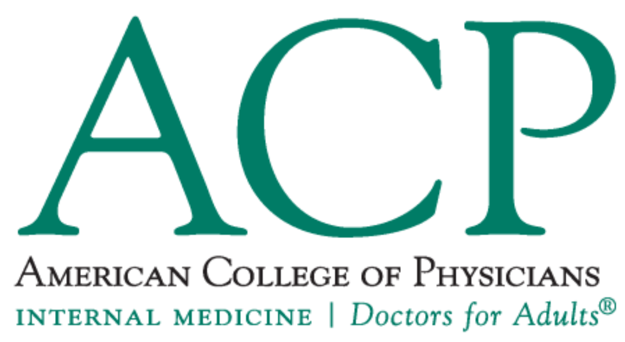

An Internist's Practical Guide to Understanding Health System Reform

Prepared by: ACP's Division of Governmental Affairs and Public Policy

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How to use this guide:

This document is intended to serve as a practical resource guide for internists on recently-enacted health system reform legislation, the Patient Protection and Affordable Care Act (PPACA). The guide can be printed out in its entirety (109 pages) or by provision-of-interest. For easy viewing, provisions in the table of contents are equipped with hyperlinks that will take viewers directly to the respective provisions within the guide. Simply place the cursor over a given provision in the table of contents, and left click with the mouse. This document is also in a "searchable" format in Adobe Acrobat, which allows viewers to search for items of interest using key words and phrases.

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I. Introduction

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Summary of Key Health System Reforms Affecting Patients

The following summary of key provisions affecting patients is written in language that is intended to be understandable by much of the general public. Physician users of this guide have the option of printing out only this one-page summary and making it available to their patients.

Effective 2010:

- If you get sick or hurt, your insurer can no longer drop your coverage.
- Your children can remain on your health insurance plan until they turn 26.
- If you have not been able to get health insurance because of an on-going medical condition, you will be able to join a "pool" where you can get insurance. You will also receive added financial help. You can join this "pool" until 2014. At that time, no one can be turned down for insurance because of an on-going medical condition.
- Your children up to age 19 with on-going medical conditions cannot be turned down for health insurance.
- If you are sick for a long time, your insurance company will not be able to limit the dollar value of your benefits over the course of your life.
- If you have Medicare prescription drug coverage, you will receive $250 from Medicare in 2010 to help with the cost of your drugs. To receive the $250, you must be in the "donut hole." The "donut hole" is a gap in coverage where you must pay the total cost of your prescription drugs.
- Insurers writing new policies must pay for recommended preventive care for adults, infants, children and teenagers, including recommended shots to fight off diseases; and additional services for women, such as mammograms.
- If you have health insurance and have stopped working before age 65, you may be protected by a program that provides financial help to employers who have many health care claims from early retirees.
- If you have health insurance, your insurance company must tell you how much of your premium goes toward medical care and how much goes toward administrative and marketing costs.
- If you are a small company with no more than 25 employees, you may be able to get tax credits to help buy insurance for your employees. Average annual wages must be less than $50,000.

Effective 2011:

- If you have Medicare prescription drug coverage and are in the "donut hole," brand-name drugs will cost 50 percent less and generic drugs will cost 7 percent less.
- If you have Medicare coverage, you will be able to have a physician or other qualified health professional evaluate your health each year, paid for by Medicare.
- Your health plan will be required to give you money back if they do not direct 85 percent of premium costs to medical care. For small insurers and individual plans, it is 80 percent.

Effective 2014:

- If you live in the U.S. legally, you cannot be turned down for health insurance for any reason.
- No one can be turned down for health insurance because of an existing medical condition.
- If you live in the U.S. legally, you may be able to get tax credits from the federal government to help with the cost of health insurance.
- If you live in the U.S. legally, you have to buy health insurance or pay a small penalty. The federal government will not send you to jail if you do not buy insurance.
- If you do not have health insurance through your job, you will be able to shop for reasonable coverage in a new market-place called a "health exchange."
- If you work for a large company that does not provide you with health insurance, the company may have to pay a penalty. Small companies – those with fewer than 50 employees – would not have to pay the penalty.
- All children, parents, and adults with no children below certain income levels will have access to health insurance under Medicaid. You cannot have Medicare coverage at the same time.

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Summary of Key Provisions of Health System Reform Affecting Internists

EFFECTIVE 2010
Coverage
Provides sliding scale tax credits to help businesses (2010-2013) purchase health insurance for their employees. In order to be eligible for tax credits, businesses must employ no more than 25 people and average annual wages must be less than $50,000. Small employers would have to contribute at least 50 percent of the cost of employees' health insurance to receive tax credits.
Requires all health plans to provide affordable and non-discriminatory coverage to children up to age 19 with pre-existing conditions.
A temporary national high risk pool will be created to provide coverage for individuals/adults with pre-existing medical conditions starting in June 2010 until Jan 1, 2014, when the universal ban on pre-existing exclusions will go into effect.
Requires all new health plans to provide evidence-based preventive services with no cost-sharing, with the ability to compete by offering more benefits; existing individual and employer-sponsored insurance plans are exempt, but they will be required to: extend dependent coverage to individuals up to age 26, eliminate lifetime limits on coverage, restrict use of annual limits on essential coverage, cannot rescind coverage, and must eliminate waiting periods greater than 90 days.
Workforce
Increases funds for the National Health Service Corps (NHSC), which includes a guaranteed funding stream for a portion of those funds. The law includes an increase in full-time awards for the NHSC from $35,000 to $50,000 per individual and a new part-time award program.
Allows up to 50 percent of the time spent teaching by an NHSC member to be counted towards his or her service obligation. The provision would not necessarily apply to individuals who are fulfilling their NHSC service requirement through work in private practice.
Increases funding for Health Professions programs under Title VII. Specifically, the new law increases the award amounts for the Faculty Loan Repayment Program from $20,000 to $30,000. The program is designed to assist health professionals from disadvantaged backgrounds in pursuing academic careers.
Increases funding for the Scholarship for Disadvantaged Students Program, also under Title VII, which provides scholarships to full-time, financially needy students who are from disadvantaged backgrounds and are enrolled in health professions and nursing programs.
Creates a national workforce commission in 2010 to determine whether the demand for health care workers is being met; to identify barriers to improved coordination at the federal, state, and local levels and recommend ways to address such barriers; and to encourage innovations to address population needs, constant changes in technology, and other environmental factors. The Commission is to analyze and make recommendations for eliminating barriers to entering and staying in careers in primary care, including physician compensation.
Provides grants and Graduate Medical Education funding for Teaching Health Centers to train primary care physicians in community based settings, beginning in 2010.
Creates the Primary Care Extension Program that would help to educate and provide technical assistance to primary care physicians and other health professionals including general internists currently in practice about evidence-based therapies, preventive medicine, health promotion, chronic disease management and mental health and in developing the capabilities to become Patient-Centered Medical Homes.
Authorizes student loan repayment tax relief by including state funded loan repayment programs as eligible for exemption from federal income taxation.
Payment and Delivery System Reforms
Creates a new public-private partnership to fund and coordinate research on comparative effectiveness to inform clinical decision-making.
Creates a new Medicare and Medicaid Center on Innovation to accelerate pilot-testing of innovative payment and delivery system reforms, including Patient-Centered Medical Homes. The Center has funds to launch a variety of pilots, and the law requires that they put priority on models to reform primary care payment systems, with consideration given to the medical home as one of the models tested in the Center.
Provides a grant program to establish community-based interdisciplinary, inter-professional teams to support primary care practices. The health team must establish contractual agreements with primary care clinicians to provide support services and support patient-centered medical homes. A clinician who contracts with a care team shall provide a care plan to the care team for each patient participant; provide access to participant health records; and meet regularly with the care team to ensure integration of care.

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EFFECTIVE 2010 (continued)
Provides direction to the Secretary of Health and Human Services (HHS), largely carried out through CMS, for identifying and correcting mis-valued services; and requiring the Secretary of HHS to establish a process to validate relative value units for physician fee schedule services.
Increases the discount that applies to the technical component payment for advance imaging services on consecutive body parts during a single session from the current 25 percent rate set by CMS in 2006 to 50 percent beginning July 1, 2010.
Medical Liability Reform
Extends medical liability protections under the Federal Tort Claims Act to officers, governing board members, employees and contractors of free clinics.

EFFECTIVE 2011
Coverage
Requires, among other things, that drug manufacturers provide a 50 percent discount on brand name prescriptions while the beneficiary is in the Medicare coverage gap known as the "donut hole."
If an insurer directs less than 80 percent of an individual insurance or small group plan's premium or 85 percent of a large group plan's premium to clinical and quality care improvement costs, the insurer will be required to refund the difference to the enrollee.
Workforce
Redistributes unused residency slots to hospitals that agree to maintain their current primary care levels and use the new slots for primary care and general surgery. Under the new law, 65 percent of the slots must be redistributed to primary care and general surgery.
Payment and Delivery System Reforms
Provides a 10 percent Medicare bonus payment on top of the fee schedule payment for designated primary care services—office, nursing home, and custodial care visits—furnished by primary care physicians beginning Jan. 1, 2011-2015. The law defines primary care physicians as those practicing in the following specialties: general internal medicine; family practice; geriatrics; and pediatrics. The new law does not include hospital visits in the bonus. Also, in order to qualify, 60 percent of a primary care physician's total Medicare allowable charges must be for office, nursing home, home and custodial care visits. This means that some primary care internists may not qualify if more than 40 percent of their total Medicare allowed charges are for services other than the designated primary care services.
Establishes a Medicaid state plan option, called Health Homes, to address specifically the needs of beneficiaries with chronic conditions beginning in January, 2011.
Beginning on January 1, 2011, establishes a new benefit through which beneficiaries are eligible to receive an annual wellness visit that focuses on establishing a personalized prevention plan. Also effective on January 1, eliminates co-payments, co-insurance and deductibles for most Medicare-covered preventive services, meaning that Medicare pays the full allowable payment amount for such services.
Creates grants to eligible entities to support community-based collaborative care networks for low-income populations. The grant funds can assist low-income individuals to access and appropriately use health services, enroll in health coverage programs, and obtain a regular primary care clinician or a medical home.
Medical Liability Reform
Authorizes $50 million in demonstration grants (2011-2015) for state innovations in medical liability reform.

EFFECTIVE 2012
Coverage
Develops reporting requirements for health plans in order to improve health outcomes through the implementation of activities such as: quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical home model for treatment or services under the plan or coverage (to occur no later than two years after enactment of law).
Workforce
No significant new reforms but many of the reforms begun in 2010 and 2011 continue.
Payment and Delivery System Reforms
Instructs the Secretary of Health and Human Services (HHS) to implement, no later than January 1, 2012, a voluntary shared savings (accountable care) program that promotes accountability for services delivered to a defined Medicare fee-for-service (FFS) patient population.
Promotes simplification of the administrative burden endured by physicians by requiring a study to identify administrative transactions for which establishing standard processes would reduce physician practice burden, among other things.

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EFFECTIVE 2012 (continued)
Medical Liability Reform
No significant new reforms but reforms begun in early years will continue.

EFFECTIVE 2013
Coverage
No significant new reforms, although 2013 will be the year that most states will need to develop implementation plans to support the coverage expansions that take effect in 2014.
Workforce
No significant new reforms but many of the reforms begun in earlier years will continue.
Payment and Delivery System Reforms
Raises Medicaid payments (2013-2014) for evaluation and management services and immunizations provided by general internists and other primary care physicians to no less than the applicable Medicare rates, fully paid for by the federal government.
Instructs the Secretary of Health and Human Services (HHS) to implement, no later than January 1, 2013, a voluntary national pilot program focused on payment bundling that aligns incentives to promote integrated care and joint responsibility among providers across the continuum during an episode of hospitalization under fee-for-service Medicare for a defined set of conditions.
Beginning in 2013, additional federal subsidies to Medicare Part D beneficiaries will be gradually phased-in for brand-name drugs in the Part D coverage gap reducing the beneficiary co-insurance rate in the gap from 100 percent to 25 percent by 2020 – in addition to the 50 percent manufacturer brand discount that began in 2011.
Promotes simplification of the administrative burden endured by physicians by standardizing the process through which practices verify patient insurance eligibility and check on the status of claims submitted to receive payment for services rendered, among other things.
Medical Liability Reform
No significant new reforms but reforms begun in earlier years will continue

EFFECTIVE 2014
Coverage
Expands coverage to 32 million people—about 95 percent of all legal residents—by filling gaps in our current system.
Provides sliding scale tax credits to help individuals and families buy coverage. The law provides tax credits for individuals, with incomes of 133 percent to 400 percent of the federal poverty level, to purchase health insurance. 133 percent of the federal poverty level equates to $14,404 for an individual and 29,327 for a family of 4 (2009 figures—will be updated by 2014), 400 percent equates to $43,320 for an individual and $88,200 for a family of four.
Provides tax credits to eligible small businesses of 50 percent of the employer's contribution (35 percent for non-profit firms) towards their employees' health insurance premium.
Makes all persons up to 133 percent of the Federal Poverty Level eligible for Medicaid, beginning Jan 1, 2014. Eligible persons include those individuals earning up to $14,404 or $29,327 (2009 figures—will be updated by 2014), for a family of four. The federal government will reimburse states for 100 percent of the cost of expanding Medicaid to new beneficiaries from 2014 -2016, 95 percent of costs in 2017, 94 percent of costs in 2018, 93 percent of costs in 2019, and 90 percent of costs in 2020 and subsequent years.
Requires individuals to buy coverage or pay a penalty if they do not, with hardship exemptions.
Beginning Jan. 1, 2014, requires large employers to contribute to coverage or pay the costs associated with subsidies to their employees if they do not. Employers with more than 50 employees will be assessed a fee of $2,000 for every full time employee over 30 employees, provided they have at least one employee who receives a premium credit through a health insurance exchange. Employers who provide inadequate coverage and have at least one employee receiving Exchange-based coverage credits will also be required to pay a fee.
Creates health exchanges to offer one-stop-shopping for qualified health plans and to spread insurance risk so as to provide eligible individuals and small businesses with access to more affordable premiums offered by participating plans. The law will require each state to offer health insurance for their residents through a state-based exchange by 2014. If states have not implemented an exchange by this year, or if the Secretary determines by January 1, 2013, that a state has not made sufficient progress toward this goal, the Secretary would establish an exchange within that state.

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EFFECTIVE 2014 (continued)
Requires the Department of Health & Human Services to develop a strategy to provide health plans within the health exchanges that begin in 2014 with increased reimbursement or other incentives for implementing activities such as: quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through use of the medical home model for treatment or services under the plan or coverage.
Encourages employers to develop preventive care and wellness programs for their employees.
Workforce
Improves Income-Based Repayment (IBR) plan option for borrows of federal student loans.
Payment and Delivery System Reforms
Establishes an Independent Payment Advisory Board (IPAB), which must submit recommendations to Congress, beginning in 2014, to reduce the growth of Medicare expenditures while maintaining or improving the quality of care delivered.
Promotes simplification of the administrative burden endured by physicians by standardizing the process by which health plans: make electronic payment for claims, known as an electronic funds transfer; and communicate payment decision related to claims, known as remittance advice.
Medical Liability Reform
No significant new reforms but many of the reforms initiated in earlier years will continue.

EFFECTIVE 2015 AND BEYOND
Coverage
No significant new reforms but many of the reforms initiated in previous years continue.
Workforce
No significant new reforms but many of the reforms initiated in previous years continue.
Payment and Delivery System Reforms
Includes penalties on physicians who do not successfully report on evidence-based quality measures. (2015 and beyond)
Promotes simplification of the administrative burden endured by physicians by standardizing the process by which health plans: approve referrals, certifications, and authorizations; and receive electronic submission of supporting information that is attached to a claim, known as a claim attachment. (2016)
Medical Liability Reform
No significant new reforms but many of the reforms initiated in previous years continue.

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How is the Patient Protection and Affordable Care Act (PPACA) Funded?

