



The Patient Protection and Affordable Care Act Summary Implementation Timeline April 1, 2010

The MGMA Government Affairs Department developed a summary implementation timeline focusing on major issues of interest to MGMA members. Some provisions are effective immediately, while others will take years to implement. A significant number of provisions in the legislation contain language directing the Secretary of the U.S. Department of Health and Human Services (HHS) to develop implementing regulations. The summary timeline contains changes to be implemented by year, with an additional section of provisions where no time-frame is specified included at the end. MGMA will be heavily involved in working with the Secretary to make sure that group practice interests are represented as implementing regulations are proposed and finalized. In addition, we anticipate that the Centers for Medicare & Medicaid Services (CMS) will issue guidance concerning bill provisions that may impact current regulations. MGMA will continue to communicate changes and updates to the healthcare reform legislation.

Questions about the implementation timeline or healthcare reform?

- Contact the MGMA Government Affairs Department, 877.ASK.MGMA (275.6462), ext. 1300 or e-mail govaff@mgma.com.
- Discuss your questions in the "[*Federal Legislation and Red Tape Forum*](#)" in the MGMA Member Community.

2010

Reimbursement

- **Imaging:** Payment for the technical component of diagnostic services will be reduced by 50 percent for subsequent procedures on consecutive body parts beginning July 1. This is an increase from the current 25 percent reduction (Sec. 3135).
- **Geographical Practice Cost Index (GPCI) work floor:** Extended through Dec. 31, 2010. The GPCI work floor had expired at the end of 2009 (Sec. 3102).
- **Therapy cap exception process:** Extended through Dec. 31, 2010 (Sec. 3103).
- **Revision of certain Part A market basket updates and incorporation of productivity improvements:** Revises certain market basket updates and incorporates a full productivity adjustment into any updates that do not already incorporate such adjustments, including inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals and inpatient rehabilitation facilities. For inpatient and outpatient hospitals, the market basket update will be reduced by:



- o 0.25% for FY 2010-2011;
- o 0.1% for FY 2012-2013;
- o 0.3% for FY 2014;
- o 0.2% for FY 2015-2016;
- o 0.75% for FY 2017-2019.

(Sec. 3401, as modified by Sec. 10319 and Sec. 10322).

- **Practice expense geographic practice cost index (GPCI) adjustment:** Retroactively effective from Jan. 1, 2010, HHS is required to revise the calculation method of the practice expense (PE) portion of the GPCI. This revision results in increased PE GPICs for certain rural areas. Implementation of this provision will likely require CMS to reprocess certain 2010 claims (Sec. 3102 as modified by Sec. 1108 of Reconciliation).

Employer Requirements

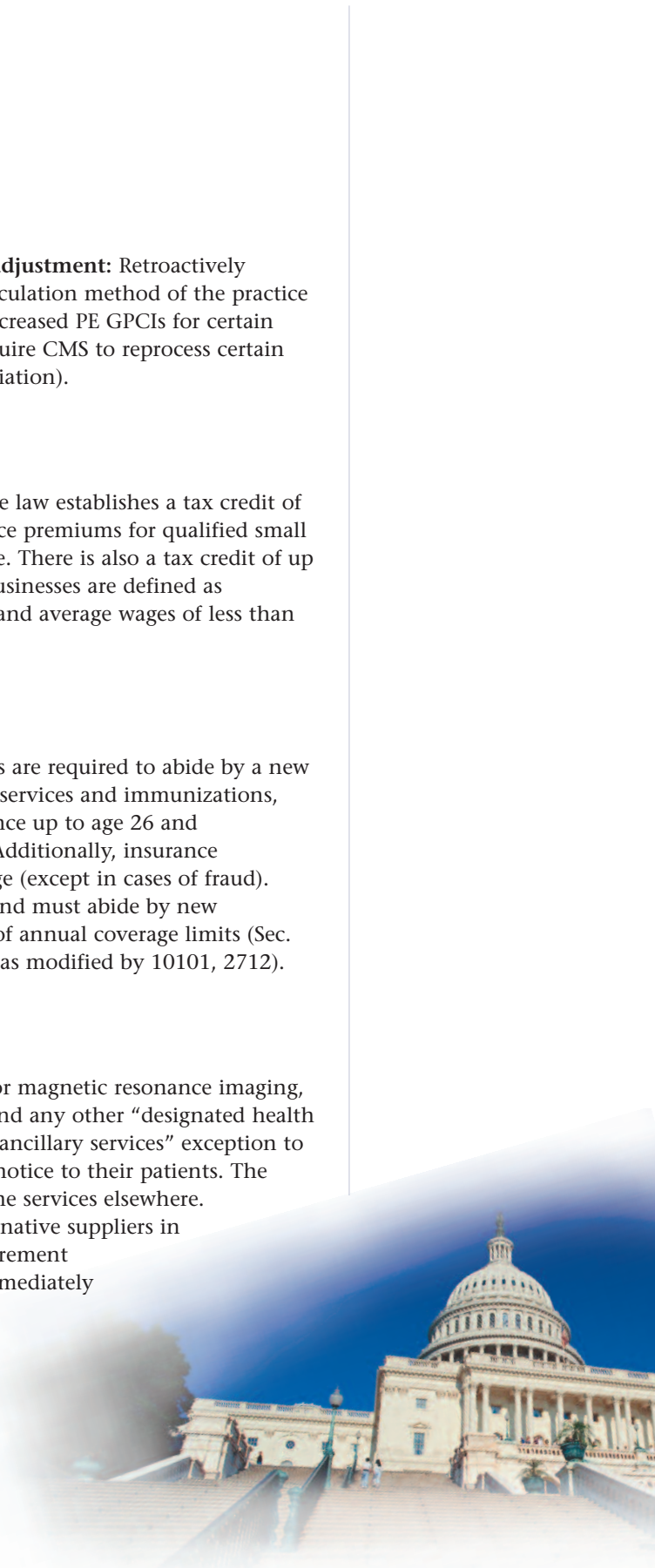
- **Small Business Tax Credit:** Effective calendar year 2010, the law establishes a tax credit of up to 35% of an employer's contribution for health insurance premiums for qualified small businesses contributing to their employees' health insurance. There is also a tax credit of up to 25% for small nonprofit organizations. Qualified small businesses are defined as employers with 25 or fewer full-time equivalent employees and average wages of less than \$50,000 (Sec. 1421 as modified by Sec. 10105).

