Timeline for Health Care Reform Implementation: System and Delivery Reform Provisions

The Commonwealth Fund

April 1, 2010

Health care reform legislation—the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act—includes numerous provisions intended to spur innovation and improve the delivery of health care. This timeline outlines when the delivery system provisions will go into effect; click on the dates to see the provisions that will be implemented during that year.

2010 **2011** **2012** **2013** **2014** **2015** **2016** **2010–2020**

Date Not Specified

2010

Primary Care

- **Coverage for Preventive Care.** All new group and individual health plans must provide first-dollar coverage for preventive services. Prohibit insurance plans (except existing grandfathered plans and those that use a value-based insurance design) from charging cost-sharing for preventive services. Effective six months after enactment.
- **Immediate Access to Care.** Create a temporary high-risk health insurance pool to provide uninsured adults with access to preventive services until the exchanges are operational in 2014. Effective 90 days after enactment.
- **Grants to Improve Efficiency.** Provide grants for improving health system efficiency, including grants that will implement medication management services. Effective May 1, 2010.

- **Provide Lower-Cost Care to Uninsured.** Direct the U.S. Department of Health and Human Services (HHS) to establish a three-year demonstration project in 10 states to provide comprehensive health care services to the uninsured at reduced fees. Effective not later than six months after enactment.
- **Tobacco Cessation for Pregnant Women.** Require coverage of tobacco cessation programs for pregnant women under Medicaid free of cost-sharing. Effective October 1, 2010.

Prevention and Wellness

- **Funding for Community Health Centers.** Establish a Community Health Centers and National Health Service Corps Fund and expand funding to community health centers by $11 billion over five years beginning in 2010.

Medical Home & Coordinated Care

- **Improve Care Coordination for Dual-Eligibles.** Establish a Federal Coordinated Health Care Office within the Centers for Medicare and Medicaid Services (CMS) to more effectively integrate benefits and improve coordination between state and federal governments for individuals eligible for both Medicare and Medicaid. Effective March 1, 2010.

Quality Measurement, Reporting, and Improvement

- **Improve the Physician Quality Reporting System.** Extend physician quality reporting system beyond 2010, penalize eligible providers who do not participate beginning 2015, expand Medicare physician feedback program, and provide reports to physicians that compare their resource use to such patterns of other physicians.
- **Interagency Working Group.** Create an Interagency Working Group to coordinate and streamline federal quality activities, as directed by the President. Must issue first report not later than December 31, 2010.

New Payment Approaches

- **Medicaid Global Payments Demonstration Project.** Establish a Medicaid global payments demonstration to fund large, safety-net hospitals in five states to alter payment from fee-for-service to a capitated, global payment structure. Demonstration projects to occur in 2010–2012.
- **Extend Medicare Hospital Gainsharing Demonstration Project.** Extend Medicare Hospital Gainsharing demonstration project through September 30, 2011.

Adjust Payment for Productivity Improvement

- **Productivity Improvement.** Modify market basket updates to provider payments under Medicare to account for productivity improvements in inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals, and outpatient hospitals. Effective 2010.

Other Payment Reforms

- **Advanced Diagnostic Imaging Services.** Set assumed utilization rate for advanced diagnostic imaging services at 75 percent for purposes of calculating the practice expense portion of Medicare physician payment. Phased in to 65 percent assumed utilization (up

from 50 percent) beginning January 1, 2010; phased up to 75 percent assumed utilization January 1, 2013.

Geographic Disparities

- **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. Effective 2010.
- **Reducing Geographic Variation.** Extend the 1.00 floor for the Geographic Practice Cost Index (GPCI) for physician work through December 2010. Adjust the GPCI for practice expense by blending local and national averages for below-average cost areas.

Prescription Drugs

- **Rebates for Medicare Part D Enrollees in "Doughnut Hole."** In 2010, Medicare beneficiaries who reach the coverage gap, or doughnut hole, in prescription drug coverage ($2,830) are eligible to receive $250 rebates.[1] The coverage gap is phased out completely by 2020.
- **Encouraging Investment in New Therapies.** A two-year temporary credit, subject to an overall cap of $1 billion, to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases. The credit would be available for qualifying investments made in 2009 and 2010.
- **Medicaid Drug Rebate Percentage.** Increase the Medicaid drug rebate percentage; increase the Medicaid rebate for non-innovator, multiple-source drugs; and extend the prescription drug rebate to Medicaid managed care plans.
- **Biologic Drugs.** Authorize the Food and Drug Administration (FDA) to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.

