dec. 31, 2010. Limits future growth.

Extends Section 508 hospital reclassification until Sept. 30, 2010.

Expands 340B drug discounts on outpatient drugs for certain children's and cancer hospitals, CAHs, SCHs and Rural Referral Centers.

Reduces Medicare inpatient, outpatient, IRF, LTCHs and psychiatric hospital payments by 0.25%.

Sets new requirements for nonprofit hospitals, including periodic community needs assessments.

Extends rural hold harmless payments Dec. 31, 2010, for all SCHs.

Requires health insurance companies to submit justification for unreasonable premium increases to states and to post online.

Prohibits all employer plans and new health plans from denying children coverage based on pre-existing conditions.

Eliminates co-payments for preventive services and exempts preventive services from Medicare deductibles.

Provides tax credit of up to 35% of paid premiums to small businesses.

Requires new health plans to cover preventive services.

Bans rescission practices and lifetime limits.

Extends coverage to those up to age 26 through parents' insurance.

Restricts use of annual limits on coverage.

Provides a $250 rebate to Medicare beneficiaries who hit the "doughnut hole."

Establishes interim health plan for companies with early retirees age 55-64.

Establishes interim high-risk pool for the uninsured.

Establishes a National Health Care Workforce Commission to provide recommendations to Congress on aligning health care workforce resources.

Expands health professional loan repayment and scholarship programs.

Establishes a Patient-Centered Outcomes Research Institute to support comparative effectiveness research.

Enhances elimination of Medicare fraud efforts.

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2011

Adjusts Medicare payments according to study on outpatient costs for PPS-exempt cancer hospitals.

Requires HHS Secretary to submit recommendations for reforming Medicare Area Wage Index.

Prevents Medicaid payments to be used to pay for HACs.

Reduces Medicare inpatient, outpatient, IRF, psychiatric hospitals' market basket by 0.25%; LTCHs by 0.5%.

Extends reasonable cost payment for clinical diagnostic lab services for rural hospitals with fewer than 50 beds to July 1, 2011.

Extends the Medicare Dependent Hospital classification for one additional year, through Sept. 30, 2012

Requires hospitals to publish a list of standard charges for items/services, including DRGs.

Requires all health plans to report annually on the share of premiums spent on medical care and rebate beneficiaries where less than 80-85% of dollars are used for benefits.

Provides free annual wellness visit and personalized prevention plan for Medicare beneficiaries.

50% discount on all brand-name drugs in the "doughnut" hole; begins phasing-in additional discounts on brand-name and generic drugs.

Expands Medicaid eligibility to all people under 133% of FPL; voluntary until 2014.

Requires new health plans to cover preventive services with little/no cost sharing. Incentives for Medicaid to cover evidence-based preventive services with no cost sharing. Requires Medicaid to cover tobacco cessation services for pregnant women.

Redistributes unused residency slots, 75% of which must be used for general surgery or primary-care slots.

Provides 10% Medicare bonus payment for primary care M.D.s, general surgeons.

Expands nursing, primary care training programs and expands scholarships/loan repayments for PCPs in underserved areas.

Gainsharing demonstration project expires, but $1.6 million in funds available until 2014.

Establishes the Community Care Transitions Program for high-risk Medicare beneficiaries.

Requires HHS Secretary to give additional Medicare funds to lowest cost counties in the country.

Establishes an Innovation Center within CMS to test and evaluate various payment structures and methodologies.

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2012

Extends Medicare Dependent Hospital classification through Sept. 30, 2012.

Begins implementation of RUGs-IV payment changes for SNFs.

Extends Medicare rural hospital FLEX program through 2012.

Reduces Medicare inpatient, outpatient, IRF, psych, LTCHs payments by 0.10%, plus an additional "productivity adjustment" estimated at 1.3%.

Increases funds for nursing and allied health professionals' loan repayment programs.

Establishes a Medicare value-based purchasing program for inpatient hospitals and reporting begins.

Begins voluntary ACO payment program.

2013

Reduces Medicare inpatient, outpatient, IRF, psych, LTCHs payments by 0.10%, plus an additional "productivity adjustment" estimated at 1.3%. Hospice providers' productivity reductions begin.

Employer mandate effective March 1, 2013. Penalties assessed for failure to provide affordable coverage.

Provides states with an FMAP increase of 23% to accommodate transition from CHIP to the exchanges. Effective Oct. 1, 2013 through Sept. 30, 2019.

Establishes a 2.3% excise tax on medical devices.

Establishes Physician Compare Web site with Medicare data comparing physicians on quality and patient experience.

Medicare VBP program for inpatient hospitals adjusts 1% of payment according to data collection and reporting on five medical conditions.

Reduces payments for hospitals with "higher-than-expected" readmissions rates for specific conditions; maximum reduction is 1%.

