

PPACA Summary

Marci Krop Cook, MD

Title 1 Insurance Reforms
Mandate – individual
employer

- Sec. 2711 Insurance Companies (private)
- no lifetime dollar limits
 - no unreasonable annual dollar limits
- } -applies only to essential benefits
-grandfathered plans excluded
- Sec. 2712 Cannot rescind coverage except for fraud
- Sec. 2713 No cost sharing (deductible, coinsurance, copay) for
- specified preventives
 - immunizations
- Sec. 2714 Must cover unmarried dependents to age 26
- Sec 2715 Standardize coverage explanations
- Sec. 2717 Report to Secretary of HHS on which plan structures improve outcomes
- Sec. 2718 Submit data to Secretary of HHS on medical loss ratio
loss (claims paid, expenses) ÷ premiums → If below threshold (80-85%),
give rebates to enrollees
- Sec. 2719 Must have effective appeals process for coverage requirements regarding
- designate PCP
 - coverage of emergencies
 - no referral for OB/gyn
- Sec. 2793 Grants to states → create offices of health insurance consumer assistance
- Sec. 2794 Secretary of HHS reviews annually premium increases to see if reasonable
- Sec. 1101 Secretary of HHS creates temporary high risk pool health insurance program to cover those with pre-existing conditions
- has out of pocket limit
 - move into exchange in 2014
- to be eligible for high risk pool insurance, must be

- citizen
- national of U.S. (i.e. Puerto Rico, etc.)
- lawfully present in U.S. (i.e. green card)

Sec. 1103 Secretary of HHS helps states establish websites so that residents & businesses of state know insurances available

Sec. 1104 To get uniformity in insurance
 -sets up requirements ↔ electronic healthcare transactions
 -penalties if plans do not comply
 Secretary of HHS sets a lot of standards for insurance companies regarding operating procedures

Sec. 2701 Premium rates vary only ↔ individual vs. family coverage
 rating area
 -federal decision overrides state decision
 1x → 3x } age
 1x → 1.5x } tobacco use
 -difference between lowest & highest premium

Sec. 2702 Plans must accept – every individual, every employer

Sec. 2705 Regardless of

- health status
- claims prior
- genetics info
- medical history

Sec. 2703 Plans must always renew coverage
 Allows cost variances of coverage if participate in wellness program

Sec. 2706 Plan cannot discriminate against provider who wants to participate in plan
 -but Secretary of HHS or insurance company can vary reimbursement ↔ performance measures

Sec. 2707 Plans for individuals & small groups must provide essential health benefits
 Cost sharing cannot go above certain limits

Sec. 2708 Plan cannot have waiting period > 90 days

Sec.1252 Uniform standards for all states for all plans
 Self-insured groups are to be studied

Sec. 1301&

Sec. 1302 “Qualified health plan” = provides essential benefits (ER, hospital, maternity, newborn, mental health, substance abuse, Rx drugs, preventives, chronic diseases, pediatrics)

= limits cost sharing

= must have option of 2 levels of coverage

4 levels ↔ what % of costs are paid by the plan

bronze = 60%

silver = 70%

gold = 80%

platinum = 90%

Limits deductibles

-\$2,000 for individual

-\$4,000 for family

“Cost sharing” = deductible, copay, co-insurance (annual limit on cost sharing)

-does NOT include premiums, balance bill if out of network, noncovered services

Allows plans to do catastrophic coverage only if < 30 yrs

– Other limitations

Sec. 1303 Abortion coverage

-states can elect to prohibit abortion coverage in exchanges

-prohibits federal funds

-cannot penalize providers who don't do abortions

-separate accounts for abortion payments

Sec. 1304 Group market means through employer

-large groups ≥ 101 employees } states can ≥ 51

-small groups ≤ 100 employees } change to ≤ 50

Sec. 1311 States must establish American Health Benefit Exchange

-done by 2014

-only qualified plans may be in exchange

-facilitates purchase of plans

-establishes SHOP = small business health plans program

-helps small businesses enroll employees

-States sustain by 2015

-Insurance companies pay user fees to be an exchange

Secretary HHS establishes criteria for health plans to be qualified

- essential health benefits
- comply with all regulations

Federal dollars to states to help establish exchanges

States can require plans to offer additional benefits
-states must pay the extra cost

State can certify an individual to be exempt from individual mandate
-state sends info to Secretary of the Treasury: name, tax ID #

“Qualified health plan may contract with provider only if such provider implements mechanisms to improve health care quality as the Secretary of HHS may require by regulation”

Sec. 1312 Employer selects coverage level for employees through exchange → employee can choose any plan that offers that coverage level

Health plans can be offered outside the exchange

Members of Congress may only choose plans created under the Act or in the exchange

Access to exchange limited to

- citizens
- nationals (U.S. overseas possessions)
- aliens lawfully present in U.S.

Secretary of HHS issues regulations of exchanges

Secretary of HHS will establish & operate exchange if state not have one by 2014

Loans & grants to states to start exchange

Sec. 1332 States can apply to Secretary of HHS for waiver of certain requirements

Sec. 1333 Secretary of HHS issues regulations to allow health insurance plans to be offered in more than one state

Sec. 1341 States must establish re-insurance programs

Sec. 1342 Secretary of HHS establishes risk corridors program

Sec. 1343 Dollars to or from plan by Secretary of HHS as needed

- Sec. 1401 If individual income 100-400% of federal poverty line
 -Social Security Act defines poverty line
 -Secretary of HHS determines how to define “income”
- Sec. 1412 get tax credit for % of cost of premiums
 - Secretary of HHS sets up program for advance pay of tax credits
- Sec. 1402 get decreased maximum limit for out of pocket expenses
 - Secretary of HHS will reimburse plan the dollars
- Sec. 1411 Individual gets no federal payments if not a citizen, national or alien that is “lawfully present” in the U.S.
- Sec. 1414 Secretary of the Treasury discloses taxpayer info to Secretary of HHS to determine eligibility for programs in PPACA
- Sec. 1421 For small business (< 25 employees, < 50k/yr. total wages)
 -employer gets tax credit up to 50% of expenses for employee health coverage
 (phased out as # or \$ gets close to limits)
- Sec. 1501 Mandate = must purchase “qualified” plan OR pay a penalty
 -qualified plan = minimal essential coverage
 - gov’t program (Medicare, Medicaid, CHIP, Tricare)
 - employer plan (employer files return for employee: name, address, tax ID#, whether qualified plan)
 - individual plan
 - other coverage (i.e. risk pools, etc.)
 -penalty waived if
 - low income
 - Indian tribe
 - hardship case
 - religious objection
 - unlawful presence
 - jailed
- Sec. 1501 Justifies mandate as economic in nature
 affects interstate commerce
 -decisions about buying health insurance are economic/financial
 -health care services are part of national economy
 -health insurance companies are national and regional
 -adds millions of new consumers to health insurance market
 -achieves near universal coverage

