Timeline for Implementation of the Major Hospital and Health System Federal Health Care Reform Provisions

April 2010

The Patient Protection and Affordable Care Act and the
Health Care and Education Affordability Reconciliation Act

2010 Provider Payment Rate Years	
Provider Payment Reductions	**<u>Medicare Update Factor Reductions—Pre-Determined Reductions:</u>** Effective April 1, 2010 to September 30, 2010, the annual Medicare update factor is reduced by 0.25 percentage points for inpatient hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long-Term Care Hospitals (LTCHs). Effective retroactive to January 1, 2010 to December 31, 2010, the annual Medicare update factor is reduced by 0.25 percentage points for outpatient hospitals.
Provider Payment Improvements	**<u>Extension of 340B Drug Discount Program:</u>** Effective January 1, 2010 and thereafter, the 340B discount program for outpatient drugs is expanded to children's hospitals, cancer hospitals, Sole Community Hospitals (SCHs) and Rural Referral Centers (RRCs) that meet certain minimum Disproportionate Share Hospital (DSH) thresholds as well as to Critical Access Hospitals (CAHs) regardless of DSH. **<u>Section 508 Medicare Wage Index Reclassifications:</u>** Effective October 1, 2009, Section 508 Medicare hospital wage index reclassifications are extended for one year for inpatient and outpatient hospitals. **<u>Medicare Outpatient Hold-Harmless Payments:</u>** Effective January 1, 2010, outpatient Prospective Payment System hold-harmless payments are extended for one year and expanded to all SCHs. **<u>Medicare Rural Home Health Agency (HHA) Add-on:</u>** Effective April 1, 2010 to December 31, 2015, the 3.0% add-on is reinstated for HHA services provided to Medicare beneficiaries in rural areas. **<u>Clinical Diagnostic Laboratory Services:</u>** Effective retroactive to July 1, 2008 to June 30, 2011, reasonable cost Medicare payments are reinstated for clinical lab tests performed by hospitals with fewer than 50 beds in qualified rural areas.

Health Delivery System Reform	**Medicaid Global Payment System Demonstration Project:** Effective immediately through September 30, 2012, the Secretary of Health and Human Services (HHS) must establish demonstrations in up to five states that will provide global/capitated Medicaid payments to eligible safety net hospital systems/networks.
Other Provider-Related Provisions	**Medicare Claims Submission:** Effective January 1, 2010 and thereafter, Medicare provider claims must be submitted within one year (instead of three years). **Expansion of the Recovery Audit Contractor (RAC) Program to Medicaid:** Effective December 31, 2010 and thereafter, Medicaid programs in every state are required to establish a program similar to the Medicare RAC program. **CAH Outpatient Payments:** Effective immediately, CAHs that elect an all-inclusive outpatient payment will receive 101% of reasonable costs for facility services, not 100% as interpreted by CMS in its FFY 2010 inpatient rule. **Rural Community Hospital Demonstration Program:** Effective immediately through December 31, 2014, the rural community hospital demonstration project, which provides cost-based inpatient payments for rural hospitals with fewer than 51 beds, is extended and expanded.
2011 Provider Payment Rate Years	
Provider Payment Reductions	**Medicare Update Factor Reductions—Pre-Determined Reductions:** Effective July 1, 2010 to June 30, 2011, the annual Medicare update factor is reduced by 0.25 percentage points for Inpatient Psychiatric Facilities (IPFs). Effective October 1, 2010 to September 30, 2011, the annual Medicare update factor is reduced by 0.25 percentage points for inpatient hospitals and IRFs. Effective October 1, 2010 to September 30, 2011, the annual Medicare update factor is reduced by 0.50 percentage points for LTCHs. Effective January 1, 2011 to December 31, 2011, the annual Medicare update factor is reduced by 0.25 percentage points for outpatient hospitals and by 1.0 percentage point for HHAs. **Cap on Medicare Outlier Payments to HHAs:** Effective January 1, 2011 and thereafter, the HHA PPS outlier pool is reduced from 5% of total payments to 2.5% and a 10% cap is set on total outlier payments for each HHA (mandates policies adopted in the 2010 HHA final rule).
Provider Payment Improvements	**Geographic Variation in Medicare Spending:** Effective October 1, 2010 - September 30, 2012, the HHS Secretary must develop a methodology to distribute $400 million in new funding to hospitals located in counties in the lowest quartile of total risk-adjusted Medicare Part A and Part B spending nationwide.

