TMA'S Health REFORM School

Texas Medical Association
Physicians Caring for Texans

Health System Reform Timeline for Provisions Effective in 2011

Mar. 23, 2010	President Obama signed the Patient Protection and Affordable Care Act to reform the nation's health care system into law. The following timeline summarizes what the law's key provisions do and their effective dates.	
Provisions effective in 2011		
Insurance Reforms		
Jan. 1, 2011	**Medical loss ratio (MLR) rebate**	Require health plans to report the amount of premium dollars spent on items other than direct medical care. By 2011, large group plans must have an MLR of 85 percent, individual and small group plans 80 percent. If health plans fall below the minimum required MLR, they must provide a rebate to enrollees, unless they have been granted a waiver by the Department of Health and Human Services. States now are adopting regulations for certain exemptions from the MLR requirement.
Jan. 1, 2011	**Prohibit discrimination**	Prohibit health insurers from limiting eligibility for coverage based on wages or salaries of full-time employees.
Jan. 1, 2011	**Health insurance guidelines**	Require the Department of Health and Human Services (HHS) secretary to develop reporting guidelines for health plans on benefits and provider payment structures that: • Improve health outcomes through implementing quality reporting, case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of medical homes model; • Implement activities to prevent readmission into hospitals through discharge planning and post-discharge reinforcement; • Implement activities to improve patient safety and reduce medical errors; and • Implement wellness and health promotion. Guidelines must be completed by March 23, 2012.
January 2011	**Premium review**	Establish a process for the annual review of unreasonable premium increases (beginning with 2010 plan year).
March 23, 2011	**Standard definitions**	Require HHS secretary to develop standards for insurers to follow in giving enrollees summaries of benefits and coverage explanations that accurately describe the coverage provided.

Medical Liability		
Begin FY 2011	**State demonstration projects**	Provide five-year grants for states projects to develop, implement, and evaluate alternative medical liability models.
Medicare		
January 2011	**Medicare fee schedule adjustments**	www.texmed.org/uploadedFiles/Governmental_Affairs/U.S._Congress/HealthReformSchoolMedicare.pdf
January 2011-15	**Increased Medicare payments for primary care physicians and general surgeons**	Allow for a 10-percent Medicare bonus payment to primary care physicians (those specializing in family medicine, internal medicine, geriatrics, or pediatrics) who treat Medicare patients. To qualify, physicians' Medicare charges for office, home health, and nursing facility visits must be at least 60 percent in primary care. A 10-percent Medicare bonus payment also is established for general surgeons practicing in health professional shortage areas (HPSAs). This bonus is in addition to existing bonuses for physicians practicing in shortage areas; it begins in 2011 and lasts through 2015.
Jan. 1, 2011	**Preventive services**	Remove cost sharing for annual comprehensive preventive visits in addition to preventive physical exams. Some of the screenings covered include mammography, pelvic exams, and screenings for colorectal and prostate cancer.
Jan. 1, 2011	**Prescription drug discounts**	Require pharmaceutical manufacturers to provide a 50-percent discount on brand-name prescriptions filled in the Medicare Part D coverage gap. Also begin phasing in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.
Jan. 1, 2011	**Restructure Medicare Advantage plan payments**	Restructure payments to Medicare Advantage plans by setting payments to different percentages of Medicare fee-for-service rates.
Jan. 1, 2011	**Medicare Advantage cost-sharing restrictions**	Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program.
Jan. 1, 2011	**CMS Innovation Center**	Create an Innovation Center within the Centers for Medicare & Medicaid Services (CMS) to test, evaluate, and expand new health care delivery payment structures and methodologies for Medicare and Medicaid.
Jan. 1, 2011	**Restrictions on physician-owned hospitals**	Restrictions on physician ownership of specialty hospitals: new requirements for meeting exception for physician ownership of hospital effective 18 months after enactment; to qualify for exception the physician ownership or investment and provider agreement must be in place by Dec. 31, 2010.

Medicaid/CHIP		
Jan. 1, 2011	**Increased Medicaid matching funds for preventive services**	Increase federal Medicaid matching funds by 1 percent for states that provide Medicaid coverage and remove cost sharing for preventive health services recommended by the U.S. Preventive Services Task Force as well as adult immunizations recommended by the Advisory Committee on Immunization Practices (ACIP). Texas expanded preventive health coverage for adult Medicaid enrollees in January 2010. The policy doesn't cover all immunizations recommended by ACIP. For more information, visit www.tmhp.com.
Jan. 1, 2011	**Medicaid plan option for persons with chronic conditions**	Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90-percent federal medical assistance for two years for health home-related services including care management, care coordination, and health promotion.
Jan. 1, 2011	**Healthy lifestyle incentives to prevent chronic conditions in Medicaid patients**	Establish a five-year grant for states to develop evidence-based comprehensive programs that reward Medicaid patients for adopting healthy lifestyles, such as weight management, smoking cessation, and diabetes management.
July 1, 2011	**Community First Choice Option**	Establish the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities.
July 1, 2011	**Health care-acquired conditions**	Prohibit federal Medicaid payments for payment of hospital-acquired conditions as determined by the HHS secretary. Texas is in the process of implementing rules to deny payment for certain "never events."
Sept. 1, 2011	**Tobacco cessation coverage**	Require all state Medicaid programs to provide coverage of comprehensive tobacco cessation services for pregnant women. Texas currently covers most tobacco cessation prescription drugs but not counseling.
Oct. 1, 2011	**State Balancing Incentive Program**	Create the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase noninstitutionally based, long-term care services.
Prevention and Wellness		
~~March 23, 2011~~	**Nutritional disclosure by chain restaurants/ vending machines**	Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. Restaurants are required to publish nutrition information on their menus, including calories, fat, and salt content. The government has stated it will not enforce this provision until the middle of 2012.
Mar. 23, 2011	**National Prevention, Health Promotion, and Public Health Council**	Establish the National Prevention, Health Promotion, and Public Health Council to develop a national strategy to improve the nation's health.