- 50% of personal bankruptcies are caused in part by medical expenses
- federal gov't has role in regulating health insurance

If no mandate, many wouldn't want to purchase until sick
 – Mandate broadens risk pool with healthy in it → lowers premiums

By creating more enrollees → lower administrative costs for insurance company → lower premiums

Supreme court ruling → insurance is interstate commerce subject to federal regulation

Sec. 5000 Penalty – included with taxpayer return
 -\$750 X COLA

Sec. 1511 Employer responsibilities – amends FLSA (Fair Labor Standards Act)
 -if > 200 full time employees & provide insurance for some
 -must enroll all in health plan
 -provide info about exchanges (employee loses employer pymt toward premium)

Sec. 1512&

Sec. 1513 If large employer (defined as > 50 full timers; full timers defined as ≥ 30 hrs/wk) fails to cover all full timers & dependents
 -employer pays a fine for each employee (\$750/employee)
 -also pays a fine if waiting period
 -> 30 days = \$400/full time employee
 -> 60 days = \$600/full time employee

Sec. 1514 Employer must file report to Secretary of the Treasury about coverage of each employee

Sec. 1552 Government transparency
 -Secretary of HHS by 30 days after passage of PPACA must publish on internet website of Department of Health & Human Services a list of all authorities provided to the Secretary under this act

Sec. 1563 CBO say PPACA will
 -reduce federal deficit between 2010 & 2019
 -decrease deficit beyond 2019
 -extend solvency of Medicare Trust Fund
 -Increase surplus in Social Security Trust Fund

Title 2 Medicaid

- Sec. 2001 Amends Medicaid part of Social Security Act
- extends Medicaid coverage
 - under 65 years & not Medicare & income < 133% of poverty line
 - starts in 2014
 - federal government pays 100% of cost of newly eligible 2014 – 2016
 - increases FMAP for the newly eligible
- Sec. 2301 Requires Medicaid to cover
- Rx drugs – including smoking cessation, barbituates, benzodiazepines
 - mental health
 - free standing birth centers
- Sec. 2502 Medicaid must cover minimal essential benefits
- Sec. 2101 Amends SSA to get more FMAP for CHIP
- Sec. 2501 &
Sec. 2503 Revises pharmacy reimbursement for Medicaid drugs
- Sec. 2551 Reduces states DSH allotment by 35-50% once states uninsured rate decreases by 45%
- Sec. 2405 Funding to expand state aging & disability resource centers
- Sec. 2703 Establish “health home services” for Medicaid
- comprehensive services provided by designated provider or health team
 - doc – internist, FP, pediatrician, OB/gyn
 - group practice
 - rural clinic
 - community health center
- Sec. 2704 Demonstration project for bundled payment for Medicaid for hospital care to hospital & docs
- Sec. 2705 Demonstration project to change from fee for service to global capitated payment for Medicaid
- Sec. 2706 Demonstration project to allow docs to be ACO to get incentive payments in Medicaid
- get these if demonstrate annual savings in expenditures for items & services

- Sec. 2801 MACPAC = Medicaid & CHIP Payment & Access Commission
MEDPAC = Medical Payment Advisory Commission
- Sec. 2707 Medicaid Emergency Psychiatric Demonstration Project
- Sec. 2901 Special rules for Indians & Alaska natives
- Sec. 2951 Grants for early childhood home visit programs
- Sec. 2701 Establish Medicaid Quality Measurement Program
-standards to report quality of healthcare received
- Sec. 2952 Expanded programs on postpartum depression & psychosis for Medicaid
- Sec. 2953 Personal Responsibility Program for Medicaid
-education about abstinence, contraception, STD

Title 3 Healthcare Delivery Models

Sec. 3001 Hospital Medicare

-Secretary of HHS determines performance measures for hospital

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hospital reports data (cost efficiency and care quality) → reports made public

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determines how hospital is paid

-incentive payments (increase base operating DRG payment)

-budget neutral } incentive payment amts for all hospitals/yr. = reduced payment amts for all hospitals/yr.

-Secretary of HHS provides adjustments to maintain desire for hospitals to treat patients with severe illnesses

Sec. 3002 Physician Medicare

-if doc does NOT submit data on quality measures → reduced fee schedule (98%)

Sec. 3003 Secretary of HHS

-will use claims data to measure resources used to care for patients and compares to other docs

-combines separate services into episodes of care groups

-develops measures to rate docs on meaningful use of EHR and quality of care

-makes reports available to public

-develops system like hospital value based purchasing system

-value based payment modifier under doc fee schedule

-payment modifier (budget neutral) to doc

-based on quality of care and cost of care (Sec. HHS determines measures)

Sec. 3004 Long Term Care Hospitals & Medicare

Sec. 3006 Quality reporting established for

- inpatient rehab hospitals
- hospice
- skilled nursing facilities
- home health agencies
- ambulatory surgery centers

If fail to submit data → decrease reimbursements

Data available to public

Establish value based purchasing program

Sec. 3007 Value based payment modifier for doc fee schedule
-looks at quality of care compared to cost of care → payment modifier

Sec. 3008 Hospital payments decrease if condition acquired in hospital

For all healthcare:

Sec. 3011 Secretary of HHS to develop national strategy to improve healthcare quality

- Sec. 3012 Establishes “Working Group on Healthcare”
-establishes multiple other agencies to do this

Sec. 3013 Secretary of HHS identifies gaps where no quality measures exist or where need to be improved

Sec. 3014 Secretary of HHS to develop hospital & doc outcome measure

-“quality measure” = standard to measure performance

- health outcomes
- coordination of care
- meaningful use of EHR
- efficiency of care
- patient satisfaction
- timeliness of care
- safety
- effectiveness of care

Sec. 3015 Secretary of HHS publishes performance information on public website

Sec. 3021 Developing new patient care models

-creates within CMS – “Centre for Medicare and Medicaid Innovation”

-tests innovative payment & delivery models with goal to reduce costs and improve quality