	Medicare Wage Index Floor: Effective October 1, 2010 and thereafter for inpatient hospitals and January 1, 2011 and thereafter for outpatient hospitals and physicians, the Medicare wage index and Geographic Practice Cost Index (GPCI) is held to a floor of 1.0 in "frontier" states.
Health Delivery System Reform	**Medicaid Healthcare-Acquired Condition (HAC) Payment Policy:** Effective July 1, 2011 and thereafter, state Medicaid programs must adopt policies to reduce Medicaid payments for conditions covered under Medicare's HAC payment policy. **Establishment of a CMS Center for Medicare and Medicaid Innovation (CMI):** Effective no later than January 1, 2011, the HHS Secretary must establish a CMI to test new/innovative Medicare and Medicaid payment and service delivery models.
Other Provider-Related Provisions	**Medicare Graduate Medical Education (GME)—Redistribution of Unused Residency Slots:** Effective July 1, 2011, 65% of the currently unused hospital resident training slots will be redistributed to hospitals based on a priority order with all residency increases occurring by March 23, 2012. **Medicare Wage Index Reform:** By December 31, 2011, the Secretary must report to Congress with recommendations for comprehensive reform of the Medicare wage index system. **Application of Budget Neutrality for the Medicare Hospital Wage Index:** Effective October 1, 2010 and thereafter, the application of budget neutrality associated with the effect of the Medicare wage index rural floor and imputed rural floor must be applied on a national, rather than state-specific basis through a uniform, national adjustment. **Hospital Reporting of Charges:** Effective October 1, 2010 and thereafter, hospitals must publicize a list of standard charges for items and services provided by the hospital, including charges related to Diagnosis Related Groups (DRGs). **Medicaid Quality Measure Development and Reporting:** By January 1, 2011, the Secretary must publish priorities for the development and advancement of Medicaid quality measures for Medicaid eligible adults for the eventual reporting and use by providers, state Medicaid programs, and health insurers/managed care entities that contract with state Medicaid programs. **Establishment of Program to Reduce Readmissions Rates:** Effective January 1, 2011 to December 31, 2015, the Secretary must establish a Community Care Transitions Program for hospitals with high readmission rates and partnership organizations to implement care transitions using evidence-based interventions for targeted high-risk beneficiaries. **Medicare Wage Index Reclassification Thresholds:** Effective October 1, 2010 to September 30, 2012, the less restrictive FFY 2008 Medicare hospital wage index reclassification thresholds are restored.