According to the Congressional Budget Office (CBO), the new health reform law (PPACA) is estimated to cost roughly $940 billion over 10 years in mandatory expenditures. The cost of the law may fluctuate depending on the amount of funding Congress appropriates to health-related discretionary programs and other factors, such as how many persons enroll in the new coverage options created by the PPACA, changes in health care spending, growth in the overall economy, and other variables. Discretionary funding means that Congress must decide, usually on an annual basis through the "appropriations" process, how much money it will put into funding each "discretionary" program authorized by the PPACA. "Mandatory" funding means that the federal government automatically is required to spend the amount of money required to support a particular program created by the PPACA, such as benefits paid out under Medicare and Medicaid.

The PPACA and its companion reconciliation legislation contain a number of provisions designed to raise revenue to offset the cost of the health reform law. After the revenue raisers are initiated, the law is estimated to reduce the federal deficit by $143 billion over the 2010-2019 period and by a trillion dollars over twenty years, according to CBO.

Annual Fee on Health Insurance Providers:

Starting in 2014, health insurers will have to pay a fee to the federal government. The amount of the fee depends on the amount of "net premiums written" by the insurer during the year. Net premiums written is the amount of premiums paid to the insurer by plan enrollees and adjusted for the cost of any reinsurance (which guards the insurer from major financial loss) held by the insurer.

Will all insurers have to pay the fee?

Some insurers with relatively low net premiums written amounts will be exempt from the assessment. Insurers with at least $50 million in net premiums written for the year will have to pay the full fee. Non-profit insurers will only have 50 percent of their net premiums written accounted for when the fee is being determined.

The following insurers are exempt from the fee:

- Self-insured plans (typically large employers who fund the insurance of their employees)
- Any government entity

How much revenue will this raise?

The Joint Committee on Taxation predicts the fee will raise $60 billion over 10 years.

Excise Tax on Indoor Tanning Services

Among the smaller revenue provisions in the PPACA is a 10 percent excise tax on indoor tanning services.

Why is this necessary?

Some proponents of the provision, such as the American Academy of Dermatologists, believe the tax will discourage the use of tanning beds which may be connected to skin cancer. The provision went into effect on July 1, 2010 and is estimated to increase revenue by $2.7 billion.

Excise Tax on Medical Devices:

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Beginning in 2013, the PPACA establishes a 2.3 percent tax on the sale of medical devices by a manufacturer, producer or importer.

Are any products exempt from the tax?

The tax will not be applied to eyeglasses, contact lenses, hearing aids or other devices determined by the federal government to be purchased for individual use by the public.

How much revenue will the tax raise?

The Joint Committee on Taxation predicts that the excise tax on medical devices will increase revenues by $60 billion over 10 years.

Annual Fee on Manufacturers and Importers of Branded Prescription Drugs:

Beginning 2011, prescription drug manufacturers and importers will have to pay an annual fee to the federal government based on the company's branded drug sales for the year.

How much will drug companies have to pay?

It depends on the combined dollar amount of brand name prescription drugs (including biologic drugs) they've sold during the previous year, including sales to federal health programs such as Medicare, Medicaid and the Veterans Health Administration. The fee gradually increases as the company's drug sales rise; companies with more than $400 million in annual drug sales will have to pay a higher fee than those with relatively modest annual sales. The amount of the fee will be determined by the federal government.

Are any branded drugs exempt?

Sales of orphan drugs – those used to treat rare diseases and conditions – are not considered in the payment formula.

By how much will the provision increase revenue?

The total revenue collected is capped each year, so in 2011 the revenue raised will equal $2.5 billion, $2.8 billion in 2012, and so on. Joint Committee on Taxation projects the annual fee will increase revenues by $27 billion over 10 years. The PPACA requires that revenue raised through the assessment be directed to the Medicare Part B Trust Fund.

Excise Tax on High-Cost Health Insurance Plans:

To help offset the cost of the law, the PPACA contains a revenue-raising provision that would place an excise tax on high-cost insurance plans, beginning in 2018. Most Americans receive health insurance through their employer and the cost of employer-sponsored health insurance is currently excluded from taxation. This means that employer-sponsored insurance is essentially subsidized through the tax system. The tax exclusion yields significant savings for some people, particularly high-income earners. For instance, if an employer provides $5,000 towards the cost of health insurance for an employee in the 28 percent tax bracket, the employee benefits from a $1,400 tax break.

Where does the excise tax idea come from?

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The PPACA does not cap or phase-out the tax exclusion on employer-sponsored health insurance. Instead it places a tax on health insurance companies who offer insurance plans with annual premiums that exceed a certain threshold.

While the health insurance tax exclusion has helped encourage the proliferation of employer-sponsored health insurance, the loss of revenue to the federal government is significant. In 2007, the exclusion amounted to $246 billion in foregone income and payroll tax revenue. Some critics of the tax exclusion argue that it pushes employers to make imprudent decisions regarding health care, encouraging them to purchase expensive and overly-generous health insurance. Others criticize the regressive nature of the tax, arguing that it disproportionately benefits high-income earners rather than those with modest incomes. Criticism of the tax exclusion is found across the ideological spectrum and interest groups as diverse as AARP and the American Medical Association have expressed support for capping or terminating the tax exclusion altogether. The excise tax on insurers may achieve the same goal of health insurance tax exclusion reform since it might lead employers to offer more focused benefits to workers.

How does the excise tax work?

In 2018, health insurers and health plan administrators will be subject to a 40 percent excise tax on coverage that exceeds a certain threshold. For single coverage, that threshold is $10,200 and for family coverage the threshold is $27,500. The thresholds will be adjusted for inflation beginning in 2020.

There are some alternate thresholds for certain groups of people:

- Early retirees aged 55-64 the threshold is $11,850 for single coverage and $30,950 for family coverage.
- Health plans for workers in high-risk professions (such as police officers; firefighters; paramedics; those in the construction, mining and fishing industries; etc.) are also subject to the above thresholds.
- Union health plans will only be subject to the family plan threshold.

Will other types of coverage or tax-advantaged accounts be affected by the provision?

Yes, the following tax-advantaged accounts will be added to the cost of the health plan in determining whether or not they meet the threshold:

- Dental and vision coverage included in the health plan (that is not a stand-alone benefit).
- Flexible spending accounts.
- Health savings accounts.
- Health reimbursement accounts.
- Medical savings accounts.

By how much will this provision increase revenue to the federal government?

The excise tax on high cost health plans is one of the health care law's most effective revenue provisions. The CBO predicts that the excise tax will increase revenues by $32 billion in 2010-2019. Since the provision is put into effect in 2018, the revenue amount will likely increase in subsequent years as health care premiums rise and more plans exceed the threshold.

Additional Resources

- *Congressional Research Service. Health-Related Revenue Provisions: Changes Made by the Reconciliation Act of 2010;* Comprehensive guide to the various revenue provisions of the health reform law.

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http://www.tha.com/healthcare-reform/public/2010/health-related-rev-ppaca.pdf

- *NY Times. Senate Plan Shifts Tax to Tanning Bed from Botox;* Article about the excise tax on tanning services.

  http://www.nytimes.com/2009/12/24/fashion/24Skin.html?_r=1&scp=1&sq=tanning%20tax&st=cse

- *CBO. Final Cost Estimate of Health Reform Law;* Estimated final cost of health reform law from the Congressional Budget Office.

  http://cbo.gov/doc.cfm?index=11379

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II. 2010 Reforms

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Small Business Tax Credit -2010

The Patient Protection and Affordable Care Act (PPACA) contains a number of initiatives that would help small businesses purchase health insurance for their employees. Small businesses often have difficulty providing health insurance for their employees because they do not have the negotiating power of large businesses and corporations and are particularly vulnerable to cost increases if an employee gets sick. State efforts to regulate insurance for small businesses vary widely across the country, creating a confusing patchwork of rules and regulations that influence the content and cost of small business insurance plans.

The PPACA provides financial assistance to qualified small businesses towards the purchase of health insurance for their employees.

To qualify, the employer:

- Would have to employ fewer than 25 full-time workers (different rules apply for part-time workers);
- Must have average annual wages of less than $50,000 per full-time employee;
- Must contribute at least 50 percent of the cost of their employees' health insurance premiums to qualify for the credit;

How much is the tax credit?

It depends on a number of factors, whether the business is for-profit or non-profit, the number of workers it employs, and the average annual wage of employees. The small business tax credit begins with a smaller amount in 2010 to 2013 and then increases in 2014 and subsequent years, until it "sunsets" by 2015. The credit is available for up to 6 years, from 2010 to 2013 and any two years after that. The amount of tax credit is provided on a sliding scale.

- From 2010-2013, the tax credit for for-profit businesses will equal up to 35 percent of the cost of their contribution to employees' health insurance. Non-profit firms who qualify can receive a smaller credit of up to 25 percent of an employer's contribution.
  - The Congressional Research Service (CRS) offers this example: if the total premium of an employee's health plan is $7,500 and the employer contributes to 60 percent of the cost of the premium ($4,500), than the maximum credit would be $1,575, or 35 percent of the 60 percent contribution.
- The amount of tax credit is provided on a sliding scale. According to CRS, employers with average annual wages of $25,000 and 10 employees will receive the maximum credit. The level of credit is phased down as the number of employees and average annual wages increases.

How do qualifying small business owners, e.g. physicians who qualify, claim the tax credit?

The tax credit is available now, and an employer can claim it on their annual income tax return. The IRS is determining the process for tax-exempt firms. Business owners would not include their income in a calculation to determine eligibility or amount of the credit. This restriction would include a shareholder owning more than 2 percent of an "S" corporation, a sole proprietor, a partner in a partnership, an owner of more than 5 percent of other businesses, or a family member or dependent of such an individual. Additionally, an owner would not count as an employee when calculating the number of full-time employees. So, if a physician is also the owner of his/her practice, his/her salary would not be counted when determining if his/her firm qualifies for the small business tax credit. The salary of a physician employed by a practice would be considered if they do not meet the above criteria (e.g. partner in a partnership, sole proprietor, etc.). Employers (other than tax-exempt employers) with no taxable income for the year cannot qualify for the credit since it is applied to the employer's

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income tax liability. However, the IRS notes that an unused health insurance credit that is considered a general business credit can be carried forward up to 20 years. It is unclear if physicians who claim business income as personal income for tax purposes will be eligible for the credit. Physicians are encouraged to consult their financial advisor to determine if their practice is eligible for the small business tax credit.

Additional Resources

- *Internal Revenue Service. Small Business Health Care Tax Credit: Frequently Asked Questions,* Provides detailed information on how to determine whether your business qualifies for the credit and what you need to do to claim the credit.

  http://www.irs.gov/newsroom/article/0,,id=220839,00.html

- *Small Business Majority. Health Insurance Premium Tax Credit Calculator;* Interactive calculator that helps you determine if your business may qualify for the tax credit and the amount you may be able to claim.

  http://smallbusinessmajority.org/tax-credit-calculator/

- *New York Times. How the Health Care Law Affects Your Business;* Features a number of questions and answers related to how the health care reform law will affect small businesses, including inquiries on the tax credit.

  http://boss.blogs.nytimes.com/2010/03/31/how-the-health-care-law-affects-your-business/

- *American Medical News: Tax Credits Help Offset Staff Insurance Costs;* Article regarding how physician's practices might be able to benefit from the small business tax credit.

  http://www.ama-assn.org/amednews/2010/05/03/bica0503.htm

- *Internal Revenue Service: 3 Simple Steps for Employers to Qualify;* Worksheet to help determine if you qualify for the tax credit.

  http://www.irs.gov/pub/irs-utl/3_simple_steps.pdf

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New Requirements for Health Insurers - 2010

The Patient Protection and Affordable Care Act (PPACA) contains a number of provisions that are designed to improve access to health coverage and that go into effect in 2010. This document provides an outline of what the provisions intend to do, but over the coming months the Department of Health and Human Services and other federal government agencies will be releasing regulations that will provide detailed guidance.

Grandfathered Plans

A number of new requirements may not apply to grandfathered plans. In general, a grandfathered plan is an insurance plan that existed prior to March 23, 2010. To meet the definition of grandfathered, an insurance plan must also meet a number of other requirements outlined in a regulation released by the federal government. If an insurance plan no longer qualifies as grandfathered, the insurer or employer will have to abide by insurance rules established in the law required of new insurance plans written after March 23, 2010.

Among the grandfathered status rules, a health plan or insurer:

- Cannot eliminate all or most benefits to diagnose or treat a particular condition;
- Cannot increase or alter cost-sharing beyond a designated limit (e.g. if a health plan increases cost-sharing after March 23, 2010 by the greater of the rate of medical inflation plus 15 percent or five dollars increased by medical inflation, the plan is no longer considered grandfathered);
- Cannot dramatically raise so-insurance;
- Cannot significantly increase deductibles; and,
- Cannot add or alter the annual limit on the dollar value of what the health plan will cover.

Additional Resources

- *Healthcare.gov: Questions and Answers Keeping the Plan You Have:* information on how insurance plans can qualify as a grandfathered plan.

  http://www.healthreform.gov/about/grandfathering.html

Coverage for Dependents up to Age 26:

Young adults are often unable to access affordable, comprehensive health insurance and make up a significant portion of the uninsured. According to the Commonwealth Fund, nearly 14 million young people aged 19 to 29 were without health insurance in 2006. In most cases, once young adults reach age 18 or 19, they are no longer eligible for coverage through their parent or guardian's health insurance unless they enroll in college full-time. Once a young person graduates college, they are usually unable to enroll in their parent or guardian's health plan. A number of states have addressed this problem by requiring health insurers to cover dependents until they reach a certain age, but not all states have taken such action.

The PPACA will require individual and new group health plans (including self-insured plans where an employer directly pays for the health benefits of its employees) that provide dependent coverage to allow children or dependents to remain on their parent's or guardian's health insurance plan until they turn 26 years of age. Dependents can enroll in their parent's group plans that existed prior to March 23, 2010 only if they do not have access to group coverage elsewhere. This restriction phases out in 2014.

How does this work?

- Married and unmarried children can qualify for coverage.

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- The new requirement takes effect for plan years beginning on or after September 23, 2010; however some insurers have indicated that they may begin extending dependent coverage prior to that date for those who would otherwise become uninsured. The actual effective date of the coverage may vary, as the plans years for some insurance plans – particularly those offered by employers – begin on January 1, 2011.

- It is still unclear how the dependent coverage requirement will affect existing plans' premiums or whether dependents with pre-existing conditions will have services for such conditions covered. One estimate suggests that premiums will increase by less than 1 percent.

- The cost of the dependent's insurance will be excluded from the employee's income through the end of the taxable year when the child turns 26. This tax exclusion applies to workplace, retiree, and self-employed individuals who apply the self-employed health insurance tax deduction.

- For young adults who are unable to enroll in early coverage, an open enrollment period for their parent's plan will be initiated on September 23, 2010. Insurers and employers are required to provide notice of the open enrollment period.

- Prior to full implementation of the provision, those interested in seeking dependent coverage should contact their human resources department for enrollment information or consult their state insurance commission to see if their state already requires coverage of young adult dependents.

Additional Resources

- *The Associated Press* (AP) suggests that 485,000 young adults would gain coverage under the provision.

  http://www.mynorthwest.com/?nid=178&sid=314166

- *Department of Health and Human Services – Young Adults and the Affordable Care Act Fact Sheet.*

  Information on the dependent care coverage provision.

  http://www.hhs.gov/ociio/regulations/adult_child_fact_sheet.html

Temporary High-Risk Pools:

Oftentimes, people with pre-existing conditions are unable to find affordable coverage through the individual and small business health insurance market. Many states have established high-risk pools for individuals unable to acquire coverage elsewhere. Since the cost of coverage for people with complex health care needs can be significantly burdensome, high-risk pools often provide some premium and cost-sharing subsidies. Unfortunately, many existing high-risk pools are underfunded and unable to meet the growing demand. Beginning in July 2010, the Department of Health and Human Services will provide assistance to states to establish or expand high-risk pools for the uninsured. The high-risk pool program is temporary; in 2014, states will be required to establish health insurance exchanges and individuals covered in the high-risk pool will be transitioned to an exchange-based plan. Further, beginning in 2014, insurance companies will be required to accept all applicants regardless of health status and will only be allowed to vary premiums based on a person's age, whether they are applying for family or individual coverage, whether they use tobacco, and whether they live in a high, medium or low cost area of the country. There will be limits to how much premiums can vary based on age and tobacco use.