Insurance Reform

- **Initial Insurance Reforms:** Effective Sept. 23, 2010, insurers are required to abide by a new regulations including: mandating coverage for preventative services and immunizations, allowing children to remain on their parents' health insurance up to age 26 and eliminating pre-existing condition exclusions for children. Additionally, insurance companies are no longer allowed to rescind existing coverage (except in cases of fraud). Insurers are prohibited from using lifetime coverage limits and must abide by new restrictions, as defined by the Secretary of HHS, on the use of annual coverage limits (Sec. 2713, 2714, 1253/1255 and modified by 10103, 2714, 2711 as modified by 10101, 2712).

Compliance

- **Imaging/self-referral:** Physicians who refer their patients for magnetic resonance imaging, computed tomography or positron emission tomography (and any other "designated health services" the Secretary deems appropriate) on the "in-office ancillary services" exception to the Stark/physician self-referral law must provide a written notice to their patients. The notice must inform the patient that he or she may obtain the services elsewhere. The patient must also be supplied with a written list of alternative suppliers in the area where the patient resides. The law makes this requirement effective Jan. 1, 2010; providers should begin complying immediately (Sec. 6003).
- **Submission of Medicare claims:** Effective Jan. 1, Medicare Part B claims must be submitted no later





than 12 months after the date of service. For services furnished before Jan. 1, 2010, a bill or request for payment must be submitted no later than Dec. 31, 2010 (Sec. 6404).

2011

Reimbursement

- **Primary care incentives:** For 2011 through 2016, primary care providers (family medicine, internal medicine, geriatrics and pediatrics physicians or nurse practitioners, clinical nurse specialists and physician assistants) must charge at least 60 percent of their total allowed Medicare charges as office, nursing facility or home visits in order to qualify for a 10 percent bonus payment. This payment will be distributed on a monthly or quarterly basis (Sec. 5501).
- **General surgery in HPSA incentive:** For 2011 through 2016, general surgeons furnishing major procedures (10-day or 90-day global service period) in a health professional shortage area (HPSA) will be eligible for a 10 percent bonus payment to be paid on a monthly or quarterly basis (Sec. 5501).
- **Imaging:** For Medicare physician fee schedules for 2011 and thereafter, the utilization assumption for services using “expensive diagnostic imaging equipment” (currently defined by CMS to include magnetic resonance imaging and computed tomography) will be set at 75 percent. The utilization assumption is used to calculate the practice expense relative value units in the technical component payment. Through 2009, the utilization assumption for such equipment was set at 50 percent. In 2010, CMS increased the assumption to 90 percent, to be phased in over four years. This means that the 2010 assumption is roughly 60 percent. By increasing the assumption to 75 percent on Jan. 1, 2011, practices could see a further cut in the technical component payment for services using this equipment. However, beginning in 2012, this cut will be less than it would have been under the 90 percent assumption. (Sec. 3135, as modified by Rec. Sec. 1107).
- **Physician Quality Reporting Initiative (PQRI):** The incentive payment for successful participation in the 2011 PQRI shall be one percent of a practice’s total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period. By Jan. 1, 2011 at the latest, the Centers for Medicare & Medicaid Services (CMS) must establish an informal appeals process for PQRI participants that did not satisfactorily participate. Beginning in 2011, CMS will offer an additional participation method through a continuous assessment program, such as a qualified American Board of Medical Specialties Maintenance of Certification (ABMS MOC) program. Practices that utilize this new method for PQRI reporting years 2011 through 2014 will be eligible for an additional 0.5 percent incentive payment (Sec. 3002).