	MedPAC Review of Medicare Payments for Rural Areas: By January 1, 2011, MedPAC must review and report to Congress on Medicare payment adequacy for rural health care providers. **Urban Medicare Dependent Hospital (MDH) Study:** By November 2010, CMS must study and make recommendations to Congress on whether the rural MDH payment methodology should be extended to urban MDHs. **Rural MDH Classification Extension:** Effective October 1, 2011 to September 30, 2012, the special rural MDH classification is extended for one year. **Medicare Payment Adjustment for Low-Volume Hospitals:** Effective October 1, 2010 to September 30, 2012, the calculation of the Medicare low-volume add-on amount is modified and access to the add-on is expanded. **Medicare Rural Hospital Flexibility Program:** Effective October 1, 2010 to September 30, 2012, the "FLEX" program is extended and the Small Rural Hospital Improvement grant program will make funding available to support small rural hospitals' participation in the bill's delivery system reform programs. **Medicare Skilled Nursing Facility (SNF) Payment Changes:** Effective October 1, 2010, implementation of Version 4 of Resource Utilization Groups is delayed for one year. **Updating Medicare Outpatient Payments for PPS-Exempt Cancer Hospitals:** Effective January 1, 2011, if appropriate, payments to cancer hospitals must be adjusted upward if a CMS study of Medicare outpatient costs for PPS-exempt cancer hospitals compared to hospitals paid under the PPS deems such an adjustment is appropriate. **Medicare Advantage (MA) Payment Rates:** Effective January 1, 2011, MA payment rates are frozen at 2010 levels for one year.
2012 Provider Payment Rate Years	
Provider Payment Reductions	**Medicare Update Factor Reductions—Pre-Determined Reductions:** Effective July 1, 2011 to June 30, 2012, the annual Medicare update factor is reduced by 0.25 percentage points for IPFs. Effective October 1, 2011 to September 30, 2012, the annual Medicare update factor is reduced by 0.10 percentage points for inpatient hospitals, IRFs, and LTCHs. Effective January 1, 2012 to December 31, 2012, the annual Medicare update factor is reduced by 0.10 percentage points for outpatient hospitals and by 1.0 percentage point for HHAs. **Medicare Update Factor Reductions—Productivity Offsets:** Effective October 1, 2011 and thereafter, the annual Medicare update factor is reduced by a productivity offset (currently estimated at 1.3 percentage points) for inpatient hospitals, IRFs, SNFs, and LTCHs.

	Effective January 1, 2012 and thereafter, the annual Medicare update factor is reduced by a productivity offset (currently estimated at 1.3 percentage points) for outpatient hospitals.
Health Delivery System Reform	**Establishment of Accountable Care Organizations (ACOs) Under the Medicare Program:** Effective no later than January 1, 2012 and thereafter, the Secretary must establish a program to allow groups of providers to be recognized as ACOs and share in the cost savings they achieve for the Medicare program. **Establishment of Program to Reduce Readmissions Rates:** By March 2012, the Secretary must establish a quality improvement program for hospitals with high severity-adjusted readmission rates. **Medicare Value-Based Purchasing (VBP) Program Development for HHAs and SNFs:** By October 1, 2011, the Secretary must submit plans to Congress related to the development of VBP programs for HHAs and SNFs. **Medicare VBP Program Development for CAHs and Small Hospitals:** By March 2012, the Secretary must establish two separate, three-year VBP demonstration programs, one for CAHs and one for small hospitals excluded from the inpatient hospital VBP program. The Secretary must report to Congress with recommendations for permanent VBP programs for these providers. **Establishing a HAC Medicare Payment Policy for Providers Paid Outside of the Inpatient PPS:** By January 1, 2012, the Secretary must study and report to Congress on establishing, beginning in FFY 2015, a HAC Medicare payment policy for hospitals paid outside of the inpatient PPS. **Medicaid Payment Bundling Demonstration Project:** Effective January 1, 2012 to December 31, 2016, the Secretary must establish demonstrations in up to eight states to evaluate the use of bundled Medicaid payments for an episode of care that includes a hospitalization and concurrent physician services. **Medicaid Pediatric ACO Demonstration Project:** Effective January 1, 2012 to December 31, 2016, the Secretary must establish demonstrations to allow pediatric medical providers that meet specified requirements to be recognized as an ACO and share in the cost savings they achieve for the Medicaid program.
Other Provider-Related Provisions	**Medicaid Quality Measure Development and Reporting:** By January 1, 2012, the Secretary must publish an initial core set of Medicaid quality measures (based on quality measure priorities to be developed by January 1, 2011 [see above]) that are applicable to Medicaid eligible adults for the eventual reporting and use by providers, state Medicaid programs, and health insurers/managed care entities that contract with state Medicaid programs. **MA Payment Rates:** Effective January 1, 2012 and thereafter, MA county-level benchmark rates are reduced such that the average MA payment per beneficiary is about 100% of per capita spending for traditional FFS Medicare with adjustments for measures of spending per capita and on MA plans' performance on quality and patient satisfaction measures.