-promotes broad payment & practice reform

-away from fee for service

-toward comprehensive payment or salary base

Vary payment to docs who order advanced diagnostic imaging according to docs adherence to appropriateness criteria for ordering services

Pg. 273: “Pay docs who use patient decision support tools (from Public Health Service Act) that improve doc & patient understanding of treatment options”

Payment incentives to use nationally recognized evidence based guidelines

Promotes models of care where professional other than M.D. can refer for a service or establish care plan (i.e. outpatient services such as PT)

Establish comprehensive payments to Healthcare Innovation Zones (i.e. teaching hospital & its docs)

Models to be expanded nationwide if improve care quality & reduce spending

Sec. 3022 Medicare Shared Savings Program

- develop ACO (accountable care organization)
 - goal = high quality, efficiency (cost)
 - group = group practice
 - network of individual practices
 - hospital & M.D. – partnership or employment
- must have primary care M.D.
- get ≥ 5000 beneficiaries assigned by Secretary of HHS
- evidence based medicine
- quality & cost measures → submit data
- Secretary of HHS determines reporting requirements
- incentive payments ↔ EHR, eprescribing
- payment is traditional fee for service Medicare A & B
- if ACO meets quality performance standard AND goes below benchmark established by Sec. HHS (expenditure per capita) then get payment for shared savings to ACO (ACO distributes payments as sees fit)
- Secretary of HHS can sanction ACO if feels it is avoiding high risk patients

Sec. 3023 National pilot program on payment bundling (Medicare)

- goal = improve quality, efficiency, coordination
- “episode of care” – hospitals (inpatient/outpatient)
 - 3 days prior to admission
 - hospital stay
 - 30 days following discharge

Sec. 3024 Independence at home demonstration projects

- service delivery model
 - docs & NP provide home care with 24/7 coverage
- payment incentive
 - get incentive payment if actual expenses < target expenses

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Some % of difference
 Between actual & target
 -if no incentive payments → stop program

Sec. HHS determines target

- Sec. 3025 Hospital Readmission Reduction Program
 - reduce payment for hospital admission if there is a readmission (base operating DRG payment X adjustment factor)
 - use patient safety organizations to reduce readmissions

- Sec. 3102 Medicare changes to doc fee schedule
 - work geographic index floor
 - practice expense geographic adjustment

- Sec. 3111 Reduces payments for DEXA scans (70% of 2006 rates)

- Sec. 3114 Midwives fees increased from 65% to now 100% of doc fee

- Sec. 3133 Reductions to Medicaid DSH
 - as less uncompensated care as more insureds

- Sec. 3134 Secretary of HHS to adjust work relative value units of doc fee schedule (Medicare)

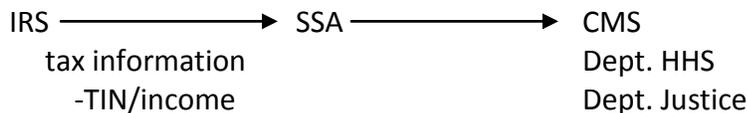
- Sec. 3135 Increases technical component discount for sequential imaging on contiguous body parts at same visit (from 25% to 50%)
 - Equipment utilization footer for advanced imaging studies
 - increases utilization rate from 50% to 65% (presume use equipment 65% rather than 50% therefore assume reduced expenditure)

- Sec. 3201 Changes to Medicare Advantage payments

- Sec. 3210 New standards for medigap plans

- Sec. 3301 Changes to Part D Medicare (Drugs)
 - requires manufacturer to participate in coverage gap discount program
 - formulary must include drugs from every class of drug
 - premium for Part D may be waived for low income

- Sec. 3308 Premium increased for income > threshold
 - increase taken out of Social Security payments



Sec. 3306 Assistance to low income programs

Sec. 3403 Ensuring Medicare sustainability

- establishes Independent Medicare Advisory Board (IPAB)
 - goal = reduce per capita rate of growth of Medicare spending
 - proposals must result in net reduction in Medicare spending
 - can NOT include
 - ration healthcare
 - raise premiums
 - raise beneficiary cost sharing
 - restrict benefits
 - modify eligibility criteria
- board consists of 15 members appointed by President
 - will include M.D.
 - may not have any other employment
 - 6 yr. terms
 - only the President can remove members
 - recommendations from House & Senate
 - involved in health care management
 - may obtain any information from any agency of U.S. as needed
 - board may accept gifts and donations
- cannot change payment rates to docs in services already scheduled to reduce inflation update
- can include reducing Medicare payment rates for
 - Part C (Medicare Advantage)
 - Part D (drugs)
- will send proposals to
 - MedPAC
 - Secretary of HHS
 - Congress → expedited process limits debate
 - high threshold to oppose
 - President

Sec. 3501 Conduct research into practice models (via gov't grants)

- goals = improve doctor skills, patient safety, efficiency
- translate evidence into practice recommendations & changing models of care

Sec. 3502 Establish community "health teams" (interdisciplinary team of healthcare providers) to provide patient centered services = medical home

- PCP practices
- OB/gyn practices
- must use health information technology
- get capitated payments

- Sec. 3503 Implement medication management service in treatment of chronic diagnosis
-run by licensed pharmacists
-goal = increase quality and decrease costs
- Sec. 3504 Federal programs to expand research into emergency medicine, basic science, delivery models
- Sec. 3506 “Program to facilitate shared decision making”
-help patient & docs make decisions about treatment
-grants to entities (shared decision making resource centers) to develop patient decision aids
-to improve patient understanding of options
-make sure decisions meet standards of care
-make available to public
-grants to docs who get trained by centers
- Sec. 3508 Grants to entities to develop curriculum that integrates quality improvement in clinical education of health professionals
- Sec. 3509 Establish National Women’s Health Information Center

Title 4 Public Health Issues - improving public health
- prevention of chronic disease

- Sec. 4001 President establishes within Dept. of HHS
- National Prevention, Health Promotion & Public Health Council (“council”)
 - Surgeon General is chairman
 - Members from 13 other federal agencies
 - Goal = develop national prevention, health promotion, public health & integrative health care strategy to:
 - improve health status of Americans
 - reduce preventable disease
 - reduce disability
- } addresses issues like
sedentary behavior, poor
nutrition, tobacco use

President establishes advisory group to “council”
-25 members appointed by President
-advises the “council”
-ensures that all programs are consistent with scientific evidence
-takes recommendations from Center of Disease Control & Prevention (CDC)

Secretary and Comptroller General do periodic reviews of every federal disease prevention & health promotion program