Programs to Reduce Fraud, Waste, and Abuse in Medicare and Medicaid

- **Reducing Fraud, Waste, and Abuse.** Require enhanced screening procedures for health care providers to eliminate fraud and waste in the health care system. Effective within six months of enactment.

Other Medicare/Medicaid Changes

- **Medicaid Money Follows the Person Rebalancing Demonstration.** Extend the Medicaid Money Follows the Person Rebalancing Demonstration through September 2016 and allocate $10 million per year for five years beginning in 2010 to continue the Aging and Disability Resource Center initiatives.

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[1] Under the "standard" Part D benefit, the coverage gap starts when the retail cost of a beneficiaries' medications reaches $2,830 and continues until the beneficiary has spent $4,550 in out-of-pocket costs (which would be reached when the covered cost of medications reaches $6,440). Most plans have some variant of the "standard" benefit, with many offering lower or no deductibles and alternative cost-sharing, and some offering coverage of at least some, usually generic, drugs when the coverage gap has been reached.

Comparative Effectiveness

- **Patient-Centered Outcomes Research Institute.** Create a private, nonprofit Patient-Centered Outcomes Research Institute to set a national research agenda and conduct comparative clinical effectiveness research. The Institute will be governed by a public–private sector board. Would prohibit any findings to be construed as mandates on practice guidelines or coverage decisions and would contain patient safeguards to protect against discriminatory coverage decisions by HHS based on age, disability, terminal illness, or an individual's quality of life preference. Effective date of enactment.

Health Information Technology (HIT)

- **Health Information Technology.** Develop and update interoperable standards for using HIT to enroll individuals in public programs. Effective six months after enactment.

Public Health

- **Improving Public Health Prevention Efforts.** Create a National Prevention, Health Promotion, and Public Health Council to establish a national prevention and health promotion strategy and develop interagency working relationships to implement the strategy. Create a Prevention and Public Health Investment Fund to expand and sustain funding for prevention and public health programs. Council must issue first report not later than July 1, 2010.
- **Nonprofit Hospitals.** Impose additional requirements on nonprofit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to inform patients about the financial assistance policy before undertaking extraordinary collection actions.
- **Young Women's Breast Health.** Require HHS to develop a national education campaign for young women and health care professionals about breast health and risk factors for breast cancer. Effective 2010.

Long-Term Care

- **Background Checks on Long-Term Care Employees.** Establish national or state background checks on certain employees and providers in long-term care facilities; provide federal matching funds to states to support the checks. Report on implementation required six months after enactment; federal matching funds begin between 2010 and 2012.

Workforce Improvements

- **Establishing a National Health Care Workforce Commission.** Establish a National Health Care Work Force Commission to review health care workforce and projected workforce needs. Provide comprehensive, unbiased information to lawmakers on how to align resources with national need. Effective not later than September 30, 2010.
- **Strengthening the 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.

- **Tax Relief for Health Professionals with State Loan Repayment.** Exclude from gross income payments made under any state loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. This provision is effective for amounts received by an individual in taxable years beginning after December 31, 2008.

2011

Primary Care

- **Increasing Reimbursement for Primary Care.** Strengthen primary care by providing primary care physicians with a 10 percent Medicare payment bonus for primary care services for five years beginning in 2011. General surgeons providing care in a designated Health Professional Shortage Area (HPSA) also would be eligible for a 10 percent bonus on payments for major procedures.
- **Improving Preventive Health Coverage.**
    - Provide Medicare beneficiaries access to an annual wellness visit, including a comprehensive health risk assessment and creation of a personalized prevention plan, with no copayment or deductible. Eliminate cost-sharing for evidence-based preventive services under Medicare and eligible private plans. Effective January 1, 2011.
    - Cover proven preventive services in Medicare and Medicaid and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. Effective January 1, 2011.
    - Create a state option to allow Medicaid beneficiaries with chronic conditions, including serious and persistent mental health conditions, to designate a provider as a health home. Qualified providers would be required to report applicable quality data. Effective January 1, 2011.