2013 Provider Payment Rate Years	
Provider Payment Reductions	**Medicare Update Factor Reductions—Pre-Determined Reductions:** Effective July 1, 2012 to June 30, 2013, the annual Medicare update factor is reduced by 0.10 percentage points for IPFs. Effective October 1, 2012 to September 30, 2013, the annual Medicare update factor is reduced by 0.10 percentage points for inpatient hospitals, IRFs, and LTCHs and by 0.30 percentage points for hospice providers. Effective January 1, 2013 to December 31, 2013, the annual Medicare update factor is reduced by 0.10 percentage point for outpatient hospitals and by 1.0 percentage points for HHAs. **Medicare Update Factor Reductions—Productivity Offsets:** Effective July 1, 2012 and thereafter, the annual Medicare update factor is reduced by a productivity offset (currently estimated at 1.3 percentage points) for IPFs. Effective October 1, 2012 and thereafter, the annual Medicare update factor is reduced by a productivity offset (currently estimated at 1.3 percentage points) for hospice providers.
Health Delivery System Reform	**Medicare Hospital Readmissions Payment Policy:** Effective October 1, 2012 and thereafter, a program is established to reduce Medicare inpatient payments for acute care hospitals with higher than expected risk-adjusted readmission rates related to certain conditions. Medicare payment reductions are capped at 1.0% in FFY 2013, 2.0% in FFY 2014 and 3.0% in FFY 2015. CAHs are not subject to the Medicare readmissions payment policy. **Medicare Hospital VBP Program:** Effective October 1, 2012 and thereafter, the Secretary must implement a budget-neutral Medicare VBP program to reimburse hospitals based on performance on certain quality measures related to select conditions. The VBP pool will be funded by Medicare inpatient payment reductions of 1.0% in FFY 2013, 1.25% in FFY 2014, 1.50% in FFY 2015, 1.75% in FFY 2016 and 2.0% in FFY 2017 and subsequent years. CAHs and small hospitals with insufficient numbers of cases are excluded from the program. **Medicare Payment Bundling Pilot Program:** Effective by January 1, 2013, the Secretary must establish a program to test the bundling of Medicare payments for select conditions. The bundled service would include care delivered three days prior to hospital admission and extend through 30 days following discharge; and would cover all inpatient, outpatient, physician, and post-acute care services. The pilot program would last five years, and could be extended for providers participating at the end of the five-year period if certain spending and quality conditions are met.
Other Provider-Related Provisions	**Medicaid Quality Measure Development and Reporting:** By January 1, 2013, the Secretary, in consultation with states, must develop a standardized format for Medicaid quality reporting based on the initial core set of adult Medicaid quality measures (to be developed by January 1, 2012 [see above]) and create procedures

	to encourage states to use those measures to voluntarily report information regarding the quality of care for Medicaid eligible adults. The Secretary must also establish a Medicaid Quality Measurement Program. **Public Reporting of Physician Quality Data:** By January 1, 2013, the Secretary must implement a plan for making publicly available, through a Physician Compare Web site, information on physician performance that provides comparable information on quality and patient experience measures with respect to physicians enrolled in the Medicare program.
2014 Provider Payment Rate Years	
Provider Payment Reductions	**Medicare Update Factor Reductions—Pre-Determined Reductions:** Effective July 1, 2013 to June 30, 2014, the annual Medicare update factor is reduced by 0.10 percentage points for IPFs. Effective October 1, 2013 to September 30, 2014, the annual Medicare update factor is reduced by 0.30 percentage points for inpatient hospitals, IRFs, LTCHs, and hospice providers. Effective January 1, 2014 to December 31, 2014, the annual Medicare update factor is reduced by 0.30 percentage points for outpatient hospitals. **Medicare DSH Reductions:** Effective October 1, 2013 to September 30, 2019, the Secretary must reduce Medicare DSH payments to hospitals. Over the six-year period, 25% of Medicare DSH payments, considered to be the "empirically justified" component of DSH, will continue to be paid to each hospital based on the current methodology. The remaining 75% of Medicare DSH payments will be subject to reductions to reflect reductions in the uninsured population and will be distributed based on each hospital's level of uncompensated care compared to total uncompensated care for all hospitals. **Medicaid DSH Reductions:** Effective October 1, 2013 to September 30, 2020, the Secretary must develop a methodology, within certain parameters, to reduce federal DSH allotments to all states over a seven-year period to achieve mandated savings nationwide of $500 million in FFY 2014, $600 million in FFY 2015, $600 million in FFY 2016, $1.8 billion in FFY 2017, $5.0 billion in FFY 2018, $5.6 billion in FFY 2019, and $4.0 billion in FFY 2020. **Establishment of Independent Payment Advisory Board (IPAB) to Reduce Medicare Spending:** Effective January 15, 2014 and thereafter, the IPAB (established by the legislation) is required to submit proposals to Congress that would reduce Medicare by targeted maximum amounts of 0.5% in 2015, 1.0% in 2016, 1.25% in 2017, and 1.5% in 2018 and beyond if it is determined that there is excess cost growth in the Medicare program. Providers scheduled to receive a reduction to their marketbasket update in excess of the productivity-based reduction are exempt from any proposed reductions from the Board through 2019. These providers include inpatient and outpatient hospitals, IRFs, IPFs, HHAs, LTCHs, and hospice providers. CAHs are not exempt from IPAB's proposals.