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Beginning in June 2010, the PPACA authorizes $5 billion to fund the establishment or expansion of high-risk pools and the Department of Health and Human Services is permitted to work with states to facilitate the process or operate its own high-risk insurance program if a state fails to do so.

Who is eligible for coverage through a temporary high-risk pool?

- Must be a U.S. citizen or legal resident.
- Not have been covered by creditable coverage (e.g. employer-based coverage) for the previous 6 months prior to applying for high-risk pool coverage.
- Must have a pre-existing condition.
- Individuals already enrolled in their state's existing high-risk pool are prohibited from enrolling in the new temporary high-risk pool program unless they discontinue coverage and remain uninsured for 6 months.

Are there any rules related to the type of coverage offered in the high-risk pool?

- Health insurance plans must cover a minimum of 65 percent of health care costs.
- Out-of-pocket (excluding premiums) costs cannot exceed $5,950 for an individual.
- There can be no pre-existing condition exclusions.
- Premiums can vary based on a person's age (but cannot be greater than a ratio of 4 to 1).
- Premiums must reflect the standard rate for a standard population, rather than for a high-risk population.
- New high-risk pools may be required to cover a minimum benefit package.

States have the option of operating their own temporary high-risk pool or permitting the federal government to do so. A list of participating states can be found in the Additional Resources section below. Thirty-five states currently operate a high-risk pool for people who are unable to enroll in a health insurance plan. The PPACA prohibits states from reducing their existing high-risk pool programs. Uninsured individuals who are currently unable to receive coverage because of a pre-existing condition should contact their state insurance commission (or other relevant entity) to determine how they can enroll in the temporary high-risk pool in their state.

Additional Resources

- *Letter from HHS Secretary Sebelius to Governors, Insurance Commissions to Assess Interest in Temporary High-Risk Pool Program:*

  http://www.hhs.gov/news/press/2010pres/04/20100402b.html

- *Kaiser Family Foundation: Questions about Temporary High-Risk Pool:*

  http://www.kff.org/healthreform/upload/8066.pdf

- See how many states have thus far elected to participate in the high-risk pool:

  http://www.healthcare.gov/law/provisions/preexisting/index.html

Pre-existing Conditions Exclusions Banned for Children:

Beginning with plan years on or after September 23, 2010, the PPACA will also prohibit new individual and group plans (including self-insured plans) as well as group plans established on or before March 23, 2010, from excluding coverage of pre-existing conditions for children younger than age 19. While the law states that pre-existing condition exclusions will be banned for children starting in 2010, the provision does not guarantee that

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health plans will enroll children into coverage. To address this issue, America's Health Insurance Plans, a trade group representing health insurers, has stated that its member companies will accept all children who apply for coverage regardless of pre-existing condition.

Additional Resources

- *Kaiser Health News: Article Regarding Child Coverage of Pre-Existing Conditions,*

  http://www.kaiserhealthnews.org/daily-reports/2010/march/31/kids-stuff.aspx?referrer=search

Restricting Annual or Lifetime Dollar Limits on Coverage:

Some health insurance plans place limits on the dollar amount of coverage they will provide. For instance, a health plan may cover up to $5 million in health care services over a patient's lifetime. Some health plans restrict the dollar amount of coverage an enrollee can receive in a year. Beginning in September 2010, new and existing group health plans (including self-insured plans, where an employer directly pays for the health benefits of its employees) and individual plans are prohibited from establishing lifetime limits on the dollar value of benefits for any participant or beneficiary.

Additionally, new and existing group plans and new individual plans are allowed to impose only a restricted annual limit on the benefits that are deemed "essential health benefits" as determined by the federal government. The federal government would ensure that there is access to needed services available with minimal impact on premiums. Group health plans and health insurance issuers would be permitted to place annual or lifetime limits on specific covered benefits that are not essential health benefits, to the extent that such limits are otherwise permitted by federal and state law. Essential benefits include preventive and wellness services and chronic disease management, ambulatory patient services, emergency services, hospitalization, mental health services, among others.

Prohibiting Coverage Rescissions:

The PPACA also restricts the controversial practice of rescission, which refers to the practice of canceling medical coverage after policyholders have become sick or injured. The law prohibits the use of rescission for all insurers beginning in September 2010. Rescissions would still be permitted in cases where the covered individual committed fraud or made an intentional misrepresentation as prohibited by the terms of the plan or coverage. A cancellation of coverage in this case would require prior notice to the enrollee. As of April 28, 2010, health insurers *WellPoint* and *UnitedHealth* announced that it will stop rescinding policies on May 1, 2010.

Justifying Premium Increases:

Starting with the 2010 plan year, health insurers are required to submit to the federal government and relevant State regulators a justification for premium increases deemed unreasonable before implementation of the premium increase. Premium increases and justifications will be made public by the federal government. States are also required to submit information to the Secretary regarding premium trends in their state. Once the health insurance exchanges are operating, premium increase information will be considered when determining whether an insurer should be allowed to participate.

Directing Premiums toward Improving Care:

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Beginning in 2010, health insurers – including plans offered before March 23, 2010 – are required to submit information documenting the amount of an enrollee's premium that is devoted to clinical, administrative, and quality care improvement costs.

Covering Core Preventive Services:

Beginning in September 2010, the PPACA will require individual and group market plans (including self-insured plans) established after March 23, 2010 to cover – at a minimum – evidence-based items and services that have a rating of "A" or "B" in the recommendations of the U.S. Preventive Services Task Force (USPSTF) if they are provided by an in-network physician or other health care professional. Insurers are allowed to cover additional preventive benefits beyond those given a rating of "A" or "B" by the USPSTF. Plans that existed on or before March 23, 2010 and meet the definition of a grandfathered plan are **not** required to abide by this provision.

What do these ratings mean?

- An "A" rating means that the service is recommended and that there is a high level of certainty that it will yield substantial benefit to the patient.
- A "B" rating indicates that the service is recommended and that there is a high level of certainty that the services will yield at least a moderate benefit to the patient.

What are insurers required to cover?

- Recommended immunizations;
- Preventive care for infants, children and adolescents;
- And additional services for women outlined in comprehensive guidelines supported by the Health Resources and Services Administration.

A plan or issuer would be permitted to cover or deny additional services not recommended by the USPSTF. The current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention would be considered the most current other than those issued in or around November 2009.

Cost-sharing for these services is prohibited and such services are exempt from deductibles. The provision also requires HHS to update required services following the release of recommendations issued by the relevant entity, e.g. USPSTF.

In addition to the requirement that physicians be in-network, a regulation issued by the federal government in July 2010 establishes a number of other rules that influence whether or not an insurer is required to cover a preventive service without cost-sharing:

- If the recommended preventive service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit;
- If a recommended preventive service is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit;
- If a recommended preventive service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit;

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- An insurer is permitted to use "reasonable medical management" to determine frequency, method, treatment, or setting for a recommended preventive item or service if such information is not provided in the USPSTF's (or other relevant entity) recommendation; and,
- If a service/item is no longer recommended by USPSTF, HRSA, etc., insurers are no longer required to provide such service without cost sharing. Insurers are required to alert enrollees of revision of benefit plans.

Additional Resources

- *Healthcare.gov – Recommended Preventive Services*

  http://www.healthcare.gov/center/regulations/prevention/recommendations.html

Health Coverage Assistance for Early Retirees:

Ineligible for Medicare coverage and potentially facing receding employer-based retiree health benefits, many early retirees have trouble finding affordable health insurance. Early retirees may seek out coverage in the individual market, but without strong negotiating power and rules that require insurers to accept all applicants, such insurance may be out of reach.

To reduce the rate of uninsurance among early retirees – a demographic with higher health care costs than younger workers – the PPACA authorizes $5 billion to provide financial assistance in the form of reinsurance to employers who provide coverage for early retirees.

What is reinsurance?

- Reinsurance is like an insurance plan for insurance plans. Employers who face rising health care costs because of early retiree health coverage can safeguard against significant cost increases by using reinsurance.
- The program would protect insurance devoted to retirees age 55-64.
- The program ends in 2014, when the bulk of the PPACA insurance reforms and financial assistance go into effect.

How does it work?

- Beginning in June 2010, the program reimburses employers for 80 percent of the cost of providing health insurance for an early retiree if costs are between $15,000-90,000 a year. These limits will be adjusted in subsequent years
- Reimbursements must be used by the employer to reduce premium costs or premium contributions and cost-sharing for participants.
- The funds cannot be used for general revenue purposes.

Additional resources:

- *USA Today: Health care law helps companies insure early retirees.*

  http://www.usatoday.com/money/industries/health/2010-05-10-reinsuranceqa10_ST_N.htm

Option for Early Medicaid Coverage Expansion:

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As of April 1, 2010, states were permitted to begin covering nonelderly, childless adults and receive the current federal reimbursement rate. A number of states – particularly those who currently cover childless adults using state funding – are considering this option.

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Rebates through Medicare's Prescription Drug Program

The Patient Protection and Affordable Care Act (PPACA) begins making changes to the Medicare Part D Prescription Drug Program in 2010 in order to help reduce Medicare beneficiaries' out-of-pocket drug cost and make their prescribed drugs more affordable.

What is the Medicare Part D Program coverage gap ("donut hole") and how does the PPACA reduce beneficiaries' out-of-pocket costs within the gap?

In 2010, the standard Medicare Part D benefit includes a $310 deductible and a 25 percent coinsurance until the enrollee reaches $2,830 in total covered drug spending. After this initial coverage limit is reached, there is a gap in coverage in which the enrollee is responsible for the full cost of the drugs (often called the *donut hole*) until total costs hit the catastrophic threshold, $6,440. It is estimated that about 25 percent of beneficiaries reach the coverage gap in a given year. Once reaching the catastrophic threshold, beneficiaries are covered for at least 95 percent of their drug expenses for the rest of the year.

Under PPACA, beneficiaries who reach the coverage gap will receive a $250 rebate. This rebate is only in effect for 2010. Additional subsidies to reduce and eventually eliminate the doughnut hole will be available in subsequent years.

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National Health Care Workforce Commission

The Patient Protection and Affordable Care Act (PPACA) includes the establishment of a National Health Care Workforce Commission, a multi-stakeholder workforce advisory committee charged with developing a national health care workforce strategy beginning in 2010.

What are the objectives of the Commission?

- Provide recommendations to Congress and Administration on national health workforce priorities, goals, and policies
- Review current and projected health care workforce supply and demand (in consultation with relevant Federal, State and local entities)
- Review implementation/performance of a separate State Health Care Workforce Development Grant Program also created by the PPACA.
- Assess education and training activities to determine whether demand for health care workers is being met
- Study effective mechanisms for financing education and training for careers in health care
- Analyze, and make recommendations for, eliminating the barriers to entering and staying in primary care, including provider compensation.
- Submit to Congress and the Administration an annual report due by October 1 each year (starting in 2011) that includes:
    - Current supply/demand data and projections;
    - Health care workforce education and training capacity and projections;
    - Implications of Federal policies affecting workforce;
    - Workforce needs of special populations underserved;
    - Recommendations for Title VII and VIII loan repayment and scholarship programs and programs for low income, minority medical students
- Submit to Congress and the Administration a second separate annual report due by April 1 of each year (starting in 2011) on choice of specified "high priority" areas or other areas as required by the Commission or Congress in the future.

How many members will be on the Commission?

There will be 15 members appointed to the Commission for staggered 3 year terms.

Who will be represented on the Commission?

The law dictates that the majority of members should not be directly involved in health professions education or practice. The Commission will comprise of at least 1 representative from each of the following:

- Health care workforce and health professionals
- Educational institutions (elementary or higher)
- Employers
- Third-party payers
- Individuals skilled in health care services and health economics research
- Representatives of consumers
- Labor unions
- State or local workforce investment boards

Additional membership requirements:

- Combination of professional perspectives
- Broad geographic representation
- Balance of rural/urban/suburban/frontier perspectives

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Who will staff the Commission?

An Executive Director (and other staff as may be required) is to be appointed. He/she will seek assistance and support from appropriate Federal departments and agencies, work closely with the National Center for Health Workforce Analysis, use existing data but may conduct and award grants/contracts for original research when available data is inadequate, can submit independent requests for appropriations; and enter into contracts. The PPACA authorizes "such sums as may be necessary."

When are appointments to the Commission going to be made?

Members, including a designated chairman and vice chairman, will be appointed by the U.S. Comptroller General by Sept. 30, 2010. Nominations were due by June 30, 2010.

HEALTH WORKFORCE DATA, ANALYSIS AND PLANNING

State Health Care Workforce Development Grants

Beginning in 2010, the PPACA establishes a competitive state health care workforce development grants program to enable state partnerships to plan and implement activities leading to workforce development strategies at the state and local levels.

Who will administer the grants?

The program is administered by the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS in consultation with National Health Care Workforce Commission.)

Who can apply for grants?

Eligible entities are state workforce investment boards that include or modify their memberships to include at least one representative from each of the following:

- Health care employer
- Labor organization
- A public 2-year institution of higher education
- A public 4-year institution of higher education
- The recognized state federation of labor
- The state public secondary education agency
- The state P-16 or P-20 council, if one exists
- A philanthropic organization engaged in providing learning, mentoring and work opportunities to recruit, educate and train individuals in health care careers.

What type of grants will be available?

One year planning grants of up to $150,000 with a 15 percent matching requirement to states to analyze health care labor markets; identify current and projected needs; and identify short and long-term workforce development strategies; identify existing Federal, State, and private resources for health workforce recruitment, education, training, and retention (authorized at $8M). Up to 2 year implementation grants with a 25 percent State match for previous planning grant awardees to encourage regional partnerships and promote innovative workforce pathway activities. The PPACA authorizes $150M for FY 2010 and such sums as necessary in subsequent years.

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An estimated 30 grants are expected to be awarded in 2010.

How can a state workforce investment board apply for a grant?

The application period for 2010 was from June 17, 2010 through July 19, 2010. Awards are expected to be announced by September 30, 2010.

HEALTH WORKFORCE PROGRAM ASSESSMENT

The law establishes a National Center for Health Workforce Analysis to develop information describing and analyzing the health care workforce and related issues, oversee the state health care workforce development grant program, develop performance measures, and establishes a national Internet registry of grants awarded. The National Center will include three advisory groups: 1) The Advisory Committee on Training in Primary Care Medicine and Dentistry; 2) The Advisory Committee on Interdisciplinary Community-based Linkages; and 3) The Council on Graduate Medical Education.

The law also creates grants for state and regional centers for health workforce analysis. Entities eligible for these state workforce grants are a state workforce investment board, public health or health professions school, academic health center, or appropriate public or private nonprofit entity. Grants for longitudinal health workforce studies are also increased by the law.

How much funding will be available?

The law authorizes the appropriations of:
- $7.5 million for the National Center for fiscal years 2010 through 2014,
- $4.5 million for State and Regional Centers for fiscal years 2010 through 2014, and
- Any sums necessary for grants for the Longitudinal Evaluations for fiscal years 2010 through 2014

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Teaching Health Centers

In an effort to increase the size of the primary care workforce and encourage training in non-hospital settings, the Patient Protection and Affordable Care Act (PPACA) establishes a Title VII grant program to teaching health centers (THCs) in 2010 to establish new or expand existing accredited primary care residency programs.

GRANTS TO DEVELOP TEACHING HEALTH CENTERS

The law authorizes $25 million for FY2010, $50 million in FYs 2011 and 2012, and such sums as may be necessary in subsequent years. Of the total funding, up to $5 million per year may be spent on "technical assistance program grants" a term that is not defined in the statute and will have to be explained through regulation. Beginning in 2011, teaching health centers also will be eligible for Medicare direct medical education (DME) and indirect medical education (IME) funds.

What is a teaching health center?

Teaching health centers are defined as community based, ambulatory patient care centers that operate a primary care residency program. They can include federally qualified health centers, community mental health centers, rural health clinics, and health centers operated by the Indian Health Service.