- Sec. 4002 Establish Prevention & Public Health Fund
-furnishes dollars for above programs

- Sec. 4003 Director of Agency for Healthcare Research & Quality creates independent Preventive Services Task Force to review scientific evidence related to health & cost effectiveness & public health services

Director of CDC creates same independent task force to do same thing

- Sec. 4004 Secretary of HHS to implement national public-private partnership for education to raise public awareness of health improvement across life span

Secretary of HHS acts through Director of CDC to establish media campaign & develop federal website about disease prevention
-“such website shall be designed to provide information to healthcare providers and consumers

- Sec. 4101 Grants for school board health centers

- Sec. 4102 Campaign for education on oral hygiene

- Sec. 4103 Medicare to cover personalized prevention plan with no cost sharing (annual wellness visit)
-outlines what the visit should consist of (pg. 436)
- Sec. 4104 Eliminates cost sharing for certain preventive services recommended by U.S. Preventive Services Task Force (Medicare)
- Sec. 4105 Secretary of HHS can change Medicare coverage of preventive services based on USPSTF recommendations
- Sec. 4106 Medicaid to provide coverage of preventives & vaccines consistent with USPSTF with NO cost sharing
- Sec. 4107 Medicaid to provide coverage of comprehensive tobacco cessation services (counseling, drugs) to pregnant women with no cost sharing
- Sec. 4108 Secretary of HHS awards grants to states to carry out incentive plans to get Medicaid enrollees to participate in programs to lower health risks
- Sec. 4201 Secretary of HHS awards grants to states to provide public health preventive activities
- healthier school environments
 - infrastructure for active living
 - worksite wellness incentives
 - healthy options at restaurants
 - reduce ethnic disparities
- Sec. 4202 Do same as above for Medicare beneficiaries
- Sec. 4203 Medical diagnostic equipment to be accessible to disabled to allow independent entry, use, exit (i.e. exam tables, chairs, scales, etc.)
-Architectural & Transportation Barriers Compliance Board sets forth the standards
- Sec. 4204 Secretary of HHS to negotiate with vaccine manufacturers to purchase vaccines
- States can purchase vaccines at same price
- Dollars to preventive health programs to give vaccines for free
- Sec. 4205 At chain food outlets (≥ 20 with same name)
-(i.e. restaurants, vending machines, etc.)
- | | | |
|-------------|---|--|
| -on menu or | } | must provide info on food – nutrient content, # calories |
| menu board | | |
- must do statement about recommended daily calories

Sec. 4207 If > 50 employees → must have reasonable time & place for nursing mothers
-break time for 1 year (not paid for up to 1 year)
-not bathroom

Sec. 4301 All federal programs in public health
- report data and develop national standards for data management

Sec. 4303 Director of CDC provides technical assistance for employer based wellness programs

Director of CDC does survey of all employer based health policies & programs

There is no mandate for workplace wellness programs

Grants to state & local health departments to assist public health agencies to improve surveillance of & response to public health diseases

Sec. 4305 Secretary of HHS to convene a Conference on Pain to
-increase awareness of pain as public health problem
-evaluate the adequacy of diagnosis & treatment
-improve clinical care of pain (pg. 467)

Secretary of HHS award grants to develop programs to provide training to healthcare professionals in pain care (pg. 468)

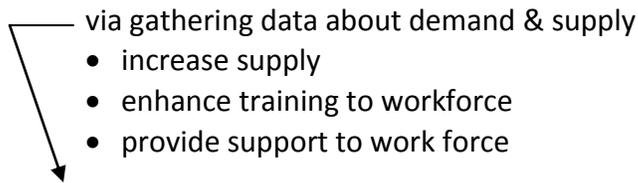
Sec. 4401 “Sense of Senate that prevention programs are difficult to score”

Title 5 Healthcare Workforce

Sec. 5001 &

Sec. 5002 To improve access to healthcare for all but particularly

- low income – improve “health literacy”
- underserved
- uninsured
- minority – improve “cultural competency”
- rurals



Sec. 5101 By – National Healthcare Workforce Commission

- makes recommendations to Congress
- 15 members appointed by Comptroller General
- Serve 3 years
- looks at how past & present policies affect supply
- identify professional skills needed

Sec. 5102 Establishes healthcare workforce development grant programs to develop strategies to increase workforce

Sec. 5103 Establishes National Centers for Workforce Analysis to provide info on workforce
-get information and develop performance measures

Sec. 5201 Increasing supply of healthcare workforce
-revises student loan repayment ↔ length of service requirement in 1^o care health

Sec. 5202 Increases maximum loans to nursing students

Sec. 5203 Secretary of HHS:

- establishes pediatric specialty (M.D. & allied) loan repayment program
- pays back loans during years they serve (35k/yr. at least 3 yrs.) in medically underserved areas

Sec. 5204 Secretary of HHS establishes public health workforce loan repayment program for public health workers
-35k/yr. – must serve at least 3 yrs.

- Sec. 5205 Expands student loan forgiveness for allieds employed in public health agencies
- Sec. 5206 Grants to states & local programs for scholarship or loan repayment to increase public health workforce
- Sec. 5207 Establish funding for National Health Service Corps to provide to provide scholarships, loan repayment
- Sec. 5208 Fund development & operation of nurse managed health clinics
-provide primary healthcare and wellness services
- Sec. 5209 Eliminates cap on number of commissioned officers in Public Health Service Regular Corps
- Sec. 5203 Revises the Regular Corps and the Reserve Corps to become Regular Corps and Ready Reserve Corps in the Public Health Service
-sets forth its uses
- serve in national emergencies & public health crisis
 - Ready Reserve Corps helps Regular Corps as needed
- Sec. 5301 Support & Development of Medical Training Programs (internal medicine, family medicine, pediatrics, physician assistant)
-grants to schools
-financial assistance to students
-operate a program for training
- Preference given to program with innovative approaches – i.e.
- team management of disease
 - use health information technology
 - training in cultural competency & health literacy
 - training minority or disadvantaged groups
- Sec. 5302 Financial aid to enrollees in long term care training programs
-agrees to work for 2 yrs. in the field
- Sec. 5303 Grants to dental programs
- Financial aid & loan repayment to dental students if agree to serve as dental faculty
- Sec. 5304 Grants to establish training for alternative dental providers to increase services in underserved areas (i.e. hygienists, primary care docs)
- Sec. 5305 Grants to entities to provide geriatric education

-“fellowships” in geriatrics – then serve in geriatrics for 5 yrs.