Prevention/Wellness

- **Evaluate Wellness Programs.** Require the Centers for Disease Control and Prevention (CDC) to study, evaluate, and provide technical assistance to small businesses to implement effective employer-sponsored wellness programs. Must issue a study within two years of enactment.
- **Medicaid Wellness Programs.** HHS to offer grants to states to provide incentives to Medicaid beneficiaries to enlist in comprehensive and proven wellness programs. Initial report due not later than January 1, 2014; final report due not later than July 1, 2016.
- **Nutritional Labeling of Standard Menu Items.** Chain restaurants and vending machines will be required to post calorie and nutritional information of regular menu items. Effective one year after enactment.

Quality Measurement, Reporting, and Improvement

- **National Strategy to Improve Health Care Quality.** Direct HHS to develop a National Strategy to Improve Health Care Quality that includes priorities to improve the delivery of health care services, patient health outcomes, and population health by January 1, 2011. Strategy to be updated annually.

- **Develop Quality Measures for Use in Federal Programs.** Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. These quality measures will include outcome measures for providers and hospitals (measures of acute and chronic diseases, and primary and preventive care). Grant program for quality measure development is funded 2010–2014; quality measures must first be made available by December 1, 2011.
- **Medicaid Quality Measurement Program.** Establish the Medicaid Quality Measurement Program to establish priorities for the development and advancement of quality measures for adults in Medicaid. Quality measures must be available for comment January 1, 2011 and published January 1, 2012. Reporting by States on these measures may begin voluntarily January 1, 2013 and will be summarized in a triennial report to Congress.
- **Physician Compare Web Site.** Require HHS to develop a "Physician Compare" Web site where Medicare beneficiaries can compare scientifically sound measures of physician quality and patient experience measures. By January 1, 2011.
- **Skilled Nursing Facilities.** Improve transparency of information about skilled nursing facilities through specific improvements to information reported on the Nursing Home Compare Medicare Web site. Effective not later than one year after enactment.
- **Bonus Payments for Quality Reporting.** Provide an additional 0.5 percent Medicare bonus payment to physicians who successfully report quality measures to CMS via a qualified Maintenance of Certification program. Effective 2011–2014.

New Payment Approaches

- **Center for Medicare and Medicaid Innovation.** Establish a new Center for Medicare and Medicaid Innovation within CMS to test new provider payment models; if successful, implement models in Medicare, Medicaid, and Child Health Insurance Programs. The secretary is given broad authority to test payment models, including State all-payer payment reform model and other state options. Requires the HHS secretary to focus on models that both improve quality and reduce costs. Effective January 1, 2011.
- **Hospital-Acquired Conditions.** Prohibit federal payments for Medicaid services related to hospital-acquired conditions. Effective July 1, 2011.
- **Improving Transitional Care for Medicare Beneficiaries.** Establish the Community-Based Care Transitions Program, a five-year home-based chronic care management program pilot project, to bring primary care services to the highest-cost Medicare beneficiaries with multiple chronic conditions in their home. Effective January 1, 2011.
- **Increasing Access to Home- and Community-Based Services.** Establish a Community First Choice Option to allow states to offer home- and community-based services to disabled individuals through Medicaid rather than institutional care. Effective October 1, 2011.
- **Emergency Psychiatric Care Demonstration Project.** Establish a Medicaid emergency psychiatric care demonstration project to expand the number of emergency inpatient psychiatric care beds available. First report required by December 31, 2013; funds of $75 million first made available in 2011 and remain available until 2015. Demonstration projects will span three consecutive years.
- **Medicare Hospital Wage Index.** Require the HHS secretary to submit a plan by the end of 2011 to reform the Medicare hospital wage index system.

Medicare Advantage (MA)

- **Transitioning to Reformed Payments in Medicare Advantage.** Freeze Medicare Advantage payments in 2011. Beginning in 2012, phase in reduction of Medicare Advantage county-level benchmark rates to equal on average approximately 100 percent of local per capita spending in fee-for-service Medicare, with adjustments to benchmarks based on per capita fee-for-service spending in each county and for plans based on performance (quality and patient satisfaction) ratings. Base benchmark rates will range from 95 percent of fee-for-service spending in the highest-cost quartile of counties, to 100 percent, 107.5 percent, and 115 percent of fee-for-service spending in each lower-cost quartile of counties. These changes will be phased in over three, five or seven years, depending on the level of payment reduction.