Administrative Simplification

- **Operating Rules for the Eligibility and Claim Status Electronic Transactions:** Operating rules for the HIPAA eligibility verification transaction and the health claim status transaction are required by July 1, 2011, with the goal of creating as much uniformity in the implementation of the electronic standards as possible.





The operating rules are to be consensus-based, will reflect the necessary business rules affecting health plans and healthcare providers and the manner in which they operate. They may also allow for the use of a machine readable identification card (Sec. 1104).

Insurance Reform

- **Health insurance plans requirement to report MLRs:** Effective 2011, health plans are required to report to the Secretary of HHS their Medical Loss Ratio (MLR), which is the proportion of premium dollars spent on clinical services and quality versus all other non-claims costs. Insurance companies will be required to meet certain MLRs or provide enrollees with rebates if the plan does not meet the required MLR. Group plans must have an MLR of 85% and individual plans must have an MLR of 80%. Beginning in 2011, insurers must report their MLR for the previous year and pay rebates if necessary (Sec. 2718 as modified by Sec. 10101).

Compliance

- **Medical liability reform:** States will be eligible to receive grants for the development, implementation and evaluation of alternatives to tort litigation for resolving disputes allegedly caused by healthcare providers or organizations. Grants can be awarded for no more than five years. A total of \$50 million is available (Sec. 10607).
- **Pre-enrollment/revalidation disclosure:** Beginning March 23, 2011, a provider or supplier who submits an application for enrollment or revalidation must disclose any current or former affiliation with any provider or supplier that has been subject to payment suspension under a federal healthcare program, excluded from Medicare, Medicaid or CHIP or has had its billing privileges denied or revoked. The Secretary will have the authority to deny enrollment based on such disclosures, subject to appeal (Sec. 6401).
- **NPI on all applications and claims:** By Jan. 1, 2011, all Medicare and Medicaid providers and suppliers that qualify for an NPI must include their NPI on all enrollment applications and claims (Sec. 6402).
- **Additional requirements for charitable hospitals:** Requires tax-exempt charitable hospitals (501(c)(3)) would be required to: conduct a community health needs assessment every two years; implement a written financial assistance policy; and impose a penalty tax for failure to comply with this requirement (Sec. 9007, as modified by Sec. 10903).

2012

Reimbursement

- **Physician Quality Reporting Initiative (PQRI):** The incentive payment for successful participation in the 2012 through 2014 PQRI shall be 0.5 percent of a practice's total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period. By Jan. 1, 2012, at the latest, CMS must provide timely feedback to PQRI participating practices (Sec. 3002).



- **Hospital value-based purchasing program:** HHS shall establish a hospital value-based purchasing program on or after Oct. 1, 2012, under which value-based incentive payments are made in a fiscal year to hospitals that meet performance standards for the fiscal year. Additionally, HHS shall establish value-based purchasing demonstration programs for critical access hospitals and hospitals excluded from the program because of insufficient numbers of measures and cases (Sec. 3001).
- **Medicaid Disproportionate Share Hospital (DSH) Payments:** This provision reduces state DSH allotments, except for Hawaii, by 50% or 35% once a state's uninsurance rate decreases by 45%, depending on whether they have spent at least 99.9% of their allotments on average during FY 2004-FY 2008. It also requires a reduction of only 25% or 17.5% for low DSH states, depending on whether they have spent at least 99.9% of their allotments on average during FY2004-FY2008. The legislation prescribes allotment reduction requirements for subsequent fiscal years. Revisions for DSH allotments for Hawaii for the last three quarters of FY 2012, and for FY 2013 and succeeding fiscal years (Sec. 2551, as modified by Sec. 10201).

