

Health Care Reform Implementation Timeline: Selected Dates

2010

Expansion of the Recovery Audit Contractor (RAC) Program – Expands the RAC program to Medicaid and Medicare Parts C and D. The contracts between states and RACs and RACs for Medicare Parts C and D are to be in place by December 31, 2010.

Stronger Screening Process for Revalidation of Enrollment in Health Care Programs – Requires the Department of Health and Human Services to develop a new, stronger screening process for providers enrolling in Medicare, Medicaid and CHIP. The requirements include licensure checks, and may include criminal background checks, fingerprinting, unannounced site visits, database checks and other screening that the HHS deems appropriate. These procedures will apply to revalidation of enrollment beginning September 2010.

Disclosure Requirements for In-Office Ancillary Services – Requires providers referring services for certain advanced imaging (MRI, CT, PET) under the in-office ancillary services exception to give written notice to each patient at the time of the referral stating that the patient may obtain the advanced imaging services from a different supplier. The provision requires providers to also give the patient a list of other suppliers in the area where the patient lives. This provision is retroactively effective on January 1, 2010.

Self-Referral Disclosure Protocol – Requires the Department of Health and Human Services (HHS) to develop a Self-Referral Disclosure protocol by September 23, 2010. HHS is now authorized to reduce the amount owing for Stark violations and is instructed to consider three factors in determining whether to reduce the amount: (1) the nature and extent of the improper or illegal practice; (2) the timeliness of such self-disclosure; (3) the cooperation in providing additional information related to the disclosure.

Failure to Pay Overpayments Is a Violation of the False Claims Act – Demands providers to report and return all overpayments and explain the reason for the overpayment. Failure to do so within 60 days of discovering the overpayment creates a violation of the False Claims Act. This was effective beginning on March 23, 2010.

Small Business Tax Credit – Initiates the first phase of the small business tax credit for employers that provide health insurance for employees. The employers must have no more than 25 employees with average annual wages of less than \$50,000.

New Office within the Centers for Medicare and Medicaid Services – Improves care coordination for dual eligibles through the creation of a new office within the Centers for Medicare and Medicaid Services, the Federal Coordinated Health Care Office.

Physician-owned Hospitals - Bans new physician-owned hospitals in Medicare, requiring hospitals to have a provider agreement in effect by December 31, 2010 and limits the growth of certain grandfathered physician-owned hospitals.

Tax Relief for Health Professionals with State Loan Repayment – Excludes from gross income payments that are made under any state loan repayment or loan forgiveness program that is intended to provide for the increased access of health care services in underserved areas.

Assisting the Future Health Care Workforce – Expands and improves low-interest student loan programs, scholarships, and loan repayments for health students and professionals to increase and enhance the capacity of the workforce to meet patients' health care needs.

Quality Improvement – Supports comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute.

2011

Increase Medicare Reimbursement to Certain Health Care Professionals – Provides a 10% Medicare bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas.

Physician Quality Reporting – Requires Medicare to launch a Physician Compare website where beneficiaries can compare measures of physician quality and patient experience.

Stronger Screening Process for New Provider Enrolling in Health Care Programs – As referenced above, the Department of Health and Human Services is required to develop a stronger screening process for providers enrolling in Medicare, Medicaid, and CHIP. Beginning on March 23, 2011 these stronger screening procedures will apply to new providers attempting to enroll in those health care programs.

Market Basket Updates – Reduces annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity.

Extending Payment Protections for Rural Providers – Extends Medicare payment protections for small rural hospitals, including hospital outpatient services, lab services, and facilities that have a low-volume of Medicare patients, but play an important role in their communities.

Access to Emergency Care – Establishes a new trauma center program to strengthen emergency department and trauma center capacity.

Increase Funding to Community Health Centers – Improves access to care by increasing funding by \$11 billion for community health centers and the National Health Service Corps over five years and establishes new programs to support school health centers and nurse-managed health clinics.

Grants to Small Employers – Provides grants for up to five years to small employers that establish wellness programs.

Innovation Center at the Centers for Medicare and Medicaid Services – Creates an Innovative Center within the Centers for Medicare and Medicaid Services with the task to test innovative payment and service delivery models to reduce health care costs and enhance the quality of care provided to individuals.

CLASS Act - Establishes a national, voluntary insurance program for purchasing community living assistance services and support (CLASS). All working adults will be automatically enrolled, unless they opt out, through payroll deductions that, after five years, will qualify them for monthly payments toward services to help them stay at home should they become disabled.

Beyond December 31, 2011

Medicare Value Based Purchasing – Authorizes Medicare to reward hospitals that provide higher quality or better patient outcomes.

Accountable Care Organizations – Allows providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.

Quality Improvement Through Data Collection – Requires enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.