Prescription Drugs

- **Medicare "Doughnut Hole."** Provide a 50 percent discount on brand-name drugs purchased by enrollees who are subject to the Medicare Part D coverage gap, or doughnut hole, other than those with high incomes. The undiscounted price would be counted as out-of-pocket costs for purposes of determining when the catastrophic coverage threshold is reached. Begin phasing in additional discounts on brand-name and generic drugs to completely close the doughnut hole by 2020 for all Part D enrollees.

Programs to Reduce Fraud, Waste, and Abuse in Medicare and Medicaid

- **Increase Anti-Fraud Funding.** Increase funding for Health Care Fraud and Abuse Control Fund by $250 million over next decade. Index funds to fight Medicaid fraud based on inflation.
- **Increase Oversight of High-Risk Suppliers. Initiate a** 90-day period of enhanced oversight for initial claims of durable medical equipment suppliers when HHS identifies a high risk of fraud. Effective January 1, 2011.
- **Increased Oversight of Community Mental Health Centers.** Strengthen standards for facilities that seek reimbursement as community mental health centers to ensure these facilities are not inappropriately overpaid. Effective at least 12 months after enactment.

Workforce

- **Increasing Training Support for Primary Care.** Establish a graduate medical education (GME) policy allowing unused training slots to be redistributed for purposes of increasing primary care training at other sites (effective July 1, 2011). Increase the number of graduate medical education training positions by redistributing currently unused slots, with priorities given to primary care and general surgery; increase flexibility in laws and regulations that govern Medicare GME funding to promote training in outpatient settings; and ensure the availability of residency programs in rural and underserved areas.
- **Expanding Primary Care, Nursing, and Public Health Workforce.** Increase access to primary care by adjusting the Medicare GME program. Expand primary care and nurse training programs to increase the size of the primary care and nursing workforce. Ensure that public health challenges are adequately addressed. Effective July 2011.

Long-Term Care

- **CLASS Act.** Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). The program will provide active working individuals with functional limitations a cash benefit to purchase nonmedical

services and supports necessary to maintain community residence. After a five year vesting period, the program will begin to provide benefits. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program unless they choose to opt-out.[2]

2012

Quality Measurement, Reporting, and Improvement

- **Protect Patient Privacy.** Authorize release of Medicare claims data to measure performance of providers and suppliers in a way that protects patient privacy. Effective January 1, 2012.
- **Data Collection on Health Disparities.** All federal health care and public health programs, activities and surveys shall collect and report data on race, ethnicity, sex, primary language and disability status for applicants, recipients and participants. Effective two years after enactment.

New Payment Approaches

- **Establish a Physician Value-Based Payment Modifier.** Establish a payment modifier that provides differential payment to a physician or group of physicians based upon the quality of care provided compared with its cost. Beginning January 1, 2012, the secretary shall publish the measures, announce the date that the modification will go into effect, and announce the initial performance period.
- **Hospital Value-Based Purchasing Program.** Establish a hospital value-based purchasing program to incentivize enhanced quality outcomes for acute care hospitals. Also, require the HHS secretary to submit a plan to Congress by 2012 on how to move home health and nursing home providers into a value-based purchasing payment system.
- **Reducing Avoidable Hospital Readmissions.** Adjust Medicare hospital payments for potentially preventable readmissions for certain eligible conditions or procedures that are high volume or high expenditure, as determined by the HHS secretary. Also, provide HHS authority to expand the policy to additional conditions in future years and direct the secretary to calculate and make publicly available information on all patient hospital readmission rates for certain conditions.
- **Bundled Payment Demonstration Project.** Establish demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations. Demonstration project to begin January 1, 2012, and end December 31, 2016.
- **Home-Based Primary Care Teams Demonstration Program.** Create a new demonstration program for chronically ill Medicare beneficiaries to test payment incentive and service delivery system that utilizes physician and nurse practitioner-directed home-based primary care teams to reduce costs and improve health outcomes. To begin not later than January 1, 2012.

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[2] Effective dates of provisions within this Act vary. Tax treatment of the program begins January 1, 2011; HHS secretary must design an eligibility assessment program by January 1, 2012; HHS secretary must submit annual report on program beginning January 1, 2014.