Requires Medicaid payment to primary care M.D.s be at least 100 percent of Medicare payment rates in 2013 and 2014.

Simplifies administrative burdens by standardizing electronic exchange of health information.

Begins voluntary bundled payment pilot program. Includes payment for 10 conditions.

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2014

Establishes quality and efficiency measures for PPS-exempt cancer hospitals to report. Noncompliance results in a reduction in the market basket update.

Reduces inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by 0.3% plus "productivity" adjustment.

Begins reduction in Medicaid DSH payments, based on uninsured population and uncompensated care, excluding bad debt.

Extends Rural Community Hospital Demonstration Project through Dec. 31, 2014.

Begins reduction in Medicare DSH payments; 75% of reductions tied to coverage targets.

Implements Medicare pay-for-reporting programs for LTCHs, IRF, inpatient psych and hospice providers. Noncompliance results in 2% reduction in market basket updates.

Health plans must accept every employer/individual who applies; must renew/continue coverage for all members. No waiting period >90 days.

Requires HHS to implement quality reporting for ASCs, LTCHs, IRF, inpatient psych, PPS-exempt cancer hospitals and hospice providers to lead to VBP.

Health plans may not discriminate based on health status of applicant.

Health plans must cover participation in clinical trials.

Group plan deductibles capped at $2,000 for individuals and $4,000 for others, subject to cost-of-living adjustments going forward.

Begins state Health Benefits Exchanges.

Imposes an annual, non-deductible fee on the health insurance sector according to market share; those with net premiums of $25 million or less are exempt.

Establishes multi-state plan available from nationwide health plans.

Provides tax credit up to 50% of premiums to small businesses.

Provides 100% federal funding for costs associated for Medicaid "newly eligibles" up to 133% FPL through 2016.

Begins individual mandate for health insurance.

Establishes Independent Payment Advisory Board to submit recommendations to Congress on reducing Medicare spending. Hospitals receiving productivity adjustments are exempt from board proposals through 2019. CAHs are not exempt.

Reduces payments for hospitals with "higher-than-expected" readmissions rates for specific conditions; maximum reduction is 1%.

Expands inpatient hospitals Medicare VBP program to include more conditions and efficiency measures, including spending per beneficiary. Adjusts payments by 1.25%.

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2015

Reduces Medicare inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by 0.2%, plus "productivity" adjustment.

Provides 100% federal funding for costs associated for Medicaid "newly eligibles" through 2016.

Provides hospitals in the worst 25th percentile of certain HAC rates with a 1% Medicare payment reduction.

Expands readmission policy to include more conditions. Maximum reduction in payments to hospitals with higher-than-expected readmissions rate increases to 3%.

Establishes mandatory physician quality reporting with 2% reduction in payments by 2016 for non-compliance.

Expands inpatient hospitals' VBP program payment adjustments to 1.5%

2016

Reduces Medicare inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by 0.2% plus "productivity" adjustment.

Provides 100% federal funding for costs associated for Medicaid "newly eligibles" through 2016.

Allows Medicare VBP program to adjust inpatient hospitals' payments by 1.75%. Establishes VBP pilot programs for psych, LTCH, IRF and cancer hospitals and hospice programs.

Expands bundled payment program after Jan. 1, 2016, according to HHS Secretary's plan.

2017

Reduces Medicare inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by 0.75% plus "productivity" adjustment.

Allows employers with more than 100 employees to enter the exchanges at the discretion of the state.

Reduces federal funding for costs associated with Medicaid "newly eligibles" to 95% of costs.

Allows Medicare VBP program to adjust payments by 2%.

2018

Reduces Medicare inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by 0.75% plus "productivity" adjustment.

Reduces federal funding for costs associated with Medicaid "newly eligibles" to 94%.

An excise tax is imposed on high cost employer-provided health plans.

2019

Reduces Medicare inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by 0.75%, plus "productivity" adjustment.

Reduces federal funding for costs associated for "newly eligibles" in Medicaid to 93%.

2020

Reduces federal funding for costs associated with "newly eligibles" in Medicaid to 90%.

This information is based on THA DataGen's initial analysis of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Affordability Reconciliation Act of 2010. Further analysis may result in updates and modifications; check the Texas Hospital Association's Web site at www.tha.org for the most current information.

Note: Unless otherwise noted, dates are for the calendar year. For example, federal fiscal year 2012 begins Oct. 1, 2011.

Glossary

CAH — Critical Access Hospital
CMS — Centers for Medicare & Medicaid Services
DSH — Disproportionate-Share Hospital
FMAP — Federal Medical Assistance Percentage
FPL — Federal Poverty Level
HAC — Hospital-Acquired Condition
IRF — Inpatient Rehabilitation Facility
LTCH — Long-Term-Care Hospital
PPS — Prospective Payment System
RAC — Recovery Audit Contractor
SCP — Sole Community Hospital
VBP — Value-Based Purchasing