- Sec. 5306 Grants to schools to promote recruitment of students for social work, mental health areas
 - at least 4 must be black colleges or other minority
- Sec. 5307 Grants to foster training of health workers in cultural competency, public health, disabilities
- Sec. 5308 Grants to nurse programs that encourage midwives
- Sec. 5311 Increases loans to nurses & loan repayment if agree to be faculty at nursing school for ≥ 4 yrs.
- Sec. 5313 Grants to entities that encourage positive health behaviors in underserved areas (use community health workers)
- Sec. 5314 Grants for training in epidemiology, public health informatics
- Sec. 5315 Establishes U.S. Public Health Sciences Track
 - established at existing schools by Secretary of HHS
 - awards advanced degrees in public health, epidemiology, emergency response to nurse, M.D., allied
 - students get funding to enroll
 - students must serve 2 yrs./school year in commissioned Corps of Public Health Service
- Sec. 5401 Change fund allocation to schools to assist those that educate minority students
- Sec. 5402 Loan repayment for faculty for schools that offer physicians assistant programs
 - Scholarships for disadvantaged students
 - To support nursing
 - increase education for disadvantaged
 - stipends for nurses to get more training
 - scholarships for nursing degrees
- Sec. 5405 Secretary of HHS to establish Primary Care Extension Program to educate PCP about preventive health, mental health, evidence based treatment
 - Grants to states to accomplish this
 - Medicare incentive (10% more pay) payments to docs who practice in health

professional shortage areas

- M.D. = general surgeons, internists, family practitioners, geriatrics, pediatrics
- non-M.D. = nurse practitioners, physician asst.

-budget neutral

Sec. 5503 Reallocates unused residency positions to qualifying hospitals
-pays hospital for graduate medical education costs

Sec. 5507 Grants to states to provide low income individuals training for healthcare jobs in high demand areas
-i.e. home healthcare aids certificate programs

Sec. 5508 Grants to develop new PCP residency programs (internists, FP, OB/G, pediatrics, geriatrics, psychiatry, dentistry)

50% of time spent teaching by member of National Health Service Corps is considered toward fulfilling service obligation

Secretary of HHS pays direct & indirect expenses for graduate medical residency programs

Sec. 5509 Grants to hospitals to provide graduate nurse education

- clinical nurse specialist
- nurse practitioner
- CNA
- Nurse – midwife

Sec. 5601 Dollars to federally qualified health centers to serve underserved populations

States can award grants to providers who treat high percentage of underserved

Title 6 Oversight Penalties

- Sec. 6001 Prohibits Doc-owned hospitals that don't have provider agreement with Medicare by 8/1/10 to participate with Medicare
- participation requirements
 - rural provider
 - no conflict of interest (must report to Sec. of HHS)
 - cannot expand,
 - info must be made available to public
- Sec. 6002 Medical manufacturers to report to Secretary of HHS
- any transfers of value to docs (excludes anything < \$10 unless yearly aggregate > \$100) and excludes product samples and education material completely
 - any doc/doc's family ownership or investment in company
 - dollar penalties for noncompliance
- Sec. 6003 Docs must inform patients in writing (with written list of suppliers) that they may get imaging studies (MRI, CT, PET, anything else Sec. deems fit) elsewhere other than with doc owned location
- Sec. 6004 Drug manufacturers & distributors to report to Sec. of HHS about drug samples
- what, how much, doc requesting
- Sec. 6005 Requires pharmacies that contract with Medicare or exchange plan to report to Secretary of HHS data about generic dispensing, rebates, payment differences between health plans
- Sec. 6101 SNF under Medicare or Medicaid to disclose to Secretary of HHS information on ownership & governing body
- Sec. 6102 SNF & NF must have compliance & ethics programs to prevent & detect violations
- Secretary of HHS to establish quality assurance programs for SNF & NF
- Sec. 6103 Secretary of HHS to publish data for public about nursing homes on nursing home compare Medicare website
- Sec. 6104 SNF must report wages & benefits for all staff
- SNF must report all expenditures
- Sec. 6105 Secretary of HHS to develop standardized complaint form for patient or guardian to file with state → state to process and resolve complaints

- Sec. 6111 Secretary of HHS can reduce civil dollar penalties by 50% for SNF & NF if self report & correct deficiency by 10 days
- Sec. 6112 Secretary of HHS to establish demonstration project about national monitoring programs for SNF & NF chains
- Sec. 6113 SNF & NF must relocate all residents prior to closure
- Sec. 6121 SNF & NF to train staff on dementia, abuse prevention
- Sec. 6201 Secretary of HHS to establish nationwide program for background checks on employees of long term care facilities
- Sec. 6301 Establishes Patient Centered Outcomes Research Institute
- nonprofit corporation; not a government agency
 - carries out national comparative outcomes research
 - has peer review process for 1^o research
 - prohibits institute from allowing data to be used by those who have financial interest in the results unless approved by the institute
 - has tax exempt status
 - research findings to be broadly published
 - Sec. of HHS transfers dollars from Medicare Trust Fund (FHITF) to trust fund for the institute
 - institute enters into contracts (gov't agencies gives priority) for funding and research
 - institute has access to data from CMS & other federal & private agencies
 - institute has Board of Governors
 - 19 members
 - from federal agencies, private citizens, one M.D.
 - appointed by Comptroller General of U.S.
 - 6 year term
- “research finding....not to be construed as mandates, guidelines, recommendations....for payment, coverage or treatment....promote the timely incorporation of research findings....into clinical practices....”
- “Secretary of HHS may use findings from research to determine coverage, reimbursement or incentive programs....”
- Sec. 9511 Dollars for Institute from Federal Hospital Insurance Trust Fund (FHITF) & goes into trust fund for Institute to be kept in the Treasury
- Sec. 4375 &
Sec. 4376 Fee imposed on each health insurance policy & self insured plans

-annual fee of \$2 X # insured lives

-treated as a tax

-issuer of policy pays the fee – insurance company, employer, employee group

Sec. 6302 Federal Coordinating Council for Comparative Effectiveness Research is disbanded

Sec. 6401 Secretary of HHS establishes procedures to screen providers & suppliers of Medicare, Medicaid, CHIP

-level of screening ↔ risk of fraud

- license check
- criminal background check
- fingerprinting
- unannounced site checks
- prepayment review & payment caps — provisional period of 30 days to 1 year for new providers
- anything else the Sec. HHS deems necessary

-fee for screening imposed on provider

- \$200+/individual in private practice
- \$500+/individual in institutional setting

Providers & suppliers enrolling or re-enrolling (Medicare/Medicaid) must disclose any prior or current affiliations with any provider or supplier that has payments suspended or has been excluded from federal programs

- Secretary of HHS can deny enrolment if these affiliations pose “undue risk”

Providers & suppliers (Medicare/Medicaid) must establish a compliance program

Sec. 6402 Secretary of HHS can adjust payments (Medicare/Medicaid) to providers & suppliers with same Taxpayer ID # for past due obligations even if that individual has different National Provider ID #

Overpayments (Medicare/Medicaid) must be reported and returned within 60 dys.