Administrative Simplification

- **Standardized Health Plan Enrollment and Claim Edits:** The HHS Secretary is to seek input by Jan. 1, 2012, on whether the health plan enrollment process could be made electronic and standardized, and whether there could be greater transparency and consistency of the methodologies and processes used by health plans to establish claim edits (Sec. 10109).
- **Health Plan Identifier:** HHS is required to develop a final rule by Oct. 1, 2012, establishing a unique health plan identifier based on the input of the National Committee on Vital and Health Statistics. This identifier will greatly assist practices by simplifying and improving the routing of healthcare transactions and the administration of healthcare plan benefits (Sec. 1104).

2013

Reimbursement

- **Medicaid/Medicare payment parity:** Medicaid payments to primary care physicians (specialties designated as family medicine, general internal medicine or pediatric medicine) furnishing evaluation and management services and immunizations are raised to match Medicare rates for 2013 and 2014. Additional federal funds are allocated to states to account for this payment increase (Sec. 1202 of the Health Care Education Affordability Reconciliation Act (H.R. 4872)).

Administrative Simplification

- **Effective Date for the Operating Rules for the Eligibility and Claim Status Electronic Transactions:** Effective Jan. 1, 2013, operating rules for the HIPAA insurance eligibility verification transaction (270/271) and the health claim status transaction (276) will





be set with the goal of creating as much uniformity in the implementation of the electronic standards as possible, and this may allow for the use of a machine readable identification card (Sec. 1104).

2014

Reimbursement

- **Mandates Medicare Advantage MLR:** Effective Jan. 1, 2014, Medicare Advantage (MA) plans are required to have Medical Loss Ratio (MLR) of 85%. If the Secretary of HHS determines that a plan fails to achieve the stipulated MLR, the MA plan must pay a rebate to HHS and could possibly face suspension of their beneficiary enrollment or contract termination (Sec. 1103 of Reconciliation).
- **Independent Payment Advisory Board IPAB:** By Jan. 15, the non-elected Independent Payment Advisory Board (IPAB) may begin to develop and submit to Congress advisory reports on matters related to the Medicare program. The IPAB is given authority to formulate comprehensive regulatory and legislative recommendations to slow the growth in national health spending. In certain circumstances, the IPAB would have the authority to make binding Medicare policy recommendations and non-binding private payer policy recommendations to Congress. Empowering an IPAB with authority to make binding Medicare policy recommendations based on expenditure targets inflicts physicians with an additional expenditure constraint in addition to the sustainable growth rate formula. No later than July 1, and annually thereafter, the IPAB shall produce a public report containing standardized information on system-wide healthcare costs, patient access to care, utilization, and quality of care that allows for comparison by region, types of services, types of providers and both private and public payers (Sec. 3403, as modified by Sec. 10320).

Employer Requirements

- **Expansion of small business tax credits:** Effective Jan. 1, 2014, eligible employers who purchase coverage through the State Exchange can receive a tax credit for two years of up to 50 percent of their contribution. Tax-exempt small businesses may receive tax credits of up to 35 percent of their contribution. Qualified small businesses are defined as having 25 or fewer full-time equivalent employees and average wages of less than \$50,000 (Sec. 1421 as modified by Sec. 10105).
- **Employer contribution requirement:** Effective Jan. 1, 2014, penalties are implemented on companies with 50 or more employees that do not offer coverage and have at least one full-time employee who receives the premium assistance tax credit. The penalty is equal to \$2,000 per year for each full-time employee, but the first 30 employees are not counted. For employers with more than 50 employees who do offer coverage but have at least one full-time employee receiving a premium tax credit, the penalty is the lesser of either \$2,000 per full-time employee, or \$3,000 for each employee receiving the premium credit (Sec. 1513 but modified by Sec. 1003 of the Reconciliation bill).
- **Small business participation in exchanges:** Effective Jan. 1, 2014, employers with up to 100 employees may select to enroll in the state based Small Business Health Options Program (SHOP) (Sec. 1311).



Individual Provisions

- **Individual coverage requirement:** Effective Jan. 1, 2014, individuals are required to have acceptable health insurance coverage for themselves and their dependents or pay a fine. People with incomes below the filing threshold are exempt from fines. The penalty is the greater of either a flat fee (\$95 in 2014) or a percent of income (1% in 2014). Individuals can qualify for tax credits and cost-sharing subsidies based on income (Sec. 5000A as modified by Sec. 10106, but changed in Reconciliation Sec. 1002).