What residency programs qualify for the grant?

Residency programs that qualify are: family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general and pediatric dentistry, and geriatrics.

How much funding can each teaching health center apply for?

Each THC may apply for awards up to $500,000 a year for up to 3 years.

What can award funds be spent on?

Funds must be spent to cover the costs of establishing or expanding a primary care residency program including expenses related to curriculum development, recruitment, training, and retention of residents and faculty, accreditation, and faculty salaries during the development phase. Funds can also be used to cover technical assistance provided by entities including area health education centers (AHECs). The AHEC program is dedicated to addressing the shortage of primary care services, common to certain communities, by creating collaboration and partnerships between academic health centers and these communities. The Secretary of Health & Human Services is instructed to give preference to applicants that have an existing affiliation agreement with an AHEC.

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Loan and Scholarship Programs under Title VII

Primary Care Loan Program

The Primary Care Loan (PCL) program, part of the Health Resource and Services Administration's (HRSA) Title VII student loan programs, is a low cost federal loan program for medical students who commit to practicing in primary care. The interest rate is 5 percent and begins to accrue following a one year grace period after graduation.

The Patient Protection and Accountable Care Act (PPACA) made changes to the Primary Care Loan Program by establishing a lower default rate (2 percent greater than the rate the student would pay if compliant, instead of 18 percent). It also requires primary care loan recipients to practice primary care for 10 years or the date the loan is repaid if it is less than 10 years. In addition, loan guidelines will be amended to no longer require parental information to determine financial need for independent students.

How can I apply for a Primary Care Loan?

Apply for this loan at the student financial aid office of the school where you are or intend to be enrolled.

Additional Information:

- *Health Resources and Services Administration:*

  http://bhpr.hrsa.gov/dsa/pcl.htm

Faculty Loan Repayment Program

The Faculty Loan Repayment Program was established to increase the recruitment and retention of faculty members from disadvantaged backgrounds in eligible health professions disciplines who have a health professions degree or certificate to serve at an eligible health professions school for a minimum of 2 years.

PPACA increases the maximum award for the Title VII faculty loan repayment from $20,000 to $30,000, and reauthorizes the program at $5 million for each of FYs 2010-2014. The program expects to make between 22 and 25 awards in 2010.

How can I apply for the Faculty Loan Repayment Program?

The application cycle for FY 2010 is closed. Applicants selected to receive funding were notified no later than July 31. However you can sign up to be notified by email when the application cycle for FY 2011 opens here http://www.hrsa.gov/loanscholarships/repayment/faculty/

Scholarships for Disadvantaged Students

The PPACA reauthorizes the Title VII Scholarships for Disadvantaged Students program at $51 million for FY 2010 (and such sums for each of FYs 2011-2014).

How can I apply for a scholarship?

Apply for this scholarship at the student financial aid office of the school where you are or intend to be enrolled.

Additional information

- *Health Resources and Services Administration;* http://bhpr.hrsa.gov/dsa/sds.htm

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Changes to Primary Care Training Programs - Title VII, Section 747

Section 747 of Title VII of the Public Health Service Act provides grants to or contracts with accredited public or nonprofit private hospitals, medical schools, or other public or private nonprofit entities, or affiliated physician assistant training programs, for a variety of programs and activities to support training programs in primary care.

Beginning in 2010, the Patient Protection and Accountable Care Act (PPACA) amends the Title VII primary care medicine programs (Sec. 747) to authorize primary care medicine programs distinctly from primary care dentistry programs. It also authorizes grant/contract payments for five years (instead of three years). In addition, it eliminates the ratable reduction, a formula in the statute that secured a proportion of funding for a specific specialty, to ensure allocation of training funds on the basis of national need and merit.

What types of grants or contracts will be awarded?

Grants will be given to, or contracts will be entered into with eligible entities that propose:

- To plan, develop, operate, or participate in an accredited professional training program, including an accredited residency or internship program in the field of family medicine, general internal medicine, or general pediatrics for medical students, interns, residents, or practicing physicians as defined by the Secretary;
- To provide need-based financial assistance in the form of traineeships and fellowships to medical students, interns, residents, practicing physicians, or other medical personnel, who are participants in any such program, and who plan to specialize or work in the practice of the fields, as defined in the law;
- To plan, develop, and operate a program for the training of physicians who plan to teach in family medicine, general internal medicine, or general pediatrics training programs;
- To plan, develop, and operate a program for the training of physicians teaching in community-based settings;
- To provide financial assistance in the form of traineeships and fellowships to physicians who are participants in any such programs and who plan to teach or conduct research in a family medicine, general internal medicine, or general pediatrics training program;
- To plan, develop, and operate joint degree programs to provide interdisciplinary and inter-professional graduate training in public health and other health professions to provide training in environmental health, infectious disease control, disease prevention and health promotion, epidemiological studies and injury control.
- To plan, develop, and operate a physician assistant education program, and for the training of individuals who will teach in programs to provide such training;
- To plan, develop, and operate a demonstration program that provides training in new competencies, as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act, which may include—
    - Providing training to primary care physicians relevant to providing care through patient-Centered medical homes (as defined by the Secretary for purposes of this section);
    - Developing tools and curricula relevant to patient-centered medical homes; and
    - Providing continuing education to primary care physicians relevant to patient-centered medical homes.

Capacity Building Grants

The PPACA also authorizes five year "capacity building" grants to medical schools to establish, maintain, or improve academic units or programs that improve clinical teaching and research in family medicine, general internal medicine, or general pediatrics; or programs that integrate academic administrative units (AAU) in such fields to enhance interdisciplinary recruitment, training, and faculty development.

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What will be the priorities in awarding "capacity building" grants?

Priority for awards will go to applicants that:

- Propose a collaborative project between academic administrative units of primary care;
- Propose innovative approaches to clinical teaching using models of primary care, such as the patient centered medical home, team management of chronic disease, and inter-professional integrated models of health care that incorporate transitions in health care settings and integration physical and mental health provision;
- Have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers trained, who enter and remain in primary care practice;
- Have a record of training individuals who are from underrepresented minority groups or from a rural or disadvantaged background;
- Provide training in the care of vulnerable populations such as children, older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with HIV/AIDS, and individuals with disabilities;
- Establish formal relationships and submit joint applications with federally qualified health centers, rural health clinics, area health education centers, or clinics located in underserved areas or that serve underserved populations;
- Teach trainees the skills to provide inter-professional, integrated care through collaboration among health professionals;
- Provide training in enhanced communication with patients, evidence-based practice, chronic disease management, preventive care, health information technology, or other competencies as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act; or
- Provide training in cultural competency and health literacy.

How much funding has been authorized for Title VII, Section 747 Programs?

The new law authorizes $125 million in FY 2010 and such sums as may be necessary for each of FYs 2011 through 2014, for all programs under this section except integrating AAUs. For integrating AAUs, the legislation authorizes $750,000 for each of FYs 2010 through 2014.

Is Title VII, Section 747 funding mandatory or discretionary?

Unlike the National Health Service Corps and Community Health Centers, Title VII did not receive mandatory funding in addition to traditional discretionary funding and is subject to solely to discretionary authorization by Congress.

What is the difference between "mandatory" and "discretionary" spending?

Mandatory spending is also known as entitlement spending and goes to programs such as Social Security, Medicare and Medicaid. Discretionary spending must be approved by the Congress every year in the appropriations process and, unlike most mandatory spending, is subject to a predetermined limit—as established in the authorizing legislation—each year. So, for instance, the PPACA "authorizes" $125 million in FY 2010 for the Title VII primary care medicine programs (Sec. 747) described above, but Congress could decide to provide discretionary funding up to that full amount authorized or it could provide a lesser amount.

How can I find out about funding opportunities and application deadlines?

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The Health Resources and Services Administration (HRSA) recently announced that the health professions funding opportunity announcements will be reissued to reflect changes in the authorizing legislation as a result of the Patient Protection and Affordable Care Act. When they are reissued, they will be posted here http://www.hrsa.gov/grants/apply/reissues.html

How can I find out about specific changes to grants under Title VII, Section 747?

The PPACA made changes to the program authority, including lengthening the project period, increasing the program areas and scope of activities as well as the funding priority and preferences, and separating out dental training programs. HRSA provides practical information on the changes and contact information here http://bhpr.hrsa.gov/recovery/medicine/primarycareqa.pdf

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Time Spent By Residents in Non-hospital Settings

Medicare currently authorizes teaching hospitals to receive Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments associated with residents training in non-hospital sites, such as clinics or physicians' offices, if they incur "all or substantially all" of the training costs. In 1999, the Centers for Medicare and Medicaid Services (CMS) issued a regulation defining "all or substantially all" of the training costs as the residents' stipends and benefits plus physician supervisory costs. In 2005, CMS changed the regulatory definition of "all or substantially all" of the non-hospital site training costs to be 90 percent of the residents' stipends and benefits plus physician supervisory costs at the non-hospital site. This resulted in a major administrative burden for hospitals because they imposed significant compliance difficulties in obtaining actual physician salary data, and computing the amount of physician time spent supervising that does not involve patient care activities.

The Patient Protection and Affordable Care Act (PPACA) clarifies this requirement to mean that a hospital incurs ―all or substantially all of the required costs for both DGME and IME purposes, so long as the hospital incurs the costs of the resident stipends and benefits for the time the resident spends in that setting.

What is the difference between DGME and IME?

DGME payments partially compensate teaching programs for residency education costs; whereas IME payments compensate hospitals for higher patient care costs due to the presence of teaching programs.

What is the effective date of this provision for DGME purposes?

This provision is effective for cost reporting periods beginning on or after July 1, 2010.

What is the effective date of this provision for IME purposes?

This provision is effective for discharges occurring on or after July 1, 2010.

What records must the hospital keep?

Hospitals are required to maintain and make available to the Secretary records of the time residents spend in non-hospital sites as well as how much time they spend in non-hospital sites compared to a base year (a year to be determined by the Secretary).

Will written agreements continue to be required?

In most instances, it will no longer be necessary to enter into agreements with, or establish a payment trail to, the teaching physicians providing services in the non-hospital settings. The hospital will only need to demonstrate that it is incurring the cost of the residents' stipends and fringe benefits while the residents are in the non-hospital setting.

A written agreement will be required if more than one hospital incurs the costs of training — either directly or through a third party — the hospitals will be able to count the proportional share of the time only if that share is documented in a written agreement between the hospitals.

Can hospital cost reports be reopened for purposes of this new provision?

Hospital cost reports may not be reopened for purposes of this provision unless a proper DGME or IME appeal was pending as of March 23, 2010.

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Counting Didactic Time for DGME and IME Payments

Didactic Time

Medicare previously paid hospitals for time residents spent in didactic training – i.e. conferences and seminars not related to the care of a patient – only when the resident was training in the hospital. In addition, didactic time could only be counted for DGME payments, not for IME payments.

DGME Changes

The law now permits hospitals to count resident didactic time spent in non-hospital training sites for DGME purposes, beginning July 1, 2009.

IME Changes

The law now permits hospitals to count resident didactic time spent in the hospital for IME payment purposes, beginning January 1, 1983. Didactic training that takes place in non-hospital sites cannot be counted for IME payment purposes.

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State Loan Repayment Tax Exclusion

In the past, loan repayments to participants of federal or state health professions loan repayment programs were considered taxable income and taxed at 39 percent of the loan repayments by the Internal Revenue Service (IRS). In 2004, a federal law was passed that excluded loan repayment awards from being treated as taxable income for health professionals participating in a National Health Service Corps program, or state programs operating under federal rules. This change did not affect state-funded loan repayment programs in states that had set up their own programs.

The Patient Protection and Affordable Care Act (PPACA) authorizes student loan repayment tax relief by including state funded loan repayment programs as eligible for exemption from federal income taxation.

Now, payments made under the National Health Service Corps or 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 will be excluded from gross income, effective for amounts received by an individual in tax years beginning after Dec. 31, 2008.

Who qualifies for this exemption?

Recipients of State loan repayment or loan forgiveness awards and NHSC awardees who received awards after December 31, 2008. These health professionals and their employers also may be entitled to a refund of taxes paid under the Federal Insurance Contributions Act on payments covered under the new exclusion.

How can I amend prior years' taxes?

Health care professionals who have already filed for 2009 may exclude eligible amounts by filing Form 1040X, Amended U.S. Individual Income Tax Return. This form can be downloaded from this website http://www.irs.gov/pub/irs-pdf/f1040x.pdf or obtained by calling the IRS toll-free at 1-800-TAX-FORM (1-800-829-3676). Individuals filing Form 1040X to claim this exclusion should write "Excluded student loan amount under 2010 Health Care Act" in the Explanation of Changes box. Health care professionals may request an employer or other issuer to provide a Form W-2c, Corrected Wage and Tax Statement, or 1099 and may attach the corrected form to the Form 1040X. However, the Form 1040X may also be filed without attaching a corrected form.

How do I receive an exemption in future returns?

The IRS will be responsible for implementing the amendments to the code (Code Sec. 108(f)) and has not provided guidance on the issue yet.

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Comparative Effectiveness Research

The Patient Protection and Affordable Care Act (PPACA) establishes a non-profit, tax exempt corporation, known as the "Patient-Centered Outcomes Research Institute" to provide comparative effectiveness information to assist patients, clinicians, purchasers, and policy makers in making informed health decisions. The Institute will focus on clinical comparative effectiveness research, defined as research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments or services. The Institute will prioritize the healthcare areas to address, engage in research and evidence synthesis efforts, and disseminate its finding to all stakeholders in an understandable manner. The function of the Institute is solely informational; it is specifically precluded from making mandates regarding coverage, reimbursement or other policies for any public or private payer. Nonetheless, it is expected that both private and public payers will over time use the comparative effectiveness information from this trusted source in various policy decisions.

The federal government is permitted only to use the evidence and findings from the Institute to make a Medicare coverage determination if the process is iterative (based on multiple sources), transparent, includes public comment and considers the effect on subpopulations. Furthermore, the federal government is prohibited from using this information in determining Medicare coverage, reimbursement, or incentive programs in a manner that would preclude or have the intent to discourage individuals from choosing health care treatments based on how the individual values the tradeoff between extending the length of life and the risk of disability. The legislation also specifically prohibits the Institute from using cost-effectiveness analyses (e.g. quality adjusted life years (QALY) for establishing as a threshold what health care is cost-effective or recommended).

How is the Institute governed?

The Institute, which will be established in 2010, is governed by a Board of Directors consisting of the Directors of the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH) and an additional 17 members appointed by the Comptroller General representing patients and health care consumers, physicians and providers, private payers, pharmaceutical, device, and diagnostic manufacturers or developers, representatives of quality improvement or independent health service researchers, and representatives of the federal government or the states. The selection process for the Board of Directors began in spring of 2010 with appointments expected in early fall. The processes of the Institute must be transparent, include strong conflict-of-interest safeguards, and allow stakeholders and other individuals to provide informed and relevant information with respect to any determinations, to review draft proposals of the determinations and to submit public comments with respect to draft proposals.

How is the Institute funded?

The Institute will be funded through federal appropriations from the Treasury of $10 million and $50 million for years 2010 and 2011 respectively. Beginning in 2013 and for each year after, the federal contribution from the Treasury will be $150,000. Also beginning in 2013, the Institute will receive additional funding of $1.00 ($2.00 starting in 2014) from the Medicare Trust Fund for each beneficiary covered under Medicare A for the year, and a similar amount from each insured and self-insured health plan contract offered in the private sector during that year. By 2014, total funding for the Institute from all sources is estimated to be approximately $600 million.

How will the Institute specifically affect my practice and my patients?

This Institute is expected to be a trusted source of information about which clinical strategies work best, under what circumstances and for whom for both you and your patients. The AHRQ and National Institutes of Health currently support such comparative effectiveness efforts and publish their findings in such journals as the College's *Annals of Internal Medicine*. In addition, AHRQ, through its Effective Health Care program, currently publishes each year a limited number of guides focused on the needs of physicians and patients that synthesize available comparative effectiveness research on selected clinical issues. The guides are available at:

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http://www.effectivehealthcare.ahrq.gov/index.cfm/guides-for-patients-and-consumers/. The creation of the Institute will significantly increase the scope and volume of this much needed information. Furthermore, both AHRQ and NIH will be significantly involved in the Institute in the form of representation on the Board of Directors and priority status for research contracts offered by the Institute that fall under their purview.