- **Quality Payment Modifier.** Require HHS to apply physician payment modifier to Medicare fee-for-service payment to pay physicians differentially based on quality and costs of care. Publish measures in 2012; phase in modifier from 2015 to 2017.
- **Bonus Payments for Medicare Advantage Plans.** Medicare Advantage plans with four-star or higher quality rating will receive bonus payments, giving plans an incentive to improve clinical quality, and patient experiences with care and the plan. Bonus payments are 1.5 percent in 2012, 3 percent in 2013, and 5 percent in 2014.

Accountable Care Organizations (ACOs)

- **Encouraging Integrated Health Systems.** Implement physician payment reforms that enhance payment for primary care services and encourage physicians to join together to form "accountable care organizations" to gain efficiencies and improve quality of care. Allow providers organized as accountable care organizations (ACOs) that meet quality-of-care targets and reduce costs relative to a spending benchmark to share in savings they generate for Medicare; allow HHS secretary to use payment systems currently in place in private sector.
- **Accountable Care Organizations Demonstration Project.** Establish a demonstration project to allow pediatric providers to organize as ACOs and partake in federal and state cost-saving generated under Medicaid. Demonstration project to begin January 1, 2012, and end on December 31, 2016.

Public Health

- **Diabetes Report Card.** Require HHS and CDC to jointly issue a national Diabetes Report Card, which will include aggregate health outcomes for patients diagnosed with diabetes. These measures will include preventive care practices and quality of care, risk factors, and outcomes, with trend analysis over time. First report on need to improve medical education on diabetes due not more than two years after enactment. Report cards to be published biennially, but no start date given.

2013

Primary Care

- **Reduce Cost-Sharing in Medicaid Program.** States that expand Medicaid coverage to include preventive services approved by the U.S. Preventive Services Task Force and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) with no cost-sharing will receive an increased federal medical assistance percentage (FMAP) contribution for these services. Effective January 1, 2013.

Health Goals and Priorities for Performance Improvement

- **Administrative Simplification.** Health plans must adopt and implement uniform standards and business rules for the electronic exchange of health information to reduce paperwork and administrative burdens and costs.

New Payment Approaches

- **Bundled Payment Pilot Program.** Direct HHS to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models that

span three days before and 30 days after a hospitalization. Require the HHS secretary to establish this program by January 1, 2013, for a period of five years. Before January 1, 2016, the secretary also is required to submit a plan to Congress to expand the pilot program if doing so will improve patient care and reduce spending.

Other Payment Reforms

- **Increase Payments to Medicaid Providers for Two Years.** Require Medicaid payment rates to primary care physicians for furnishing primary care services be no less than 100 percent of Medicare payment rates in 2013 and 2014. Provide 100 percent federal funding for incremental costs to states to meet the requirement.
- **Improve Payment Accuracy.** Improve payment accuracy of home health payments starting in 2013. Improve payment accuracy of Medicare hospice payment system starting in 2013.
- **Financial Disclosure.** Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

2014

Quality Measurement, Reporting, and Improvement

- **Quality Reporting for Certain Providers.** Place certain providers—including ambulatory surgical centers, long-term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, prospective payment system-exempt cancer hospitals and hospice providers—on a path toward value-based purchasing by requiring the HHS secretary to implement quality measure reporting programs in these areas and also pilot test value-based purchasing for each of these providers in subsequent years.

Other Payment Reforms

- **Medicare DSH Payments.** Require the HHS secretary to update Medicare hospital payments to better account for hospitals' uncompensated care costs. Beginning in 2014, reduce hospitals' Medicare disproportionate share hospital (DSH) payments to reflect lower uncompensated care costs relative to increases in the number of insured.
- **Medicaid DSH Payments.** Reduce federal Medicaid DSH payments beginning in 2014, with HHS to determine methodology of reduction. Extend through 2013 the federal DSH allotment for a state that has a $0 allotment after FY 2011.

Medicare Advantage (MA)

- **Improve Medicare Advantage Efficiency.** Require an 85 percent medical loss ratio on Medicare Advantage (MA) plans beginning 2014. A plan that does not meet this requirement must provide rebate of difference to CMS. If a plan does not meet the requirement for three consecutive years, enrollment is limited. If the plan does not meet the requirement for five consecutive years, the plan is terminated.