For excluded docs (Medicare/Medicaid) – civil penalties (up to \$50k) if order a service, provide an item, not return overpayments

Secretary of HHS can issue subpoenas, examine medical records, require witnesses to testify

Secretary of HHS can suspend pay to provider or supplier pending fraud investigation

Secretary of HHS may require a provider or supplier to provide secretary with surety bond (>\$50k) ↔ volume of billing done

- Sec. 6403 Terminates the Healthcare Integrity & Protection databank and transfers all information into National Practitioner databank
- Secretary of HHS must furnish bank with actions taken against providers & suppliers
- Sec. 6404 Reduce filing time for Medicare claims after date of service from 3 yrs. to 1 yr.
- Sec. 6405 Requires DME or home health services to be ordered by an enrolled Medicare provider
- Secretary of HHS can extend this to other Medicare services or items
- Secretary of HHS can disenroll for up to one year (Medicare/Medicaid) provider or supplier that fails to maintain & provide access to written orders for DME, home health services or referrals for other items or services
- Sec. 6406 Secretary of HHS can exclude from participation (Medicare/Medicaid) any entity that fails to provide adequate documentation to verify payment
- Sec. 6407 For Medicare/Medicaid – provider must have face-to-face encounter with patient prior to ordering home health or DME
- Sec. 6408 Enhanced civil penalties (Medicare/Medicaid) for false statements, delaying inspections, employ or contract with an entity that committed a violation
- Sec. 6411 Expands recovery audit contractor program (RAC)
-states establish contracts with Recovery Audit contractors to recover overpayments in Medicare, Medicaid, PaAD
- Sec. 6501 Medicaid requires state to terminate entity from Medicaid if terminated from Medicare
- Sec. 6506 Medicaid to exclude individual from participating for a time period if failed to repay overpayments or affiliated with an entity that was terminated from Medicaid
- Medicaid managed care entity must maintain patient encounter data to identify doc who delivered the service vis-à-vis frequency & detail
- Extends from 60 days to 1 year after discovery for State to collect over-payments
- Sec. 6507 Requires Medicaid claims to be compatible with National Correct Coding Initiative

Sec. 6702 Requires long term care facilities owner & employees to report suspected crimes at facility

Block grants to states to provide protection to elderly from abuse, neglect; especially in long term care facilities

Sec. 6801 Grants to long term care facilities for implementing certified HER Malpractice – “encourages states to test alternatives”

Title 7 All about drugs - help innovation
- price competition

Sec. 7002 Allows a person to submit application for license of biologic product (generic) based on its similarity to a licensed biologic product (reference product)
-Secretary of HHS must approve it if it is the same as reference but cannot get license until > 12yrs. After reference license

Applications will have fees attached

Sec. 7101 Expands the 340B Drug Program (a program that limits the cost of covered drugs to certain federal grantees) to

- children's hospitals
- cancer hospitals
- rural centers
- sole community hospitals

Hospitals can use generic drugs when cheaper

Manufacturers must offer 340B enrollees covered drugs at prices \leq ceiling price

Title 8 CLASS Act (Community Living Assistance Services & Supports Act)

Sec. 8001 Establishes a national voluntary insurance program for purchasing community living assistance services

All employees automatically enrolled but can opt out
-Payroll deductions pay monthly premiums

Benefits provide tools for those with limitations so can maintain their personal & financial independence & live in the community

Establishes in Treasury – “CLASS Independence Fund”
-Board of 7 trustees to manage it
-Advisory committee to advise Board

Must pay premiums for at least 5 years prior to benefits (must be employed to pay premiums)

Must have at least minimum earnings

Premium is tied to

- age
 - ability to pay
- } Secretary of HHS will determine the premium

Must have financial limitation to get benefit

Benefit amount ↔ functional ability
-at least \$50/day

No lifetime limit on benefits

Only underwriting for premium determination is age

Benefit goes into Life Independence Account
-electronic management via debit cards
-used for home modifications, assistive technology, homemaker services, nursing support, etc.
-Secretary of HHS keeps account of all withdrawals from account

Beneficiary must resubmit eligibility periodically

When die – CLASS gets remainder of account

Title 9 All About Raising Dollars via Taxes

- Sec. 9001 Excise tax on high cost employer sponsored health coverage
-excise tax = 40% of excess benefit
-excess benefit
= over \$8,500 for single per calendar year
= over \$23,000 for family per calendar year
-penalty if fail to calculate proper amount
-exceptions if retiree or high risk occupation (policeman, fireman, EMT, construction, mining, agriculture/forestry/fishing)
-if in high cost state, then excise tax = 120% of the 40%
-applies also to self-employed individual
- Sec. 9002 Employers to include on each employee W-2
-total cost of employer sponsored health coverage that is excludable from the employees gross income

Restricts payments from HAS, MSA, FSA, to prescribed drugs (whether need Rx or not); not non Rx drugs
- Sec. 9004 Increase penalty (tax) to 20% (was 10-15%) for distributions from HAS, MSA, FSA that is not qualified medical expense
- Sec. 9006 Reporting requirements for corporations for payments \geq \$600 to vendors
- Sec. 9007 For charitable hospitals (tax exempt)
-document needs assessment every 2 years
-adopt written financial assistance policy for patient who had financial assistance for hospital care
-refrain from collections form patients until financial assistance is determined
- Sec. 9008 Secretary of the Treasury reports to Congress on private, tax exempt, taxable & gov't hospitals about levels of charitable care, bad debt, unreimbursed costs, costs for community benefit activities
- Sec. 9007 If hospital fails to meet requirement of 501(c)(3) for any taxable year \rightarrow pays tax of \$50,000
- Sec. 9008 Imposes annual fee (excise tax) on branded (non-generic) Rx drug sales $>$ \$5m on manufacturers & importers of drugs
-amount =
— drug sales of entity for preceding yr. (gross receipts) \div drug sales of all entities
 \searrow
= $X \div 2,300,000,000$