Sept. 1, 2011	**Grants for wellness programs**	Provide grants for up to five years to small employers who establish wellness programs.
Oct. 1, 2011	**School-based health centers**	Grant funding to support school-based health centers, with preference to centers with a large population of children eligible for Medicaid or the Children's Health Insurance Program. Comprehensive care includes physical assessments of minor, acute, and chronic medical conditions; mental health and substance use disorder assessments; crisis intervention; and the like.
Quality and Reporting (effects on physicians)		
Jan. 1, 2011	**Collaborative Care Network Program**	Establish a community-based Collaborative Care Network Program to support consortiums of health care providers who coordinate and integrate health care services for low-income, uninsured, and underinsured populations.
Jan. 1, 2011	**PQRS bonuses**	Provide bonuses for the Physician Quality Reporting System (PQRS) starting in 2011 through 2014, with 1-percent bonus in 2011 and 0.5-percent bonus in 2012, 2013, and 2014. Establish a new PQRS option allowing physicians to submit data to the PQRS through a maintenance of certification (MOC) program, with additional PQRS 0.5-percent bonus payment for three years (2011-14). Also establish informal appeals process for determining successful participation in PQRI. The current 2010 incentive payment for satisfactorily reporting PQRS measures is 2 percent. In 2011, the incentive payment drops to 1 percent, and for 2012, 2013, and 2014, the incentive payment drops to 0.5 percent. In 2015, a penalty of -1.5 percent will be applied to eligible professionals who did not satisfactorily report, and in 2016 and forward a -2.0-percent penalty will be assessed. Feedback to eligible professionals on their reporting performance must happen in a timely fashion.
Mar. 23, 2011	**Quality improvement strategy**	Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health.
June 30, 2011	**Need to act now to avoid e-prescribing penalties in 2012**	Eligible physicians who do not report successful e-prescribing on their claims and have not received an exemption will be penalized 1 percent of Medicare Part B claims in 2012. To avoid the 1-percent penalty in 2012 — by June 30 — physicians must e-prescribe successfully and report via claims using the G-code 8553 on at least 10 Medicare encounters.
Oct. 1, 2011	**Community health center funding**	Increase funding by $11 billion for community health centers over five years; establish new programs to support school-based health centers and nurse-managed health clinics.
Dec. 31, 2011	**Need to act now to earn 2012 e-prescribing bonus and avoid penalties in 2013.**	Physicians who report 25 claims by Dec. 31 2011 using the G-code 8553 will be eligible for the 1-percent 2012 bonus and avoid the 1.5-percent penalty in 2013.
By January 2012	**Episode groupers**	Develop episode groupers (combines separate but clinically related items and services into an episode of care for an individual). Details of the episode groupers will be made public. In addition, reports comparing patterns of resource use of individual physicians with patterns of other physicians will be made available in 2012. Adjustments to the reports will be made to account for differences in socioeconomic and demographic characteristics, ethnicity, and health status of individuals. The methodology will be made available to the public. The law does not allow for administrative or judicial review.

Tax Implications		
Jan. 1. 2011	**Health savings accounts (HSAs)**	Increase the tax on distributions from a HSA or an Archer medical savings account that are not used for qualified medical expenses to 20 percent of the disbursed amount.
Jan. 1, 2011	**W-2 reporting**	Require employers to disclose the value of all tax-excluded health benefits on employees' W-2 forms. This is optional in 2011 but will be required in 2012.
Jan. 1, 2011	**Medical expense exclusions**	Prohibit costs for over-the-counter drugs from being reimbursed through a health reimbursement account or flexible spending account and from being reimbursed on a tax-free basis through an HSA or Archer medical savings account unless the patient has a prescription.
Workforce		
July 1, 2011	**HPSA methodology**	Require HHS secretary to establish an updated comprehensive methodology and criteria for designating medically underserved populations and health professional shortage areas.
By July 1, 2011	**GME training slots**	Increase graduate medical education (GME) training positions, with priority for primary care and general surgery, by reallocating up to 65 percent of currently unused Medicare GME slots. Priority will go to states with greater needs, e.g. the lowest resident physician-to-population ratios. This provision is expected to have minimal impact with fewer than 300 slots for the entire United States.
FY 2011	**Reauthorize funding for preventive medicine and public health training**	Provide for continuation of federal support for preventive medicine and public health GME programs, two types of programs that Medicare-funded GME typically does not include.
Oct. 1, 2011	**National Health Service Corps scholarship and loan repayment program**	Authorize increased funding for the National Health Service Corps scholarship and loan repayment program.