Administrative Simplification

- **Health Plan Identifier:** Jan. 1, 2014, is set as the effective date for a unique health plan identifier (Sec. 1104).
- **Electronic Funds Transfer (EFT) and Health Care Payment and Remittance Advice:** An effective date of Jan. 1, 2014, for EFT final rule and for the set of operating rules for EFT, healthcare payment and remittance advice, claims and referral certification and authorization (Sec. 1104).
- **Health Claims Attachments:** HHS to issue a final rule by Jan. 1, 2014, establishing a standard and single set of associated operating rules for health claims attachments (Sec. 1104).
- **Health Plan Penalties for Non-Compliance:** No later than April 1, 2014, and annually after that, the HHS Secretary shall assess a penalty fee against a health plan that has failed to meet the requirements with respect to certification and documentation of compliance with the standards and associated operating rules (Sec. 1104).

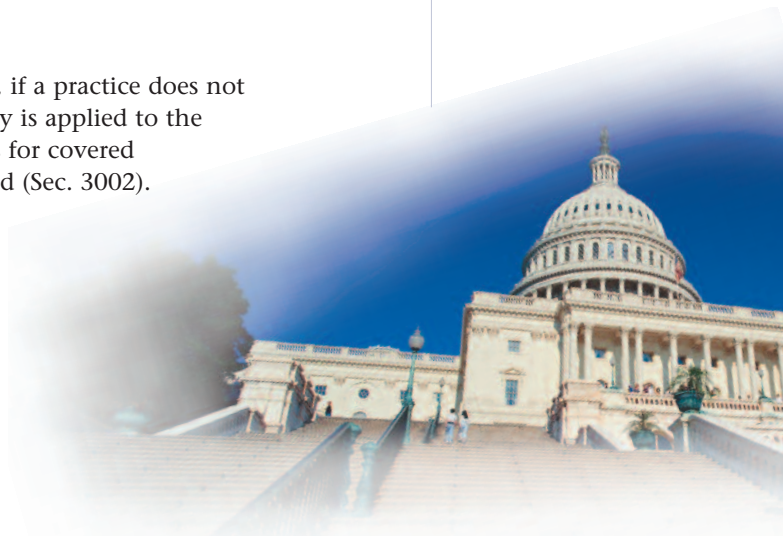
Insurance Reform

- **Insurance Reforms:** Effective Jan. 1, 2014, insurers must abide by new requirements such as no longer being able to deny coverage to people with pre-existing conditions, and they may not discriminate based on medical history, health status, genetic information, disability, evidence of insurability or any other factor determined appropriate by HHS. Insurers will have new limits on rate differentials for things such as age or tobacco use and are required to issue new coverage and renew coverage. Annual and lifetime limits are prohibited. (Sec. 2704).

2015

Reimbursement

- **Physician Quality Reporting Initiative (PQRI):** In 2015, if a practice does not satisfactorily participate in the PQRI, a 1.5 percent penalty is applied to the practice's total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period (Sec. 3002).





- **Hospital Acquired Conditions (HACs):** Starting in 2015 to reduce HACs, HHS is given the authority to add a 1 percent penalty adjustment in payments to hospitals in the top quartile of rates of HACs (Sec. 3008).

Individual Provisions

- **Individual Mandate Penalty Increases:** Effective Jan. 1, 2015, the penalties for uninsured individuals increase, and the new penalty is the greater of either \$325 or 2% of income. (Sec. 5000A as modified by Sec. 10106, but changed in Reconciliation Sec. 1002).

2016

Reimbursement

- **Physician Quality Reporting Initiative (PQRI):** In 2016 and beyond, if a practice does not satisfactorily participate in the PQRI, a 2 percent penalty is applied to the practice's total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period. (Sec. 3002)

Individual Provisions

- **Individual Mandate Penalty Increases:** Effective Jan. 1, 2016, the penalties for uninsured individuals increase, and the new penalty is the greater of either \$695 or 2.5% of income (Sec. 5000A as modified by Sec. 10106, but changed in Reconciliation Sec. 1002).

Administrative Simplification

- **Effective Date for Standard and Operating Rules:** The effective date of Jan. 1, 2016 is set for the health claims attachments standard and operating rules for claims attachments, claims, and referral certification and authorization (Sec. 1104).

No Specified Date:

Administrative Simplification

- **ICD-9 to ICD-10 CROSSWALK:** The Secretary must make appropriate revisions to the crosswalk between the International Classification of Diseases, 9th Revision (ICD-9) to ICD-10. Crosswalks between the old and the new code sets would allow at least temporary use of "legacy" billing systems. These crosswalks will be critical as physician practices and others are required under a 2009 regulation to transition to this new code set by Oct. 1, 2013 (Sec. 10109).