Isn't there an Institute of Medicine (IOM) committee on comparative effectiveness research? How does it relate to this new Institute created under the PPACA?

The Institute of Medicine has been a strong advocate for the need for more comparative effectiveness research in this country. The IOM, with the help of federal funding through the American Recovery and Reinvestment Act (ARRA) of 2009, was tasked to organized a committee to recommend national priorities for research questions to be addressed by comparative effectiveness efforts—Hal Sox, MD, MACP, former editor of the College's *Annals of Internal Medicine"* was the Chair of that Committee. The Committee released its report in June of 2009. It is expected that the new Institute's efforts to prioritize its comparative effectiveness activities will be informed by this IOM report.

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Center for Medicare & Medicaid Innovation

The Patient Protection and Affordable Care Act (PPACA) establishes a new Center for Medicare & Medicaid Innovation that would allow the Centers for Medicare and Medicaid Services (CMS) to test models that promote broad payment and practice reform within Medicare, Medicaid and the Children's Health Insurance Program (CHIP) while preserving or enhancing the quality of care. In selecting these models, the Secretary of Health and Human Services (HHS) is required to give preference to models that improve the coordination, quality, and efficiency of health care services. In addition, the Secretary is required to consult with relevant federal agencies and experts in medicine and health care management while developing and testing these models. The provision calls for the appropriation of $5 million for design, implementation and evaluation of models in 2010, and for $10 billion to cover the activities of the Center for the fiscal years 2011 through 2019.

What specific payment and practice reform models does the provision suggest be tested within the Center?

The new law provides the Secretary of HHS significant leeway regarding the specific models to be tested. Most relevant to the College, the provision specifically suggests the consideration of models that promote broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment. The law also suggests consideration of models that support the establishment of community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self management, activities.

How do the projects within the Center differ from the demonstration and pilot projects previously developed under CMS?

The projects conducted within the new Center have at least three potential advantages over the demonstration projects traditionally implemented by CMS:

- Budget-neutrality is not a requirement for project approval and implementation. Budget-neutrality requires that the project is projected not to lead to any increase in expenditures compared to expenditures anticipated if the project was not implemented. In previous CMS demonstrations, a lack of budget-neutrality has precluded approval, and the failure to achieve budget neutrality following implementation has lead to such actions as early termination of the project and reduction of project payments to participating practices.
- The Secretary had significant authority to broadly implement into the Medicare, Medicaid and CHIP programs aspects of projects that have been found to be successful without the necessity of further legislative approval.
- The Center has substantial funding to help ensure that the projects chosen by the Center can be effectively developed, implemented and evaluated.

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Community Health Teams to Support the Patient Centered Medical Home

The Patient Protection and Affordable Care Act (PPACA) requires the Secretary of Health and Human Services (HHS) to implement a grant program in 2010 to establish community-based interdisciplinary, inter-professional health teams to provide service and financial (capitated payments) support to primary care practices serving as Patient Centered Medical Homes to individuals with chronic conditions. Grantees are required to be state or state designated entities. Patient-centered medical home are defined in the PPACA as a mode of care that includes personal physicians with whole person orientation; coordinated and integrated care; and safe and high quality care through evidence based protocols, health information technology and continuous quality improvement; expanded care access; and payment recognizing the added value of patient-centered care.

Who will make up these health teams?

The specific members of these Community Health Teams will be determined by the Secretary of HHS as part of the regulatory process. The PPACA indicates that the team members may include "medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physician assistants."

What is required of these health teams under the grants?

The health teams are required to carry out 10 specific activities, including establishing contractual agreements with primary care physicians and other providers to provide support services; developing plans that integrate preventive services for patients; providing 24-hour care management and support during transitions in care settings; promote effective strategies for treatment planning, monitoring health outcomes and resource use, sharing information, treatment decision support, and organizing care; and other related activities.

What constitutes a primary care practice under these grants and what is required of the primary care physicians who contract with these teams?

A primary care practice is defined as a practice that provides integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care clinicians who contract with these teams would be required to provide care plans for patient participants, provide access to participant health records to the teams, and meet regularly with the care team to ensure integration of care.

What impact will these health teams have on internists' practices?

The health teams are expected to be beneficial in assisting primary care practices to offer care consistent with the Patient Centered Medical Home care model; but particularly helpful to smaller practices that often do not have the staff or financial resources to provide these services on their own. These entities will be able to provide both financial support to develop the infrastructure and capabilities to deliver medical home services, as well as access to actual resources (e.g. qualified staff to offer self care education, 24/7 triage or case management) in an effective and economical manner.

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Identifying and Correcting Mis-Valued Services Paid Under the Medicare Physician Fee Schedule

Congress requires that the Centers for Medicare and Medicaid Services (CMS) use the Resource-Based Relative Value Scale (RBRVS) to determine Medicare fee-for-service payments to physicians. The RBRVS measures the resource costs required to provide each physician service, ranking each service relative to all other services. These resource costs are expressed in the form of relative value units (RVUs). The total relative value assigned to each service is divided into three components:

- Physician work—consists of factors recognizing the time it takes to perform the service, the technical skill and physical effort, the mental effort and judgment, and the potential risk to the patient. On average, physician work accounts for slightly over 50 percent of the total RVU of a service.
- Practice expense—consists of factors recognizing the direct costs, such as for equipment, supplies, and administrative and clinical staff, and the indirect costs, such as office rent and utilities that the physician incurs in providing the service. On average, practice expense accounts for slightly under 40 percent of the total RVU of a service.
- Professional liability insurance—reflects the cost of professional liability insurance associated with performing the service. On average, professional liability insurance accounts for roughly 5 percent of the total RVU of a service.

Medicare adjusts the RVUs for each of the three components to reflect cost differences by geographic area, known as Geographic Practice Cost Indices (GPCI). It converts the geographically adjusted total RVU for each service into a payment amount by multiplying it by a dollar multiplier, called a conversion factor.

The Medicare payment formula is:

Payment Amount = [(Work RVU × Work GPCI) + (PE RVU × PE GPCI) + (PLI RVU × PLI GPCI)] × Conversion Factor

The great majority of non-Medicare payers, including private health plans, use the RBRVS as the basis for determining payments.

How does CMS maintain the values it assigns to physician services on an on-going basis?

CMS maintains the RBRVS through annual and periodic updates to RVUs assigned to each service and changes to the underlying methodology. The annual changes are limited to CMS value assignments to services for which a new procedure code is established (or an existing procedure code is significantly altered). Generally, all services for which a procedure code already exists are considered to be appropriately valued. The periodic review, which takes place every five years and is known as the "Five-Year Review," provides an opportunity to re-assess the accuracy of the values assigned to existing services. CMS relies to a large extent on recommendations from the American Medical Association/Specialty Society Relative Value Update Committee (RUC), which is comprised of representatives appointed by major physician specialty organizations and supported by an advisory group representing a broader group of specialties. While CMS makes the final decision on the relative value assigned to each service, the agency has accepted approximately 90 percent of the recommendations it has received from the RUC since Medicare began using the RBRVS as the basis for physician payments in 1992.

What does the health care reform law do to promote more accurate assignment of relative values assigned to physician services paid under the Medicare fee schedule?

The Patient Protection and Affordable Care Act contains a provision that promotes identification and correction of mis-valued physician fee schedule services. Congress included the provision on the belief that too little attention is devoted to monitoring whether services have become overvalued. The provision contains two main parts: providing direction to the Secretary of the Department of Health and Human Services (HHS), largely

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carried out through CMS, for identifying and correcting mis-valued services; and requiring the Secretary of HHS to establish a process to validate relative value units for physician fee schedule services. Details regarding the two main parts are below.

Identifying and Correcting Potentially Mis-valued Services

The Secretary shall periodically identify services as being potentially mis-valued using the following criteria:

- Codes (and families of codes as appropriate) for which there has been the fastest growth.
- Codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses.
- Codes for new technologies or services within an appropriate period (such as 3 years) after the relative values are initially established for such codes.
- Multiple codes that are frequently billed in conjunction with furnishing a single service.
- Codes with low relative values, particularly those that are often billed multiple times for a single treatment.
- Codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes).
- Such other codes determined to be appropriate by the Secretary of HHS.

The Secretary of HHS shall review the relative values for services identified as being potentially mis-valued using the above criteria and make appropriate adjustments.

To execute the requirement to review relative values and make appropriate adjustment, the Secretary of HHS may use:

- Existing processes to receive recommendations on the review and appropriate adjustment of potentially mis-valued services.
- Conduct surveys, other data collection activities, studies, or other analyses as the Secretary of HHS determines to be appropriate to facilitate the review and appropriate adjustment.
- Use analytic contractors to: identify and analyze potentially mis-valued services; conduct surveys or collect data; and relative value adjustment recommendations.
- Make appropriate coding revisions, which can be done using existing processes, e.g. the Current Procedural Terminology (CPT) code maintenance process that may include consolidation of individual services into bundled codes (that would then receive bundled payment). The language in the law notes that this approach may be especially relevant to codes with low relative value units.

The Secretary of HHS shall make adjustments to relative values in a budget neutral manner.

The Secretary of HHS may coordinate the required review/appropriate adjustment with the periodic review, known as the Medicare "Five-Year Review," also required by law.

Validating Relative Value Units

The Secretary of HHS shall establish a process to validate relative value units for physician fee schedule services. This validation process:

- May include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intra-service components of work.
- Shall include a sampling of codes for services that are identified using the above criteria listed under the "Potentially Mis-valued Codes" heading.

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- May use methods described above as options for executing the requirement that the Secretary of HHS review and adjust relative values of potentially mis-valued codes, i.e.: using existing processes, including RUC and CPT; conducting surveys; collecting/analyzing data; and using analytic contractors.
- Shall include appropriate adjustments that are made in a budget neutral manner.

When does the provision take effect? Does CMS have to take action?

The provision became effective on the date that PPACA became law, March 23, 2010. It requires that CMS assess the accuracy of the RVU assigned to essentially all services on an on-going basis (while the provision identifies certain categories of service, e.g. fastest growing, for worthy of focus, CMS has complete discretion as the last category is "such other codes as determined appropriate by the Secretary"). It requires CMS to correct any service determined to be mis-valued. While determining which services are overvalued—and determining the correct value for those that are overvalued—may take time, the provision signifies the congressional intent that CMS act diligently.

Why is this provision important?

Ensuring that physician service value assignments are accurate is important as the RBRVS drives approximately $80 billion in annual Medicare payments for physician services and substantial amount in payments made by other payers. Recent reports from the Medicare Payment Advisory Commission (MedPAC), a non-partisan research arm of the Congress, and the Center for Studying Health System Change, a well-respected think tank, have highlighted the adverse effect of improperly valued services, or mis-valued services, on our health care system. Mis-valued services distort incentives and may result in the overuse or underuse of specific services on the basis of financial, as opposed to clinical, reasons. Inappropriate valuation of services also affects physicians' decisions to enter or remain in specialty fields that perform undervalued services. These effects are magnified because of the "budget neutral" system by which Medicare pays for physician services. Congress requires that aggregate Medicare expenditures for payments for physician services remain relatively constant from one year to the next. As a result, when payment for a physician service increases, payment for all other services decreases to account for the increased expenditures from paying the single physician service for which the relative value has risen.

Although there is significant interest in moving away from a system that pays for discrete physician services in an overarching system that provides incentives to increase volume, refining the RBRVS remains crucial until new payment models are designed and implemented on a widespread basis. Innovative payment models are likely to be tested, and even models that dramatically change incentives may still, at least in part, be based on current fee-for-service payment rates that are built by RVUs. In addition, Medicare can make payment policy changes within the context of the RBRVS to facilitate a transition to models of care that focus more explicitly on improving care coordination.

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Technical Component Discounts for Advanced Imaging Services

Under the Medicare physician fee schedule, some services have separate payments for the technical component and the professional component. Imaging services generally have this two-part payment structure, with the actual taking of the image being the technical component and the interpretation of the image serving as the professional component. Medicare pays for each of these components separately when the technical component is furnished by one physician and the professional component by another. When both components are furnished by one physician, Medicare makes a single global payment that is equal to the sum of the payment for each of the components.

Since 2006, the Centers for Medicare and Medicaid Services (CMS) applies a 25 percent reduction to the Medicare technical component for advanced imaging services on consecutive body parts during the same scanning session. CMS imposed this reduction based on recommendations from two non-partisan entities that advise the Congress Medicare issues. These two entities—the Medicare Payment Advisory Commission (MedPAC) and the Government Accountability Office—noted that practices or facilities furnishing imaging services benefited from efficiencies associated with multiple same-body area scans during a single session. Under the policy, a physician is paid the full technical component amount on the highest paid imaging technical component and receives technical component payment that is 25 percent for the other same-session consecutive body parts images.

Does the new health reform law make changes that impact the advanced imaging technical component rate in 2010?

Yes. The Patient Protection and Affordable Care Act (PPACA) increases the discount that applies to the technical component payment for advance imaging services on consecutive body parts during a single session from the current 25 percent rate set by CMS in 2006 to 50 percent beginning July 1, 2010. As noted above, the idea behind discounting the technical component payment is that the cost associated with use of advanced imaging equipment to scan one body part is not fully incurred when multiple scans in the same body area are done during a single session. Congress determined that it is appropriate to discount the technical component payment in these scenarios 50 percent. A physician is paid the full technical component amount on the highest paid imaging technical component and now receives technical component payment that is 50 percent for the other same-session consecutive body parts images. PPACA explicitly stipulates that reduced expenditures, or savings, that result from lower payments associated with increasing the discount to 50 percent go back to the U.S. Treasury. Therefore, the savings are not redistributed through an increase in payments for other fee schedule services.

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Medical Liability Reform – Free Clinics and Medical Liability Immunity

The Patient Protection and Affordable Care Act (PPACA) extends medical liability protections under the Federal Tort Claims Act (FTCA) to officers, governing board members, employees and contractors of free clinics. It became effective on March 23, 2010, when the PPACA was signed into law and "appl[ies] to any act or omission which occurs on or after that date."

Because guidance from the Health Resources and Services Administration (HRSA) – an agency at the Department of Health and Human Services (HHS) – has not been issued as to application of this provision, this publication speaks about the current FTCA medical malpractice protection of volunteer free clinic health professionals, as found in HRSA's Policy Information Notice (PIN) for Federal Tort Claims Act Coverage of Free Clinic Volunteer Health Care Professionals, revised June 18, 2009, found at http://bphc.hrsa.gov/policy/pin0424.htm. When additional information is received, this publication will be updated.

Background:

The Health Insurance Portability and Accountability Act (HIPPA) granted medical malpractice coverage through the FTCA to volunteer free clinic health care professionals. The PPACA extended this coverage to board members, officers, employees, and individual contractors. Free clinic volunteers, board members, employees, or contractors who meet all the requirements may be sponsored by the free clinic and are considered a federal employee by HRSA for the purpose of FTCA medical malpractice coverage after submission of a qualifying application and the federal government acts as their primary insurer. The purpose of the program is to expand access to health care services to low-income individuals who lack access to primary care by encouraging individuals to volunteer or work at free clinics. Individuals who may have refrained from volunteering or working because of the fear of malpractice liability might be more likely to volunteer their services with FTCA coverage.

How does the FTCA program benefit volunteer health care professionals in Free Clinics?

FTCA deemed status provides the volunteer health care professional, board member, officer, employee, or contractor with immunity from medical malpractice lawsuits resulting from his/her subsequent performance of clinical medical, dental or related functions within the scope of his/her work at the free clinic. It does not provide blanket immunity from acts of medical malpractice. The functions which are eligible for medical malpractice coverage for health care service acts or omissions include those that:

- Arise from services required or authorized to be provided under Title XIX of the Social Security Act (i.e., Medicaid Program) regardless of whether the service is included in the State Medicaid plan in effect for the volunteer free clinic health care professional's work site(s);
- Arise from the provision of medical, surgical, dental or related services at a free clinic site or through offsite programs or events carried out by the free clinic; and
- Occur on or after the effective date that the Department of Health and Human Services (HHS) Secretary approves the FTCA deeming application submitted by the free clinic on behalf of its volunteer free clinic health care professionals.