	Medicare HHA Payment Rebasing: Effective January 1, 2014 to December 31, 2017, the Secretary must rebase HHA Medicare payment rates. Reduced, rebased HHA payment rates will be phased in over the four-year period and reductions cannot exceed 3.5% each year.
Health Delivery System Reform	**Geographic Variation in Medicare Spending:** Effective October 1, 2013 and thereafter, the Secretary must modify the inpatient hospital VBP program to include measures of efficiency. Measures of Medicare spending per beneficiary adjusted for age, sex, race, severity of illness, and other factors that the Secretary determines to be appropriate must be included.
Other Provider-Related Provisions	**Medicare Pay-for-Reporting Programs for Post-Acute Care Providers:** Effective October 1, 2013 and thereafter, the Secretary must establish Medicare pay-for-reporting programs for IRFs, LTCHs, and hospice providers. Providers that do not report data on select quality measures will be subject to a 2.0 percentage point reduction to the annual Medicare update. **Quality Reporting for Cancer Hospitals:** Effective October 1, 2013 and thereafter, the Secretary must establish a quality reporting program for cancer hospitals to report quality and efficiency measures. **Medicare Hospice Payment Rates:** Effective on or after October 1, 2013, the Secretary, after consultation with MedPAC and study of hospice provider Medicare payment rates, must make revisions to the payment rates to hospice providers, if necessary.
2015 Provider Payment Rate Years	
Provider Payment Reductions	**Medicare Update Factor Reductions—Pre-Determined Reductions:** Effective July 1, 2014 to June 30, 2015, the annual Medicare update factor is reduced by 0.30 percentage points for IPFs. Effective October 1, 2014 to September 30, 2015, the annual Medicare update factor is reduced by 0.20 percentage points for inpatient hospitals, IRFs, and LTCHs and by 0.30 percentage points for hospice providers. Effective January 1, 2015 to December 31, 2015, the annual Medicare update factor is reduced by 0.20 percentage points for outpatient hospitals. **Medicare Update Factor Reductions—Productivity Offsets:** Effective January 1, 2015 and thereafter, the annual Medicare update factor is reduced by a productivity offset (currently estimated at 1.3 percentage points) for HHAs.
Health Delivery System Reform	**Medicare HAC Payment Policy:** Effective October 1, 2014 and thereafter, a program is established to apply a 1.0% Medicare payment penalty for hospitals in the worst 25th percentile of risk-adjusted HAC rates. The Secretary must publicly report on hospitals' HAC measures.