(% of drug sales accounts for 0% - 100% depending on dollar amount
< \$5 million = 0%
> \$400 million = 100%

-penalty if fail to accurately report sales

Sec. 9009 Imposes annual fee (excise tax) on medical device manufacturers & importers

-amount =

gross receipts of entity for preceding yr. ÷ receipts from all entities
= $X \div 2,000,000,000$

(% of gross receipts accounts for 0% - 100% depending on dollar amount
< \$5 million = 0%
> \$250 million = 100%

-penalty if fail to accurately report sales

Sec. 9010 Imposes annual fee (excise tax) on health insurance providers

-amount =

net premiums of prior year + 200% of entities' 3rd party admin agmt fees
÷ net premiums of all entities + 200% of all entities' 3rd party admin agmt fees
= $X \div 6,700,000,000$

(% of net premium accounts for 0% - 100% depending on net premium
< \$25 million = 0%
> \$50 million = 100%

(% of fees accounts for 0% - 100% depending on fees
< \$5million = 0%
> \$10 million = 100%

-does NOT include employer who self insures

-penalty for failure to report accurately

Sec. 9012 Eliminates tax deduction for employers who maintain Part D Medicare for retirees

Sec. 9013 Increases the AGI threshold for claiming itemized deduction for medical expenses from 7.5% to 10%

Sec. 9014 Imposes limit of \$500,000 on the deductibility of remuneration paid to workers in health plans that get > 25% of premiums from coverage that meets Acts requirements

Sec. 9015 Increases hospital insurance tax rate (FICA) by 0.9% for individuals earning > \$200,000 or couples earning > \$250,000 (not on corporations)

Imposes on every taxpayer a tax equal to 0.5% of wages received for employment that are in excess of \$200,000 for individuals or \$250,000 for couples (not corporations)

-tax applied only to wages above these values

Imposes on every taxpayer a tax equal to 0.5% of self-employment income that is in excess of \$200,000 for individual and \$250,000 for joint (SECA)
-tax applied only to income above these values

- Sec. 9016 For health insurance companies
 - if % of total premium revenue expended is < 85% → must give dollars back to remain eligible for certain tax benefits

- Sec. 9017 Tax on elective cosmetic medical procedures
 - 5% of amt. paid for such procedure whether paid by insurance or self-pay
 - tax paid by patient → given to doc → doc sends dollars to Secretary
 - if tax is not paid by patient, then it must be paid by provider

- Sec. 9022 Establishes a new employee benefit cafeteria plan – Simple Cafeteria Plan
 - for employer with < 100 employees
 - employer contributes to plan or matches employee contribution
 - employee must have > 1000 hrs. in prior yr.
 - employees can elect any benefit under plan

- Sec. 9023 Therapeutic discovery project
 - get tax credit or grant

Title 10 Tort Reform Projects
Care to Underserved
Stricter accountability of docs
Amendments to other parts of law

Sec. 10101 Insurance plan cannot have lifetime limits on dollar value of benefits that are essential benefits

- can have annual or lifetime limits on nonessential benefits

“Sec. 2718” Insurance companies must report to Secretary of HHS

- Losses → claims paid out + expenses ÷ premiums in

-if < 85% (lge. grp. mkt.) or < 80% (sm. grp. mkt.) → must pay \$ back to enrollees

Hospitals make public list of charges for items & services

Health insurance company to have effective appeals process for coverage determinations & claims

“Sec. 2719A” Emergency services can be provided by any doc – even if not participating in patient plan

Direct access to OB/Gyn without need for referral

OB/Gyn can authorize tests same as PCP (pg. 772)

Establish medical reimbursement data centers

-establish fee schedules

-update fee schedules

-make healthcare cost information available to public

“Sec. 1253” Secretary of HHS to study fully-insured & self-insured group health plan markets

Sec. 10104

“Sec. 1303” State can prohibit abortion coverage in qualified health plans offered through an exchange in that state if state enacts a law to provide for prohibition

Sec. 10104 Abortion

-public funding prohibited

-public funding allowed

} segregation of funds by health insurance plans

EMTALA

-healthcare provider must provide emergency services as required by state or federal law

Health plans seeking certification as qualified health plans to participate in exchange must provide information to exchange, Secretary of HHS, public, state
-information needed per Secretary of HHS

- cost sharing
- claims payment policies
- rights
- etc.

“Sec. 1334” Multi-state plans

-director of Office of Personnel Management enters into contracts with health insurance issuers to offer at least 2 multi-state qualified health plans through each exchange in each state

- provide individual & group coverage
- director implements contract provisions
 - medical loss ratios
 - profit margin
 - premiums charged
 - coverage conditions
 - etc.

Nothing to interfere with Federal Employees Health Benefit Program (FEHBP)

Sec. 10105

“Sec. 1416” Secretary of HHS shall study the feasibility of adjusting federal poverty level in different geographic areas to better reflect the cost of living in different areas

Sec. 10106 Justification for the mandate to buy insurance

- Requirement regulates activity that is commercial & economical
- decisions about
 - how & when healthcare is paid for
 - when health insurance is purchased
- Without the requirement
 - some would forego coverage & self-insure → increases financial risks to households and medical providers
- Health insurance & healthcare services are a significant part of the national economy

- Since most health insurance is sold by national or regional health insurance companies → sales & claim payments flow through interstate commerce
- Requirement will add millions of new consumers to health insurance market → near universal coverage
- Economy loses dollars each year because of poorer health & shorter life span of uninsured
- Cost of providing uncompensated care to uninsured is high
to pay for this, healthcare providers pass on the cost to private insurers who pass on the cost to families
mandate will thus lower health insurance premiums
- 62% of bankruptcies are caused in part by medical expenses → mandate improves financial security for families
- Federal gov't plays significant role in regulating health insurance
- If no mandate → individuals wait until sick to purchase insurance → adverse risk pools as not capture healthy that pay premiums but don't cause claims
so, if want to remove underwriting then must have mandate
- Administrative costs for health insurance are 25-30% of premiums
if ↑ enrollees → economics of scale → lower admin costs → ↓ premiums

If not purchase qualified insurance then penalty applies to "taxpayers"

- monthly penalty amount
- higher of flat dollar amount or % of income (2% of taxpayers household income for that taxable year)
- can waive penalty if religious conscience objection

