



MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

Timeline for Health Care Reform

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

March 24, 2010

Color Code: Hospitals Insurance Coverage Other/Workforce Delivery System

2010

Expands the RAC program to include audits of Medicaid and Medicare Parts C and D.	Eliminates the exception for physician-owned hospitals under the Stark law. Grandfathers in providers with Medicare agreements in place before December 31, 2010.	Extends Section 508 hospital reclassification until September 30, 2010.	Expands 340B drug discounts to outpatient drugs for children's hospitals, cancer hospitals, CAHs, SCHs and Rural Referral Centers.
Requires nonprofit hospitals to conduct periodic community needs assessments.	Extends rural outpatient hold harmless payments	Establishes grants for clinics and hospitals to promote positive health behaviors in underserved areas.	Reduces Medicare inpatient, outpatient, IRF and psychiatric hospital payments by 0.25% and LTCH payments by 0.5%.
Prohibits all 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 premiums to small businesses.	Requires new health plans to cover preventive services.
Bans rescission practices and lifetime limits.			
Restricts use of annual limits on coverage.	Provides a \$250 rebate to Medicare beneficiaries who hit the "donut hole."	Extends coverage to those up to age 26 through parents' insurance.	
	Establishes interim high-risk pool for the uninsured.	Establishes health plan for companies with early retirees.	
Expands health professional loan repayment programs.	Enhances elimination of Medicare fraud efforts.	Establishes a National Health Care Workforce Commission to provide recommendations to Congress on aligning health care workforce resources.	

Establishes a Patient-Centered Outcomes Research Institute to conduct comparative effectiveness research.	Establishes an Innovation Center within CMS to test and evaluate various payment structures and methodologies.
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2011

Adjusts Medicare payments according to study on OPPS — exempts cancer hospital costs.	Requires HHS Secretary to submit recommendations for reforming Medicare Area Wage Index.	Begins implementation of RUGs-IV payment changes for SNFs.	Prevents Medicaid payments to be used to pay for HACs.
Extends reasonable cost payment for clinical diagnostic lab services for rural hospitals with fewer than 50 beds to July 1, 2011.	Reduces Medicare inpatient, outpatient, SNF, IRF, psychiatric hospital, dialysis and LTCH payments by a “productivity adjustment” of 0.1%.		
Requires all health plans to report annually on the share of premiums spent on medical care and rebate beneficiaries for excessive medical loss ratios.			
Expands Medicaid eligibility to all people under 133% of FPL; voluntary until 2014.	Establishes voluntary payroll deduction long-term-care insurance program.		
Redistributes unused residency slots, 75% of which must be used for general surgery or primary-care slots.	Provides scholarship and loan repayment funds for primary-care practitioners in National Health Services Corps area.		
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.	Gainsharing demonstration project expires, but \$1.6 million in funds available until 2014.	

2012

Reduces Medicare inpatient, outpatient, SNF, IRF, psychiatric hospital, dialysis and LTCH payments by a “productivity adjustment” of 0.1%.	Requires HHS Secretary to implement a “national quality assurance and performance improvement program” for SNFs and home health.	Extends FLEX programs through 2012.
Extends Medicare Dependent Hospital classification through September 30, 2012.		

Timeline for Health Care Reform

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

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

Establishes a Medicare VBP program that adjusts 1% of payment according to data collection and reporting on five medical conditions.

Begins voluntary ACO payment program.

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

2013

Reduces Medicare inpatient, outpatient, SNF, IRF, psychiatric hospital, dialysis and LTCH payments by a "productivity adjustment" of 0.3%.

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

Establishes a pay-for-reporting program for freestanding and unit-based inpatient psychiatric hospitals.

Establishes a pay-for-reporting program for IRFs, LTCHS, hospices and psychiatric hospitals. Noncompliance results in a 2% reduction to market basket updates.

Begins Nonprofit Consumer Operated and Oriented Plans (CO-OPs).

Establishes a 2.9% excise tax on medical devices.

Simplifies administrative burdens by standardizing electronic exchange of health information.

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

Expands Medicare VBP program to include more conditions and efficiency measures, including spending per beneficiary. Adjusts payments by 1.25%. Includes an appeals process.

2014

Reduces inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by 0.2%

Begins reduction in Medicare DSH payments. Reductions are tied to coverage

Begins reduction in Medicaid DSH payments. Reductions are not directly triggered by coverage targets.

Begins Health Benefits Exchanges.

Bans coverage refusal based on pre-existing conditions for all people, and bans lifetime and annual limits.

Timeline for Health Care Reform

Requires states to cover all former foster children up to age 26 through	Provides tax credit up to 50% of premiums to small businesses.	Provides 100% federal funding for costs associated for Medicaid “newly eligibles” through 2016.	Begins individual mandate for health insurance.
Grants for clinics and hospitals to promote positive health behaviors in underserved areas expire.			
Expands readmission policy to include more conditions. Maximum reduction in payments to hospitals with higher-than-expected readmissions rate increases to 3%.	Requires all eligible professionals to participate in the Physician Quality Reporting Initiative. Provides a 0.5% bonus to those reporting properly, and deducts funds from those that use substantially more resources than their peers.	Allows Medicare VBP program to adjust payments by 1.5%.	Provides hospitals in the top 25 th percentile of certain HAC rates with a 1% payment reduction.

2015

Reduces Medicare inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by 0.2%.	Extends Rural Community Hospital Demonstration Project through 2015.
Provides 100% federal funding for costs associated for Medicaid “newly eligibles” through 2016.	
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.	
Allows Medicare VBP program to adjust payments by 1.75%.	Expands bundled payment program according to HHS Secretary’s plan.

2016

Reduces Medicare inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by 0.75%.	
Provides 100% federal funding for costs associated for Medicaid “newly eligibles” through 2016.	Provides states with an FMAP increase of 23% to accommodate transition from CHIP to the exchanges. Increase occurs through 2019.
Allows Medicare VBP program to adjust payments by 1.75%.	

2017

Reduces Medicare inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by 0.75%.

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 percent of costs.

Allows HHS Secretary to expand VBP pilot program for IRFs, LTCHs, psychiatric hospitals, PPS-exempt hospitals and hospices.

2018

Reduces Medicare inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by .075%.

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

2019

Reduces Medicare inpatient, outpatient, IRF, LTCH and psychiatric hospital payments by 0.75%.

Reduces federal funding for costs associated for “newly eligibles” in Medicaid to 90%.

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

Glossary

CAH — Critical Access Hospital

CMS — Centers for Medicare & Medicaid Services

DSH — Disproportionate-Share Hospital

FMAP — Federal Medical Assistance Percentages

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