Medicare Commission

- **Independent Payment Advisory Board.** Create a new 15-member Independent Payment Advisory Board tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years when

Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress would be allowed to consider an alternative provision on a fast-track basis. The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. Beginning in 2014, the Board will issue an annual public report that provides information on health system costs, utilization, access, and quality of care.[3]

Programs to Reduce Fraud, Waste, and Abuse in Medicare and Medicaid

- **Increase Penalties for False Claims.** Eliminate fraud, waste, and abuse in exchanges through increased penalties for submitting false claims.

2015

New Payment Approaches

- **Physician Value-Based Payment Program.** Create a physician value-based payment program to promote increased quality of care for Medicare beneficiaries.
- **Reducing Payments for Hospital-Acquired Infections.** Reduce Medicare payments to hospitals in top 25th percentile of rates of certain hospital-acquired conditions by 1 percent beginning in 2015. Effective 2015. HHS secretary will provide hospital-specific reports in advance of this date to hospitals.

2016

New Payment Approaches

- **Pay-for-Performance Pilot Program.** Establish a pay-for-performance pilot program for eligible Medicare providers no later than January 1, 2016; pilot program must not create additional expenditures. Program to be expanded after 2018 if it reduces spending and quality of care is improved or remains the same. Such a program cannot deny or limit provision of benefits under Medicare.

2010–2020

System Savings

- Many of the system reforms listed here have a fiscal impact, with savings used to offset the cost of coverage expansion. More detail is available in a Commonwealth Fund report (http://commonwealthfund.org/Content/Publications/Fund-Reports/2009/Oct/Congressional-Health-Reform-Bills.aspx).

Date Not Specified

Primary Care

- **Improve Guidelines on Preventive Care.** Expand and improve coordination of Task Forces on Clinical Preventive Services and Community Preventive Services to develop, update, and disseminate evidence-based recommendations on the use of clinical and community prevention services, with an emphasis on health disparities. Task Forces will

[3] First report by Independent Payment Advisory Board required January 2014; recommendations will first take effect in 2015.

review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community, and updating previous clinical preventive recommendations, to be published in the Guide to Clinical Preventive Services.

Prevention/Wellness

- **Five-Year Grants to Small Businesses for Wellness Programs.** Provide grants for small and midsized employers to implement and strengthen qualified wellness programs.[4]
- **Employer Wellness Programs.** Encourage employers to provide wellness programs by conducting targeted educational campaigns to raise awareness of the value of these programs and by increasing from 20 percent to 30 percent the allowable premium discount for employees who participate in these programs. Provide reasonable alternatives for employees for whom it is unreasonably difficult or inadvisable to meet the standard. Provide technical assistance for evaluation of these programs.[5]

Medical Home/Coordinated Care

- **Grants to Improve Efficiency.** Provide grants for improving health system efficiency, including grants that will establish community health teams to support a medical home model and design and implement regional emergency care and trauma systems.

Quality Measurement, Reporting, and Improvement

- **Improve Public Reporting.** Improve public reporting of quality and performance information that includes making information available on a user-friendly Web site.

New Payment Approaches

- **Community-Based Collaborative Care Networks.** Provide grants to assist in development of community-based collaborative care networks, or integrated health care delivery systems, to service low-income or medically underserved communities. Grants available 2011–2015.[6]

Other Payment Reforms

- **Review Medicare Fee Schedule.** Direct the HHS secretary to regularly review Medicare fee schedule rates for physician services, including services that have experienced high growth rates. Strengthen the secretary's authority to adjust fee schedule rates that are found to be misvalued or inaccurate.

Medicare Advantage (MA)

- **Recover Overpayments.** Extrapolate risk score errors in risk adjustment data validation audits to Medicare Advantage plans to recover overpayments.

Prescription Drugs

- **Cures Acceleration Network.** HHS will establish the Cures Acceleration Network to expedite development of drugs, devices, and biological products for diagnosis, mitigation,

[4] No effective date specified; $200 million in funds appropriated beginning 2011.

[5] A 10-state demonstration project to evaluate employer wellness programs will begin July 1, 2014; if effective, this will be expanded on July 1, 2017.