What is the application process?

Eligible free clinics must submit an original deeming application and annual renewal deeming applications on behalf of their volunteer health care professionals to the Bureau of Primary Health Care (BPHC) at HRSA. More information can be found at: http://bphc.hrsa.gov/ftca/freeclinics/

How are claims processed?

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Claimants alleging acts of medical malpractice by a FTCA deemed volunteer free clinic health care professional must file their claims against the United States according to FTCA requirements. FTCA requires that the alleged injured party file an administrative claim with HHS prior to instituting any court action. Upon receipt of the claim, HHS will determine whether FTCA medical malpractice coverage applies to the particular claim by considering if the alleged act or omission giving rise to the claim:

- Involved a volunteer free clinic health care professional with deemed FTCA status pursuant to the Public Health Services Act;
- Involved a health care service qualifying for FTCA coverage; and
- Occurred at a free clinic or a covered offsite program or event carried out by the free clinic.

If HHS denies the claim or HHS action is pending after 6 months, the claimant can file suit against the United States. FTCA medical malpractice cases are heard in Federal district court without a jury and are defended by the Department of Justice with the assistance of the Office of General Counsel, Department of Health and Human Services. HRSA pays for all settlements and judgments from a separate Health Center FTCA Judgment Fund. No punitive damages are allowed.

Will this provision have a direct impact on ACP members and/or their patients?

If the member is an officer, governing board member, employee and contractor of free clinics, then s/he will be given medical liability protection under the Federal Tort Claims Act. The PPACA does not define an officer, governing board member, employee or contractor of free clinics; when guidance is issued from HRSA, ACP will update this publication.

What other trusted sources are available to help better understand the impact of this provision on practices?

- *Health Center Program, FTCA*, from HRSA:

  http://bphc.hrsa.gov/FTCA/

- HRSA has issued one Program Information Notice (PIN) related to the Free Clinic FTCA Program, PIN 2004-24: *Federal Tort Claims Act Coverage for Free Clinic Volunteer Health Care Professionals*. This PIN is available at:

  http://bphc.hrsa.gov/policy/#ftca.

- HRSA has initiated comments on a Policy Information Notice (PIN) entitled *DRAFT Federal Tort Claims Act (FTCA) Coverage for Individuals at Free Clinics* available at:

  http://bphc.hrsa.gov/draftsforcomment/ftcacoverageforindividualsfreeclinics/.

  Comments are due by close of business on October 22, 2010.

- *HRSA's Bureau of Primary Health Care's FTCA HelpLine*: 1-866-*FTCA-HELP (1-866-382-2435)*

- *Federal Torts Claims Act Program; Office of Quality and Data; Bureau of Primary Health Care; Health Resources and Services Administration*; 5600 Fishers Lane, Rockville, MD 20857; Phone: 301-594-0818; Fax: 301-594-5224

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III. 2011 Reforms

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Prescription Drug Discounts and Medicare

The Patient Protection and Affordable Care Act (PPACA) continues to make changes to the Medicare Part D Prescription Drug Program in 2011, having built upon changes in 2010, which consisted of a $250 rebate for qualifying beneficiaries.

As of 2010, the standard Medicare Part D benefit includes a $310 deductible and a 25 percent coinsurance until the enrollee reaches $2,830 in total covered drug spending. After this initial coverage limit is reached, there is a gap in coverage in which the enrollee is responsible for the full cost of the drugs (often called the "donut hole") until total costs hit the catastrophic threshold, $6,440. It is estimated that about 25 percent of beneficiaries reach the coverage gap in a given year. Once reaching the catastrophic threshold, beneficiaries are covered for at least 95 percent of their drug expenses for the rest of the year.

The PPACA makes the following changes within the coverage gap:

- Beginning in 2011, the PPACA requires that drug manufacturers provide a 50 percent discount on brand name prescriptions while the beneficiary is in the coverage gap. In addition, Medicare total cost calculations will include the non-discount price of the drugs; thus beneficiaries will be able to reach the catastrophic threshold more quickly while benefiting from decreased out-of-pocket spending.
- Beginning in 2011, a federal subsidy is phased in for generic drugs so that the coinsurance is reduced from 100 percent to 25 percent within the coverage gap by 2020. The specifics of the phase-in however are not provided in the language of the law.

Are there any other changes in the Medicare Part D Prescription Drug Program that will reduce beneficiary drug costs or increase drug access?

The PPACA contains several provisions to be implemented in or by 2011 that are designed to improve access to and availability of a federal low-income supplement (LIS) to Medicare beneficiaries with incomes below 150 percent of poverty. For example, the redetermination of LIS eligibility subsequent to the death of a spouse would be postponed for a year, and cost sharing would be eliminated for individuals receiving care under a Medicaid home and community based waiver who would otherwise require care in a medical institution or a facility. The PPACA also makes changes to the methodology used to determine which drug plans are eligible to enroll low-income beneficiaries so that more plans could qualify and thus reduce the number of low-income beneficiaries who need to change plans from year to year.

Is it true that some beneficiaries will be required to pay higher premiums to join a Medicare Part D Prescription Drug plan?

Yes, similar to the change made in 2007 requiring high-income beneficiaries (in 2009 defined as an individual earning $85,000 or couple $170,000) to pay higher premiums for Part B benefits, the PPACA, effective January 1, 2011, sets the same thresholds for Part D plan premium payments.

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Refunds for Excessive Health Insurance Premiums

The Patient Protection and Affordable Care Act (PPACA) states that in 2010 health insurers will be required to report to the federal government the percentage of a health insurance premium that is directed towards administrative and medical costs. The intent of this provision is to ensure that premiums are spent on providing quality care rather than wasteful administrative costs or insurer profits.

Starting in 2011, if an insurer directs less than 80 percent of an individual insurance or small group plan's premium and 85 percent of a large group plan's premium to clinical and quality care improvement costs, the insurer will be required to refund the difference to the enrollee. When fully implemented, the provision will help ensure efficient and proper use of enrollees' premiums.

Medical Loss Ratios

Not all of a health insurance premium is directed to providing an enrollee's health care. Health insurers devote premium payments to medical care as well as other costs, including marketing, claims processing, and profits. The amount of a premium that is used by an insurer to pay medical costs versus administrative and other costs is called the medical loss ratio. Because some insurers, particularly those offering individual plans, direct up to 35 percent of a premium towards non-medical care costs, the PPACA would require health insurers to pay a minimum amount of a premium on clinical medical costs and health care quality activities.

How does the law define medical care and administrative costs?

That is still being determined. The National Association of Insurance Commissioners (NAIC) is charged with developing recommendations (by December 2010) on what services are considered clinical medical care and quality improvement activities and what services count as non-medical activities. Recently, the NAIC released draft recommendations and the group is expected to issue a final report on the recommendations in the coming months. The federal government will then certify the recommendations with or without changes.

The medical loss ratio has generated controversy, since insurers advocate that activities such as fraud prevention and disease management programs, which may improve quality tangentially, be considered as quality improvement cost.

What did the NAIC recommend?

In August 2010, the NAIC unanimously approved a draft proposal intended to guide the federal government in defining the medical loss ratio requirement. The draft states that quality improvement activities may include:

- Comprehensive discharge planning
- Case management
- Care coordination
- Chronic disease management
- Health information technology expenses
- Public health education campaigns

Activities that would not be considered in the medical or quality improvement definition include:

- Fraud detection and prevention efforts
- Expenses related to the implementation of the International Classification of Disease code sets (ICD-10)
- Retrospective and concurrent utilization review
- Development and execution of provider contracts

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- Provider credentialing
- Accreditation
- Marketing

What happens if insurers fail to meet the medical loss ratio standard?

If insurers fail to meet the medical expense target they will be required to provide premium rebates to enrollees equal to the amount of non-medical expenses that exceed the target.

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National Health Service Corps

The National Health Service Corps (NHSC) was established in 1972 within the Public Health Service Act to provide support to medical, mental, and dental health professionals in exchange for service in areas identified as experiencing a health professions shortage. Since 1982, more than 30,000 health professionals have received funding through the Corps. The federal government estimates that 80 percent remain in their communities beyond the end of their service, while half dedicate their careers to health care for medically underserved populations.

Scholarship Program

The NHSC scholarship pays tuition, required fees, and some other education costs, tax free, for as many as four years. Education costs may include books, clinical supplies, laboratory expenses, instruments, two sets of uniforms and travel for one clinical rotation. Recipients also receive a monthly living stipend ($1,269 in 2009-2010). The stipend is taxable.

Loan Repayment Program

The NHSC recruits primary care medical, dental and behavioral and mental health clinicians who are dedicated to providing care to the Nation's underserved people. In return, they can reduce or eliminate their health professions student debt by providing care at a National Health Service Corps-approved site. The Full-Time Program starts with an initial award of $50,000 for 2 years of service, which is an increase from the $35,000 that was available prior to enactment of the Patient Protection and Affordable Care Act (PPACA). A new Half-Time Pilot Project starts with an initial award of $50,000 for 4 years of service. Participants may apply to extend their service until their debt is paid.

The (PPACA) permanently reauthorized the NHSC and resulted in the following changes:

THE NATIONAL HEALTH SERVICE CORPS TRUST FUND

The PPACA contains a total of $1.5 billion in new, dedicated funding for the National Health Service Corps over five years starting FY2011 ($290M) to FY2015 ($310M). The National Health Service Corps Trust Fund is in addition to existing discretionary funding, which was authorized at $320M in FY2010 and increases to $1.15B in FY2015.

What is the difference between “mandatory” and “discretionary” spending?

Mandatory spending is also known as entitlement spending and goes to programs such as Social Security, Medicare and Medicaid. Discretionary spending must be approved by the Congress every year in the appropriations process and, unlike most mandatory spending, is subject to a predetermined limit each year.

How will these funds be spent?

While the NHSC has not announced the number of scholarship or loan repayment awards this funding will provide, it is estimated that this funding will place an estimated 12,000 primary care “providers” in “provider-shortage” areas by 2016.

In FY2009, the NHSC received $135 million in appropriations to support 39 new scholars and 977 new loan repayors. The program also received $300 million American Recovery and Reinvestment Act funds to support 114 new scholars in 2009-2011 and approximately 3,300 new loan re-payors between 2009 and 2011.

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PROGRAMMATIC CHANGES

Changes to Loan Repayment

Beginning in FY2011, the award full-time Corps members can receive is increased from $35,000 to $50,000, including possible additional inflationary increases starting in FY2012.

Teaching as Eligible Service

Teaching can count for up to 20 percent of the NHSC clinical practice service obligation and teaching under the new "teaching health center graduate medical education program" can count for up to 50 percent of the NHSC clinical practice service obligation. Teaching health centers are discussed in greater detail in the 2010 section of this guide.

Part-time Clinical Practice

Corps members may satisfy their service obligation through part-time clinical practice (a minimum of 20 hours per week). The Corps member must enter into a written agreement to either double the period of obligated service or receive 50 percent of the full-time loan repayment amount.

When will these programmatic changes be implemented?

The NHSC is administered by the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS). It is anticipated that the Secretary of HHS will delegate to HRSA the primary responsibility for implementing the enhanced funding for the National Health Service Corps. Because the funding flow begins in FY 2011, it is anticipated that HRSA will issue program guidance for both funds in fall of 2010. As of September 2010, NHSC had not implemented or provided guidance on the programmatic changes.

INFORMATION FOR INTERESTED APPLICANTS

Below is information on the NHSC scholarship and loan repayment programs for FY2010 based on current guidelines. Interested applicants should check the NHSC website for updates on the status of programmatic changes as a result of the law at http://nhsc.hrsa.gov/.

When is the application deadline for the Scholarship Program?

Applications for School Year 2010-2011 were due by June 1, 2010. FY2010 applicants selected for awards will be notified by email or letter, no later than September 30, 2010. Eligible individuals who do not receive a scholarship award will be notified no later than October 31, 2010.

How can I apply?

The Application form and program guidance can be found here http://nhsc.hrsa.gov/scholarship/guidance.pdf.

What are the eligibility requirements?

You must be:

- U.S. Citizen or National
- Enrolled or Accepted for Enrollment

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- Pursuing An Eligible Degree In An Accredited Program Located in the U.S. (joint programs that provide dual degrees are not eligible):
  - Physician: MD or DO
  - Dentist: DDS or DMD
  - Family Nurse Practitioner: master's degree or post-master's certificate
  - Certified Nurse-Midwife: master's degree or post-master's certificate
  - Physician Assistant: associate, bachelor's or master's degree

What is the service commitment?

NHSC scholars are committed to serve one year for each year of support (minimum of two years service) at an approved site in a high-need Health Professional Shortage Area soon after they graduate, serve in a primary care residency (family medicine, general pediatrics, general internal medicine, obstetrics/gynecology or psychiatry for physicians and general or pediatric for dentists) and are licensed. Scholars compete for employment at the approved service sites of their choice from a listing of job vacancies in their discipline and specialty. The NHSC helps scholars select a compatible service site and pays for travel to and from interviews.

When is the application deadline for full-time service in the Loan Repayment Program?

Applications for full-time service were due by July 29, 2010. FY2010 applicants will be notified, even if they are not selected to receive awards, by October 15.

How can I apply for a full-time service award?

The application form and program guidance can be found at: http://nhsc.hrsa.gov/loanrepayment/apply.htm.

Is there a part-time option?

While the new part-time option authorized by the law has not been implemented yet, the NHSC is currently running a part-time pilot project. Participants are eligible up to $50,000 in loan repayments for an initial four-year half-time service commitment. The NHSC anticipates making approximately 400 part-time service awards.

When is the application deadline for the part-time option?

Applications for part-time service were due by May 25, 2010.

How can I apply for the part-time option?

The application form and program guidance can be found here:
http://nhsc.hrsa.gov/loanrepayment/halftime/guidance/.

What are the eligibility requirements for the loan repayment awards?

You must be:

- U.S. citizen or National
- Trained and licensed in one of the following primary care disciplines:
  - Allopathic (MD) or Osteopathic (DO) Physician
  - Primary Care Nurse Practitioner
  - Certified Nurse-Midwife
  - Primary Care Physician Assistant

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    - Dentist
    - Dental Hygienist
    - Health Service Psychologist
    - Licensed Clinical Social Worker
    - Psychiatric Nurse Specialist
    - Marriage and Family Therapist
    - Licensed Professional Counselor
- Working or applying to work at a site that is approved by or has applied to become approved by the NHSC
- Unpaid government of commercial loans for school tuition, reasonable educational and living expenses that are not consolidated with non-educational debts

What is the service commitment for the loan repayment awards?

NHSC loan repayors are committed to serve 2 years (full time) or 4 years (part time) at an approved site in a designated Health Professional Shortage Area.

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Redistribution of Graduate Medical Education Slots

The Patient Protection and Affordable Care Act (PPACA) calls for a redistribution of unused residency slots and allocates 65 percent of the slots for primary care and general surgery positions. The law also authorizes teaching hospitals to receive Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments associated with the time residents training in ambulatory settings, such as clinics or physicians' offices, if they incur "all or substantially all" of the training costs so long as the hospital incurs the costs of the residents stipends and benefits for the time the residents spend in that setting. This provision allows hospitals to avoid the administrative burden of calculating physician supervisory costs at the ambulatory site. The law also clarifies that sick leave and vacation time can be counted for IME and DGME. It also ratifies the October 1, 2001 regulation that time spent in research not involving the care of patients cannot be counted for IME.

What is the difference between DGME and IME?

DGME payments partially compensate teaching programs for residency education costs; whereas IME payments compensate hospitals for higher patient care costs due to the presence of teaching programs.