	Medicare VBP for Physicians: Effective January 1, 2015 for select physicians and groups of physicians; January 1, 2017 and thereafter for all physicians and groups of physicians, the Secretary must establish a value-based payment modifier that allows for differential payments to physicians based upon quality and cost indicators.
Other Provider-Related Provisions	**Medicare Pay-for-Reporting Programs for IPFs:** Effective July 1, 2014 and thereafter, the Secretary must establish Medicare pay-for-reporting programs for IPFs. IPFs that do not report data on select quality measures will be subject to a 2.0 percentage point reduction to the annual Medicare update. **Medicare Physician Pay-for-Reporting:** Effective January 1, 2015 and thereafter, the Secretary must implement a Medicare pay-for-reporting program for physicians. Physicians who do not report data on select quality measures will be subject to a 1.5 percentage point reduction to Medicare payment rates in the first year of the program and a 2.0 percentage point reduction to Medicare payment rates in year two of the program and thereafter.
2016 Provider Payment Rate Years	
Provider Payment Reductions	**Medicare Update Factor Reductions—Pre-Determined Reductions:** Effective July 1, 2015 to June 30, 2016, the annual Medicare update factor is reduced by 0.20 percentage points for IPFs. Effective October 1, 2015 to September 30, 2016, the annual Medicare update factor is reduced by 0.20 percentage points for inpatient hospitals, IRFs, and LTCHs and by 0.30 percentage points for hospice providers. Effective January 1, 2016 to December 31, 2016, the annual Medicare update factor is reduced by 0.20 percentage points for outpatient hospitals.
Health Delivery System Reform	**Establishment of Medicare VBP Pilot Programs:** By January 1, 2016, the Secretary must implement budget-neutral pilot programs to test VBP payments for IRFs, IPFs, LTCHs, cancer hospitals, and hospice providers.
2017 Provider Payment Rate Years	
Provider Payment Reductions	**Medicare Update Factor Reductions—Pre-Determined Reductions:** Effective July 1, 2016 to June 30, 2017, the annual Medicare update factor is reduced by 0.20 percentage points for IPFs. Effective October 1, 2016 to September 30, 2017, the annual Medicare update factor is reduced by 0.75 percentage points for inpatient hospitals, IRFs, and LTCHs and by 0.30 percentage points for hospice providers.

	Effective January 1, 2017 to December 31, 2017, the annual Medicare update factor is reduced by 0.75 percentage points for outpatient hospitals.
2018 Provider Payment Rate Years	
Provider Payment Reductions	**Medicare Update Factor Reductions—Pre-Determined Reductions:** Effective July 1, 2017 to June 30, 2018, the annual Medicare update factor is reduced by 0.75 percentage points for IPFs. Effective October 1, 2017 to September 30, 2018, the annual Medicare update factor is reduced by 0.75 percentage points for inpatient hospitals, IRFs, and LTCHs and by 0.30 percentage points for hospice providers. Effective January 1, 2018 to December 31, 2018, the annual Medicare update factor is reduced by 0.75 percentage points for outpatient hospitals.
2019 Provider Payment Rate Years	
Provider Payment Reductions	**Medicare Update Factor Reductions—Pre-Determined Reductions:** Effective July 1, 2018 to June 30, 2019, the annual Medicare update factor is reduced by 0.75 percentage points for IPFs. Effective October 1, 2018 to September 30, 2019, the annual Medicare update factor is reduced by 0.75 percentage points for inpatient hospitals, IRFs, and LTCHs and by 0.30 percentage points for hospice providers. Effective January 1, 2019 to December 31, 2019, the annual Medicare update factor is reduced by 0.75 percentage points for outpatient hospitals.
2020 Provider Payment Rate Years	
Provider Payment Reductions	**Medicare Update Factor Reductions—Pre-Determined Reductions:** Effective July 1, 2019 to June 30, 2020, the annual Medicare update factor is reduced by 0.75 percentage points for IPFs.

Note: Provider payment changes, health care delivery system reform and other provider-related provisions implemented and effective over multiple years are shown in the timeline in the first year the provision is to be implemented.

Description of provider rate years:

- inpatient hospitals, IRFs, SNFs, LTCHs and hospice providers: October 1 to September 30;
- outpatient hospitals and HHAs: January 1 to December 31; and
- IPFs: July 1 to June 30.