Large employers with waiting periods > 60 days to enroll in essential coverage under employer sponsored plan

- employer must pay \$600 for each FT employee to whom wait applies

Sec. 10108 Employer who provides health insurance to employees & pays some of the cost must provide free choice vouchers to each employee

- employee must be "qualified"
 - required contribution under employer plan between 8 – 9.8% of employees household income
 - household income is not > 400% poverty line for family size
 - does NOT participate in employer plan

- amount of voucher = dollar amount employer would have paid toward employer plan for that employee
- can use voucher like credit in the exchange
 - employer pays this to exchange
- if voucher dollars exceeds cost of premium in exchange → employee gets excess
- voucher dollars do not count as income
- employer can use voucher amounts as deductions

Sec. 10201 Medicaid & CHIP

- sets the FMAP for Nebraska at 100%
 - federal gov't pays 100% of cost of newly covered in NE
- increases FMAP for states that offer home & community long term care as alternatives to nursing homes

Sec. 10212 Establishes pregnancy assistance fund

- grants to states to assist pregnant & parenting teens – dollars go to schools (including high schools) to establish pregnant & parenting student services
 - maternity coverage
 - riders for family members in student healthcare
 - family housing
 - child care
 - flexible academic scheduling
 - education on parenting skills
 - material needs of children
 - post partum counseling

Sec. 10303 Secretary of HHS shall develop & update periodically provider-level outcome measures for hospitals & docs

Sec. 10305 Public reporting of performance information

Testing new healthcare models to reduce costs and improve care

Improve capacity of non-medical providers & non-specialized medical providers to provide health services for patients with chronic complex conditions

Sec. 10307 Partial capitation model where ACO is at financial risk for some items/services under Medicare A and all items/services under Medicare B

Sec. 10308 Pilot program on payment bundling

Pilot program for continuing care hospital model

- episode of care = all time in hospital + 30 days out

Sec. 10309 If hospital has re-admission → gets reduced payment rates for that discharge

Sec. 10320 Independent Medicare Advisory Board

-submits recommendations to Congress & President to slow growth in national health expenditures while enhancing quality of care

Sec. 10323 Make individuals exposed to environmental hazards eligible for Medicare

-Commissioner of Social Security determines who is eligible

Sec. 10324 Floor on area wage index for hospitals in frontier states

Sec. 10326 Pilot test pay-for-performance (value based purchasing program) for Medicare providers (hospitals, hospice programs)

Sec. 10327 Improvements to physician quality reporting system

(PQRI = physician quality reporting initiative)

-additional incentive payments (may then become payment modifier to determine fee schedule) to docs who report quality measures to CMS via a maintenance of certification program (annual ongoing assessments, secure exam, survey of patient experience with care)

Sec. 10328 Requires Part D plans to do comprehensive review of meds as part of their medication therapy management program

-may result in creation of a recommended medication action plan

Sec. 10330 Secretary of HHS to modernize computer system of CMS

Sec. 10331 Public reporting of performance information

-Secretary of HHS to develop Physician Compare Website

-info on docs in Medicare & docs in PQRI

-measures of docs quality & patient experiences

Consider transition to value based purchase plan for Medicare providers

Financial incentives to Medicare beneficiaries to use high quality docs

Sec. 10332 Allows Secretary of HHS to make available to entities extracts of medicine claims data for evaluation of performance of providers & suppliers

- quality
- efficiency
- effectiveness
- resource use

- Sec. 10334 Office of Minority Health transferred into office of Secretary of HHS
-goal to eliminate ethnic & racial disparities in health & healthcare
- Sec. 10406 Waive co-insurance for preventive services – defined by USPSTF
- Sec. 10407 Better diabetes care
-Secretary of HHS to do study on impact of diabetes on practice of medicine & level of diabetes medical education that should be required prior to board certification
- Sec. 10408 Secretary of HHS to award grants to employers who provide employees with workplace wellness programs
- Sec. 10409 Cures acceleration network
-Secretary of HHS via Director of NIH to implement network under which grants are awarded to accelerate the development of high need cures
-also establishes a review board
- Grants to look at dialysis care
- Sec. 10410 Grants to establish national centers of excellence for depression
- Sec. 10411 Organize national congenital heart disease surveillance system to determine needed research
- Authorizes dollars for public access defibrillation programs
- Sec. 10413 National education campaign about breast health for public and for docs
- Also conduct prevention research on breast cancer in young women
- Sec. 10501 Establish national diabetes prevention program
- Grants for 1 yr. training of nurse practitioners to serve as PCP in federally qualified health centers and nurse managed health clinics
-preference given to bilingual candidates
- Grants to healthcare providers who treat a large % of medically underserved populations
- “Sec. 749B” Grants to medical schools to recruit students who will serve in rural underserved areas (Secretary of HHS to determine curriculum)

“Sec. 768” Grants to entities to train graduate medical students in preventive medicine specialties

“Sec. 768” Secretary of HHS may issue waivers to individuals who entered into contract for obligated service under the Scholarship or Loan Repayment Program

Sec. 10502 Dollars for constructing or renovating healthcare facility
-must be affiliated with academic health center & must be states only such center

Sec. 10503 Establishes a fund to be used for community health centers & National Health Services Corps

Sec. 10504 Demonstration project to provide comprehensive health care to uninsured at reduced fees

Sec. 10606 Amend the federal sentencing guidelines to increase the offense level for any defendant convicted of a federal healthcare offense relating to a gov't program

“Provides that a person need not have actual knowledge of the prohibition against healthcare fraud nor specific intent to violate it in order to commit healthcare fraud”

Expands the scope of violations constituting a federal healthcare offense

Sec. 10607 Demonstration grants to states to create alternatives to current tort system
-but cannot limit or curtail a patients existing legal rights
-patient may opt out of alternative system
-review panel for application of such alternatives

- patient advocates
- healthcare providers
- attorneys
- medical malpractice insurers
- patient safety experts
- state officials

-funding = \$500,000 per state out of \$50M over 5 yrs. span

Sec. 10608 Extends medical malpractice coverage to free clinics by deeming all involved to be employees of the public health service

Sec. 10902 FSA limit for salary reduction is \$2,500

Sec. 10907 Excise tax on indoor tanning services

- 10% of amount paid for service
- whether paid by insurer or self pay
- tax paid by client
- if not paid by client → paid by owner

Sec. 10909 Increases from \$10,000 to \$13,170 the dollar limit on tax credit for adoption expenses – tax exclusion for employer provided adoption assistance