Redistribution of Unused Residency Slots (DGME and IME)

The law requires the Centers for Medicare and Medicaid Services (CMS) to take 65 percent of the DGME and IME residency slots that have gone unused by a hospital for the past three years and to redistribute them according to certain criteria. The DGME and IME resident caps of hospitals with three years of unused residency slots will be permanently reduced beginning July 1, 2011. To determine whether and by how many residents a particular hospital's resident cap will be reduced, CMS will look back at the hospital's last three settled or submitted cost reports for cost reporting periods ending before March 23, 2010. CMS clarified the method that will be used to determine this look-back period and other details in a proposed rule on June 30, 2010. The final rule has not been issued yet.

Are any hospitals exempt from the reduction in resident limits?

Yes, resident limits will not be reduced for rural hospitals with fewer than 250 acute care inpatient beds; hospitals that participated in a voluntary residency reduction plan and that have a plan in place to fill the unused positions by March 23, 2012; and the replacement facility for the former Martin Luther King, Jr. - Harbor Hospital (Los Angeles).

How many residency slots will be redistributed?

According to the Association of American Medical Colleges (AAMC), about 900 residency slots will be redistributed under this program, although the final number is dependent on hospital data and CMS's interpretation of the law.

Once a hospital has been awarded slots, when can it expect to start getting paid for those redistributed slots?

Hospitals awarded slots under the redistribution program may be paid for those redistributed slots beginning July 1, 2011. The per-resident amounts used to calculate DGME payments for the redistributed slots will be equal to the per-resident amount otherwise in effect for the hospital for primary care and non-primary care. The IME adjustment factor for the redistributed slots is also set at the current 5.5 percent.

How many slots may a hospital request?

Hospitals may apply to receive up to 75 slots under this redistribution program.

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What considerations will be given in awarding the redistributed slots?

CMS is required to consider factors including: (1) the hospital's likelihood of filling the additional slots within the first 3 cost reporting periods beginning on or after July 1, 2011; and (2) whether the hospital has an accredited rural training track. CMS is also required to allocate 70 percent of the redistributed slots to hospitals in states with resident-to-population ratios in the lowest quartile and 30 percent of the redistributed slots to hospitals located in (a) the 10 states with the highest proportion of their populations living in a health professional shortage area (HPSA), and (b) rural areas. CMS will make the ultimate decision of which states meet the criteria, however below is AAMC's interpretation.

13 States with Lowest Resident-to-Population Ratios	10 States with Highest Proportion of Population Living in a HPSA
Montana	Louisiana
Idaho	Mississippi
Alaska	New Mexico
Nevada	Montana
South Dakota	Wyoming
Mississippi	Alabama
North Dakota	North Dakota
Florida	Missouri
Oregon	Arizona
Georgia	
Indiana	
Arizona	

Source: AAMC Summaries of GME Sections of the Health Reform Bill.
http://www.aamc.org/reform/summary/dgmeime.pdf

Are the redistributed slots subject to any restrictions?

Yes, for five years (beginning on the date the hospital's limit was increased). The hospital may not reduce its pre-redistribution number of primary care residents below the average number of primary care residents training in the hospital during the three most recent cost reporting periods ending before March 23, 2010. Additionally, at least 75 percent of the additional slots a hospital receives through the redistribution program must be used for primary care or general surgery. If a hospital fails to comply with these requirements, all of the additional slots it gained through the redistribution program will be taken away and redistributed to other hospitals.

How many of the redistributed slots will go to primary care versus general surgery?

Although 65 percent of unused positions are to go to primary care and general surgery, the distribution has not been determined.

PAYMENTS TO TEACHING HEATLH CENTERS

The PPACA also establishes a new Title III program that provides $230 million from FY 2011-2015 to reimburse qualified teaching health centers (THC) for their direct and indirect costs. Teaching health centers are newly created under the PPACA and are defined as community-based, ambulatory patient care centers that operate a primary care residency program. They can include federally qualified health centers, community mental health centers, rural health clinics, and health centers operated by the Indian Health Service. Unlike the

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requirement for THC grants, it does not appear that a "new or expanded" residency program is required to be a primary care program for its expenses to be covered under this section. However payment is only for expansion—funding for residents above a base level—or establishment of newly accredited programs. In addition, funding is only for programs where the teaching health center is the institutional sponsor of the residency program.

Do these payments replace existing payments currently being received for DGME and IME by a teaching health center?

No, the teaching health center payments are in addition to payments made to hospitals for DGME payments.

What expenses are defined as "direct expenses" or "indirect expenses"?

The law does not define what expenses are to be included in either category. Regulations will be required to clarify these terms.

Do THC residents count toward the current Medicare limits on GME funded resident positions?

No.

Can a resident's time be "double counted" by a THC and a hospital?

No.

Additional Information:

- *Teaching Primary Care in Community Health Centers: Addressing the Workforce Crisis for the Underserved*

  http://www.annals.org/content/152/2/118.full?aimhp

- Teaching Health Centers – Summary of a Roundtable Meeting in which ACP participated.

  http://www.medicaleducationfutures.org/uploads/THCSummary.pdf

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Primary Care Extension Programs

The Patient Protection and Affordable Care Act (PPACA) establishes a new grant program in 2011 to fund the establishment of a Primary Care Extension Programs under the Agency for Health Research & Quality (AHRQ). This program is based on the model of the Agricultural Extension Service that has been provided through state and federal efforts for many years.

What are the requirements of Primary Care Extension Programs funded by these grants?

These Primary Care Extension Programs are required to (1) assist primary care clinicians to implement a patient-centered medical home; (2) develop and support primary care learning communities; (3) participate in a national network of Primary Care Extension Program hubs to develop a process to share best practices; and (4) develop a plan for financial sustainability after the initial six-year period of funding under this section is completed.

What specific types of support and education will be provided to primary care practices under this program and how will it be provided?

The program, through local community-based "health extension agents" will support and educate primary care physicians and other healthcare professionals about preventive medicine, health promotion, chronic disease management, mental health services, and the delivery of evidence-based therapies. Furthermore, these agents will assist primary care practices in implementing quality improvement or system redesign that incorporates the principles of the patient-centered medical home, provide guidance to patients in culturally and linguistically appropriate ways, and link practices to diverse health system resources.

How will this program affect my practice and my patients?

The Extension Program, in those state or multistate regions awarded these grants, is intended to provide a trusted source of information and technical support to facilitate the transformation of your practice to deliver patient-centered care consistent with the medical home model.

What are the requirements to apply for this grant and how is this program funded?

The Secretary of the Department of Health and Human Services shall award competitive grants to States for the establishment of a State or multistate level Primary Care Extension Program. A State or multistate applicant must minimally include the State health department, the entity responsible for administering the State Medicaid program, the State-level entity administering the Medicare program, and the departments of 1 or more health professions schools in the State that train providers in primary care. Two types of grants will be awarded:

- A 6 year grant to State or multistate entities that submit a fully-developed plan for the implementation of the Primary Care Extension Program.
- A 2 year planning grant to State or multistate entities with the goal of developing a plan.

Grants are authorized to be appropriated $120,000,000 for each of fiscal years 2011 and 2012, and such sums as may be necessary to carry out this section for each of fiscal years 2013 through 2014.

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Medicare Bonus Payment for Primary Care Services

Medicare uses a fee schedule to pay physicians for the services they furnish to beneficiaries. In some circumstances, Medicare provides a bonus payment on top of the fee schedule amount to facilitate specific physician actions. For example, Medicare pays a 10 percent bonus in addition to the fee schedule amount for each service provided in a designated Health Professional Shortage Area (HPSA) to encourage physicians to practice in under-served areas.

The Patient Protection and Affordable Care Act (PPACA) provides a 10 percent bonus payment on top of the fee schedule payment for select primary care services furnished by primary care physicians in calendar year 2011-2015. To qualify for the bonus, a physician must be self-designated in a primary care specialty, as explained below, and he or she must predominantly provide the select primary care services to be eligible, with the assessment of the extent to which primary care services are furnished being based on an earlier time period. To illustrate, a primary care physician is likely to receive a bonus payment on top of payment for services in 2011 if Medicare determined that he or she is eligible based on its assessment of billing from 2010. As indicated by the "Expanding Access to Primary Care Services…" title of the bonus provision in the reform law, the program recognizes the declining interest in primary care practice and aims to promote beneficiary access to primary care physicians.

Who is a considered a primary care physician eligible to receive the bonus?

The law defines primary care physicians as those practicing in the following specialties: general internal medicine; family practice; geriatrics; and pediatrics. The federal agency that administers the Medicare program—the Centers for Medicare and Medicaid Services, or CMS—has yet to define the specific rules but the most likely way CMS will determine a physician's specialty is by using the specialty each physician indicated when enrolling to participate in the Medicare program. Nurse practitioners, clinical nurse specialists, and physician assistants can also receive the bonus payment if they meet the other criteria established by the law, described below. The bonus payment, however, will be on top of the fee schedule amount that applies to the specific practitioner type. For example, Medicare pays nurse practitioners in independent practice arrangements as allowed by state law 85 percent of the allowed charge amount that applies if a physician furnishes the service.

Physicians who practice a specialty not identified in the law—whether an internal medicine subspecialty or other specialty—are not eligible for the bonus payment. While some internal medicine subspecialists may be in short supply, Congress crafted the provision with the intent of boosting access to primary care physicians. This program is one part of a broader effort to reverse the declining interest in primary care practice. ACP remains interested in the workforce needs related to subspecialties and believes that a national workforce commission that is established through PPACA will draw appropriate attention to needs across the specialty spectrum.

What services are considered primary care services?

The law defines primary care services for the purpose of this bonus payment program, by referencing the Current Procedural Terminology (CPT) service type and code range, as:

- Office/outpatient visits, CPT 99201-99215;
- Nursing facility services, CPT 99304-99316;
- Domiciliary, rest home, or custodial care services, CPT 99324-99340; and
- Home services, CPT 99341-99350.

What percentage of Medicare revenue must a general internist derive from the above select primary care services to qualify for the bonus?

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For the purposes of this program, physicians should think of Medicare revenue as their Medicare "allowed charges" as this is the term used in the law. Allowed charges include the amount that Medicare paid for services plus the amount for which the beneficiary is liable, including deductibles and copayments. Medicare allowed charges generated from providing "evaluation and management" services as defined by the CPT codes referenced above in the office/outpatient, nursing facility, domiciliary/rest home/custodial care, and home settings must equal at least 60 percent of the total Medicare allowed charges for an individual primary care physician for that physician to qualify for the bonus.

The law states that determination as to whether Medicare allowed charges meet or exceed the 60 percent threshold is to be based on a "prior period." While CMS has yet to define the specific rules, it would be logical for the prior period to be the previous year. The bonus payment would then be on top of the payment for the select primary care services furnished during the bonus period year. For example, Medicare would pay a 10 percent bonus on top of the payment for office, nursing facility, domiciliary, and home services furnished during 2011 for the physicians CMS determined eligible for the bonus based on their 2010 billing. The law states that Medicare is to pay the bonus to qualified physicians on a monthly or quarterly basis.

Will the 60 percent select primary care services revenue threshold preclude some general internists who provide primary care from receiving the bonus?

ACP believes the law structures the primary care bonus payment program in a way that may inappropriately exclude some general internists and other primary care physicians. For example, the College is working with policymakers to determine the specific services for which payment is counted toward the total Medicare revenue denominator. For example, it is unclear as to whether payments from in-office laboratory services are included.

How much could a general internist who qualifies expect to receive in a year?

Using data from member surveys and other sources, ACP estimates that a typical general internist receives approximately $200,000 in annual Medicare revenue. Assuming that a general internist receives the 10 percent bonus payment on 60 percent of Medicare revenue—which is comparable to allowed charges—in the bonus payment year, Medicare would pay a total of $12,000 throughout the bonus year. A general internist for whom 80 percent of Medicare revenue is derived from the select primary care services would receive $16,000 during the bonus year. As the bonus program runs through 2015, the general internist who is eligible for a $16,000 bonus each year will receive roughly $80,000 over the five-year period.

Eligibility for the bonus is determined at the individual physician level. Multiple general internists in the same group practice can receive the bonus. The determination as to which physicians qualify is based on the revenue associated with each individual physician during the prior assessment period.

How much will Medicare pay out in bonuses? Where is the money coming from?

The non-partisan entity that advises Congress on the cost of legislation, the Congressional Budget Office, projects that the bonus payment program will cost Medicare $3.5 billion. While Congress considered generating part of money necessary to fund this program by making a small cut in payments to all other physician services, it ultimately funded the program without reducing payments for non-primary care services. Most of the projected $3.5 billion will be paid to primary care physicians but general surgeons will receive some of the funds as the law directs Medicare to pay a 10 percent bonus on top of the fee schedule payment for major surgical procedures provided in an underserved area defined as a HPSA. That Congress established and funded this program indicates its recognition of the value of primary care and the need to preserve it.

Will this Medicare bonus payment stop the declining interest in the practice of primary care?

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The College recognizes that a 10 percent bonus payment on some primary care services over a five-year period, while significant, is not alone sufficient to ensure an adequate supply of general internists and other primary care physicians. The College believes that other provisions in the law, e.g. increased Medicaid payments for primary care services, and activities external to it, e.g. initial efforts by health plans to increase payments to physician practices recognized as a Patient Centered Medical Home, will help further. It understands, however, that more needs to be done.

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Medicaid Health Homes for Enrollees with Chronic Conditions

The Patient Protection and Affordable Care Act (PPACA) includes the establishment of a Medicaid state plan option, called Health Homes, to address specifically the needs of beneficiaries with chronic conditions beginning in January, 2011. The federal government will provide 90 percent of the cost of this initiative to each participating state for the first two years of implementation. In addition, state planning grants are available to assist states in program development. State plans must include a methodology for payment to participating providers. The programs can be focused on specific high-need chronic care populations or within specific geographic areas of the state.

What providers are eligible to participate in these state Health Home programs?

Eligible providers include physicians, clinical practices or clinical group practices, rural clinics, community health centers, community mental health centers, home health agencies, or any other entities or providers that are determined by the state to be qualified to be a health home for eligible individuals with chronic conditions on the basis of documenting that it:

- Has the systems and infrastructure in place to provide health home services; and
- Satisfies qualification standards to be established by the Secretary of Health and Human Services (HHS)

What set of services are required from eligible Health Home providers?

Home Health providers are required to provide the following set of services; comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; referral to community and social support services, if relevant; and use of health information technology to link services, as feasible and appropriate.

How will providers participating as Health Homes be paid?

Each state that chooses to participate in this optional program must include a provider payment methodology in its program application to the Secretary of HHS. States are provided with considerable flexibility to choose a payment methodology.

What are the patient qualifications to participate in these state Health Home programs?

Patients eligible for these programs must be covered by Medicaid or by a related state waiver and have at least two chronic conditions, or one chronic condition and be at risk of having a second chronic condition, or one serious and persistent mental health condition. Furthermore, they must designate an eligible Medical Home service provider.

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Medicare-Covered Preventive Services

Medicare has historically prohibited coverage of services in the "absence of sign, symptom, or injury." Congress has legislated periodic exceptions to this stipulation in the original Medicare authorizing statute to provide coverage for preventive services and other services that would otherwise be precluded from coverage. Congress has used U.S. Preventive Services Task Force (USPSTF) recommendations to guide its addition of specific prevention-related benefits but its decisions also reflect the input of other stakeholders. Through a 2008 law, Congress provided the Centers for Medicare and Medicaid Services (CMS) explicit authority to add new evidence-based preventive services. CMS maintains a complete list of the Medicare-covered preventive services at http://www.cms.gov/PrevntionGenInfo/. The beneficiary 20 percent co-payment and/or Part B deductible that usually applies to physician services has been waived for many but not all Medicare-covered preventive services.