[6] No effective date specified; "there are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2011 through 2015."

prevention, or treatment from any disease or condition that the NIH determines is a priority; and the commercial market will provide sufficient financial incentive for timely development of these products.[7]

Programs to Reduce Fraud, Waste, and Abuse in Medicare and Medicaid

- **Coordinate with IRS to Reduce Fraud.** Establish a CMS-IRS data match to identify fraudulent providers who have seriously delinquent tax debt. Include strict controls to protect taxpayer privacy.
- **One PI Database.** Eliminate fraud, waste, and abuse in public programs through the development of an integrated database to capture and share data across federal and state programs.
- **Reduce Paperwork.** Streamline procedures to conduct Medicare prepayment reviews to facilitate additional reviews designed to reduce fraud and abuse.
- **Disclosure of Financial Relationships.** Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, and other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

Public Health

- **Office of Women's Health.** Permanently establish an Office of Women's Health in HHS, CDC, the Agency for Healthcare Research and Quality, FDA, and the Health Resources and Services Administration (HRSA); provide grants to accomplish the goals of the Offices of Women's Health.[8]
- **Office of Minority Health.** Permanently establish an Office of Minority Health in CDC, AHRQ, FDA, CMS, HRSA, and the Substance Abuse and Mental Health Services Administration (SAMHSA); provide grants to accomplish the goals of the Offices of Minority Health.[9]
- **Congenital Heart Disease.** Enhance and expand infrastructure to track epidemiology of congenital heart disease.[10]
- **Depressive Disorders.** Provide grants to establish Centers of Excellence for Depressive Disorders that will develop treatments for these diseases. Although no effective date given, grants are funded 2011–2020; at least 20 centers must be created within one year of enactment.

Malpractice Reform

- **State Grants to Test Tort Alternatives.** Authorize grants to states to test alternatives to civil tort litigation. Models are required to emphasize patient safety, disclosure of health care

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[7] "There are authorized to be appropriated $500,000,000 for fiscal year 2010, and such sums as may be necessary for subsequent fiscal years. Funds appropriated under this section shall be available until expended."

[8] Although no effective date is given, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2016.

[9] Although no effective date is given, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2016. First reports are due one year after enactment.

[10] Although no effective date is given, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.

errors, and early resolution of disputes. Patients can opt out. HHS must conduct an evaluation to determine the effectiveness of alternatives. $50 million in funds appropriated beginning in 2011; first report to Congress required by December 31, 2016.

- **Sense of the Senate Regarding Tort Alternatives.** Encourage states to develop and test alternatives to the current civil litigation system as a way to improve patient safety, reduce medical errors, increase the availability of a prompt and fair resolution of disputes, and improve access to liability insurance, while preserving an individual's right to seek redress in court. Recommend that Congress consider establishing a state demonstration project to evaluate alternatives to the current litigation system.[11]

Workforce

- **State Grants to Pursue Workforce Development Strategies.** Establish a grant program to states to plan and implement activities leading to health care workforce development strategies.[12]
- **State Grants to Provide Mid-Career Public Health Professional Training**. HHS shall authorize grants to states to provide scholarships for mid-career training for public and allied health professionals at the Federal, State, Tribal or local level. $60 million in funds are authorized in 2010; "such sums as may be necessary" are available between 2011 and 2015.

Sources

Patient Protection and Affordable Care Act, Public Law 111-148, http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590eas.txt.pdf; Democratic Policy Committee, Short Summary, Detailed Summary and Section-by-Section analysis of the Patient Protection and Affordable Care Act, available at http://dpc.senate.gov/dpcdoc-sen_health_care_bill.cfm.

H. R. 4872, The Health Care & Education Affordability Reconciliation Act of 2010, introduced March 18, 2010, 111th Congress, 2nd Session, available at http://www.gpo.gov/fdsys/pkg/BILLS-111hr4872EH/pdf/BILLS-111hr4872EH.pdf; Summary and other supporting documents available at http://www.rules.house.gov/111_hr4872_secbysec.html.

Democratic Policy Committee, Implementation Timeline Reflecting the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, available at http://dpc.senate.gov/healthreformbill/healthbill65.pdf.

[11] This is a Sense of the Senate provision, and not actual legislation.
[12] Although no effective date is given, authorizations for $158 million annually begin in 2010.