The Patient Protection and Affordable Care Act (PPACA) includes a number of provisions that impact Medicare coverage of preventive services. In general, the provisions direct more specific alignment with USPSTF recommendations. The Congressional Research Service describes the USPSTF in an April 21, 2010 "Medicare Provisions in PPACA" as:

> The U.S. Preventive Services Task Force (USPSTF), administered by the Health and Human Services Agency for Healthcare Research and Quality (AHRQ), is an independent panel of private-sector experts in primary care and prevention that conducts assessments of scientific evidence of the effectiveness of a broad range of clinical preventive services, including screening, counseling, and preventive medications. It provides evidence-based recommendations for the use of preventive services, which may vary depending on age, gender, and risk factors for disease, among other considerations. Services are given a grade of A, B, C, D or an I Statement. Services graded A or B are recommended. For services graded C, the USPSTF makes no recommendation for or against their routine use. For services graded D, the USPSTF recommends against routinely providing the service to asymptomatic patients, based on evidence that the service is not beneficial, and may be harmful. "I" Statements are provided when evidence is insufficient to support a recommendation.

Annual Wellness Visit Providing a Personalized Prevention Plan:

Does the reform law explicitly provide coverage for any new preventive services?

Yes. PPACA establishes a new benefit—that begins January 1, 2011—through which beneficiaries are eligible to receive an annual wellness visit that focuses on establishing a personalized prevention plan. The law requires that the wellness visit providing a personalized preventive plan include a risk assessment that the beneficiary completes prior to or as part of the visit and consideration of the results of the beneficiary-completed risk assessment. Congress provides much discretion to CMS to decide on the other, specific elements that are required to be provided during the visit. The law does provide the following as examples of elements that CMS could include:

- Establishing or updating a beneficiary's personal and/or family history;
- Crafting a list of physicians and other providers who regularly provide care to the beneficiary;
- Taking routine measurements, such as height, weight, body mass index, blood pressure;
- Noting detection of any cognitive impairment;
- Establishing or updating a preventive service schedule;
- Documenting a list of risk factors for which interventions are underway or needed; and
- Providing personalized health advice and referral, as appropriate, to other providers, e.g. a weight loss program, or self-management program.

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CMS will define the wellness visit providing a personalized preventive plan service prior to January 2011. The agency will propose a definition, which will include the specific required elements, in summer 2010 on which it will accept public feedback. CMS will consider public feedback and announce the final details regarding the service around November 1, 2010.

Medicare will pay for the service in full, meaning that beneficiaries will not have to contribute the usual 20 percent co-payment nor pay toward any deductible that they had yet to meet.

What will Medicare pay for the wellness visit providing a personalized preventive plan service?

CMS will include a payment amount along with its proposed definition of the service. The agency's proposed payment amount will also be open to public comment.

How does coverage of this service relate to coverage of the "Welcome to Medicare" exam?

Medicare covers a one-time initial preventive physical exam (IPPE), also known as a Welcome to Medicare exam, if it is furnished to a beneficiary within the first 12 months of his or her Part B enrollment. While the IPPE has a specific definition that includes many required elements, e.g. advance care planning, it also focuses on health promotion, counseling, and provision of/referral for other Medicare-covered preventive services. Accordingly, the health reform law prohibits Medicare coverage of a wellness visit providing a personalized preventive plan service within 12 months of a beneficiary's receipt of the IPPE.

Can only physicians furnish this newly-covered service?

The service would typically be provided by a physician, but the law does allow it to be furnished by other providers, including a nurse practitioner and a physician assistant. These providers would have to be acting with their existing scope of practice as defined by state law. It can also be provided by a team of medical professionals, e.g. registered dietician, health educator, under supervision of a physician. The CMS action to define this option will be key as it is unclear how this stipulation would play out in a clinical practice setting based on solely how it is stated in PPACA.

Evidence-Based Coverage of Medicare Preventive Services:

Does the reform law do anything to ensure that Medicare-covered preventive services are truly evidence-based?

PPACA authorizes CMS to modify the coverage of any Medicare-covered preventive service in place at the time of its enactment to make the coverage consistent with USPSTF recommendations. The PPACA provision specifically allows CMS to withhold Medicare payment for these currently-covered preventive services that have an USPSTF grade of D (not recommended). The authority Congress granted CMS through a 2008 law to expand coverage to additional preventive services already comes with the stipulation that they be evidence-based.

Removal of Barriers to Preventive Services in Medicare:

What does the reform law do to remove the barrier to beneficiaries getting Medicare-covered preventive services?

PPACA eliminates co-payments and deductibles for most Medicare-covered preventive services, meaning that Medicare pays the full allowable payment amount for most services beginning January 1, 2011. Specifically, the co-payment is waived for Medicare-covered preventive services: in place at the time of PPACA enactment that are USPSTF recommended (have a grade of A or B); and for future evidence-based services that CMS

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decides to cover using the administrative authority Congress provided through the 2008 law. The deductible is essentially waived for the same preventive services covered at the time of PPACA enactment for which there is no co-payment. The PPACA provision does not prospectively waive the deductible related to evidence-based preventive services CMS decides to cover in the future using its administrative authority. Presumably, Congress declined to prospectively waive the deductible pertaining to future Medicare-covered preventive services to avoid assignment of an even higher cost to these provisions.

Further, PPACA clarifies that Medicare-covered preventive services are considered preventive even if the rendering physician initiates diagnostic testing or treatment during the course of the preventive service. This clarification ensures that beneficiaries are not subjected to a co-payment and/or deductible that does not apply for preventive services. The clarification is especially pertinent to colorectal cancer screening services. For example, Medicare will make full 100 percent allowable payment for the screening colonoscopy service—which is set at the same amount paid for a diagnostic colonoscopy even if the gastroenterologist detects and removes a polyp during the screening procedure. The clarification prevents the beneficiary from being made responsible for 20 percent of the full payment amount, which would be the case if the gastroenterologist provided a diagnostic colonoscopy. The gastroenterologist will still be paid for the extra work of removing the polyp but the beneficiary will not incur the co-payment charge, which is consistent with the beneficiary's expectation at the time of seeking the preventive service.

Are there any other provisions that encourage wellness programs?

The PPACA also establishes a grant program for businesses (those with less than 100 employees who work 25 or more hours per week) to assist them in establishing workplace wellness programs. The PPACA authorizes $200 million for the effort, beginning in FY2011. Additionally, the PPACA authorizes the Centers for Disease Control (CDC) to provide technical assistance to help employers evaluate their wellness initiatives.

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Medicare Pay-for-Reporting Program

The Medicare pay-for-reporting program, the Physician Quality Reporting Initiative (PQRI), entails physicians reporting on how care they furnish aligns with evidence-based clinical guidelines for a variety of medical conditions, e.g. diabetes, heart disease. Physicians report this information through quality measures. Physicians report by submitting specially designated quality measure billing codes when submitting the claim with the procedure code describing the associated service, e.g. an evaluation and management (E/M) service office visit, for which Medicare would make payment when the PQRI program started in July 2007. The options available for PQRI reporting have increased beyond this single approach as the program has evolved in subsequent years. Reporting options as of 2010 include:

- Individual Quality Measure Code Reporting on Claim Form;
- Measures Groups Reporting on Claim Form;
- Registry-based Reporting;
- EHR-based Reporting; and
- Group Practice Reporting.

Each option generally entails reporting on some of the 179 individual quality measures CMS maintains for PQRI 2010. The 2010 bonus payment is in the amount of 2 percent of the "allowed charges," or revenue, a physician receives from Medicare during the designated reporting period. All of the options have a full-year, 12-month reporting period. Some options also have a six-month reporting period option.

CMS will inform physicians who successfully reported during 2010 and make the bonus payment in mid-2011. In response to complaints that the process for physicians to access for their quality reporting and performance scores is needlessly complicated, the agency is making it easier for physicians to view their reports.

How does the health reform law provide continued bonus payments to physicians who successfully participate in Medicare PQRI?

Yes, the Patient Protection and Affordable Care Act (PPACA) extends bonus payments for successful PQRI reporting from performance year 2011 through 2014, establishing the bonus payment as 1 percent for 2011 and 0.5 percent for each year 2012-2014. The bonus payment amount continues to be based on the total Medicare you receive from Medicare. CMS was only authorized to make bonus payments through 2010 under previous law. In 2015, physicians who do not successfully participation in the PQRI program would be subject to payment reductions—see the 2015 section of this guide for more information on the applicable changes that will take place that year.

Is it true that I can receive a PQRI bonus payment amount through my effort to maintain my board certification?

Yes, PPACA stipulates that an additional bonus payment in the amount of 0.5 percent of Medicare revenue be made in performance year 2011 through 2014 to physicians who also meet the requirements of a Maintenance of Certification Program (MOCP). The 0.5 percent MOCP would be in addition to the bonus payment made for successful reporting on quality measures. The MOCP that pertains to internists is Maintenance of Certification as offered through the American Board of Internal Medicine (ABIM). The law defines a MOCP as a continuous assessment program that "advances quality and lifelong learning and self-assessment of board certified specialty physicians" by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism. The law further defines MOCP requirements as they pertain to physicians, including that the physician participate in an educational self-assessment program and successfully complete a practice assessment, which will be required more frequently than required for Maintenance of Certification. ABIM will submit information to CMS on behalf of the internists that have met the MOCP requirements for receiving the additional 0.5 percent of allowed charges bonus amount. It is our understanding that an internist will receive a 0.5 percent bonus for meeting the MOCP requirements from 2011

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through 2014 even if he or she does not successfully participate in the portion of the program that pays a bonus for reporting on quality measures.

Does the reform law require CMS to make any other changes to how it operates the PQRI?

Yes. PPACA makes a number of improvements to PQRI, including some that aim to address long-standing physician concerns. Specifically, the law:

- Requires CMS to provide more timely feedback on reporting—helping physicians to understand whether they are on track to being deemed as a successful participant and increasing the likelihood that the feedback can drive quality improvement;
- Establishes an appeals process to challenge CMS successful reporting determinations—addressing concerns that the agency misclassified successful participants as unsuccessful and underpaid some determined to be successful; and
- Requires CMS to develop a plan to integrate PQRI with American Recovery and Reinvestment Act of 2009 (also known as the stimulus law) Electronic Health Record (EHR) Incentive Program rules that determine if a physician is "meaningfully using" an EHR and, thus, qualifies for an incentive payment—important as demonstrating meaningful use will also require reporting on quality measures.

Where can I find PQRI information and resources?

- ACP PQRI resources are available at:

  http://www.acponline.org/running_practice/practice_management/payment_coding/pqri.htm.

- CMS comprehensive resources are available at:

  http://www.cms.gov/pqri.

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Community-Based Collaborative Care Networks Grant Program

The Patient Protection and Affordable Care Act (PPACA) requires the Secretary of Health and Human Services to offer grants beginning in 2011 to eligible entities to support community-based collaborative care networks for low-income populations.

What is a community-based collaborative care network?

A community-based collaborative care network is a consortium of health care providers with a joint governance structure that provides comprehensive coordinated and integrated health care services for low-income populations. A network, to be grant-eligible, must include at least a hospital and all federally qualified health centers in the community.

What can the grant funds be used for?

The grant funds can be used to:

- Assist low-income individuals to access and appropriately use health services; enroll in health coverage programs; and obtain a regular primary care provider or a medical home.
- Provide case management and care management.
- Perform health outreach using neighborhood health workers or through other means
- Provide transportation.
- Expand capacity, including through tele-health, after-hours services or urgent care.
- Provide direct patient care services.

What are the characteristics of grant applications that will receive priority?

The Secretary is to give priority to networks that include the capability to provide the broadest range of services to low-income individuals and includes the broadest range of providers that currently serve a high volume of low-income individuals. Further priority will be given to grant applicants that include a county or municipal department of health.

What is the significance of these community-based collaborative care network grants to practices?

Some of these networks might contract with private primary care practices in their area to provide required services.

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Advanced Imaging Service Assumed Equipment Use Rate

Under the Medicare physician fee schedule, some services have separate payments for the technical component and the professional component. Imaging services generally have this two-part payment structure, with the actual taking of the image being the technical component and the interpretation of the image serving as the professional component. Medicare pays for each of these components separately when the technical component is furnished by one physician and the professional component by another. When both components are furnished by one physician, Medicare makes a single global payment that is equal to the sum of the payment for each of the components.

A significant factor in establishing the technical component payment amount is the Centers for Medicare and Medicaid Services (CMS) assumption as to how frequently the equipment involved in furnishing the service is used. In 1997, CMS set the assumed use rate for all types of equipment, from an MRI machine to an x-ray machine, at 50 percent. In practical terms, this meant that CMS assumed that equipment was being used 25 hours out of a 50 hour practice week. The agency acknowledged that it established this assumed rate without having access to specific equipment use information. The assumed use rate impacts the technical payment amount as the CMS-determined cost for a piece of equipment is essentially divided by the number of times that the piece of equipment is assumed to be used over its lifetime—providing a per use, or per unit, amount. Use of equipment at a rate higher than the 50 percent assumed rate would lower the per-use amount as the cost of the equipment would spread over more units of service. If the assumed use rate is less than the actual use of the equipment, the payment for that equipment is higher than warranted.

In recent years, researcher have questioned whether the CMS 50 percent assumption was too low, especially as it pertained to advanced imaging equipment, which includes CT and PET in addition to MRI. A 2006 survey of select geographic markets conducted by a non-partisan entity that advises Congress indicated that advanced imaging equipment use was significantly higher than the 50 percent assumption. This and other assessments increased policymaker concern that the CMS assumed use rate was resulting in higher than justified payments for imaging services. Numerous researchers have indicated that high relative payment rates for advanced imaging services provide financial incentives that contributed to rapidly rising advanced imaging utilization. It was also noted that the high acquisition cost for advanced imaging equipment provides a strong incentive to optimize the amount of time it is in use.

After considering the available information, CMS decided to increase the assumed rate for all equipment that costs more than $1 million from 50 percent to 90 percent beginning January 1, 2010. The agency left the assumed rate at 50 percent for all equipment costing less than $1 million. This action effectively increased the assumed use rate for advanced imaging services and, thus, lowered the payment for the technical component of these services. CMS redistributed the reduced expenditures, or "savings," that resulted from lowering these payments in the form of a slight increase in payments for all other services. The law requires that agency accommodate changes it makes using its regulatory authority in a budget neutral manner, meaning that Medicare physician fee schedule expenditure's remain constant from one year to the next. Since lowering payments for advanced imaging services would reduce Medicare fee schedule expenditures below the 2009 level, CMS took the "savings," kept them in the pool of fee schedule payment dollars, and distributed them through a slight increase in payments for other services.

What does the health reform law do to change the assumed rate that equipment is used to furnish advanced imaging services?

The Patient Protection and Affordable Care Act of 2010 (PPACA) stipulates that the assumed use rate for expensive (costing over $1 million) equipment, which essentially describes equipment used in advanced imaging, that is used as a factor in determining the Medicare physician fee schedule technical component payment be set at 75 percent beginning January 1, 2011. This will serve to reduce the 90 percent rate that CMS set for 2010. The law further stipulates that the savings generated by increasing the assumed use rate from the

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50 percent used in 2009 to 75 percent, which lowers the payment for advanced imaging services, go back to the U.S. Treasury instead of being retained in the physician fee schedule payment pool. The PPACA-set 2011 75 percent assumed use rate effectively overrides the 90 percent rate that CMS set for 2010.

The PPACA provision will increase advanced imaging technical component payments beginning in 2011 compared to their 2010 payment rate and remove the slight increase in redistributed payments to all other services in effect during 2010. While there were moving parts as Congress deliberated how to handle the expensive equipment assumed rate issue concurrent to the process CMS used to make its 2010 change, it appears that Congress believes that 75 percent is the optimal advanced imaging use rate. In addition, Congress made the explicit decision to have the savings that result from lower payments—compared to 2009 payment rates—to go back to the U.S. Treasury.

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Medical Liability Reform – Demonstration Grants

The Patient Protection and Affordable Care Act (PPACA) authorizes $50 million in demonstration grant money to States for the development, implementation, and evaluation of alternatives to current tort litigation, such as certificate of merit programs, which require a finding that a suit has merit before it can proceed to trial, and health courts, which would have cases heard by a panel of medical experts rather than a lay jury. Each state applying for funds has the liberty to develop an alternative system, must allow for the resolution of disputes, and promote a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes by organizations that engage in efforts to improve patient safety and the quality of health care.

In reviewing the applications, the Health and Human Services (HHS) Secretary is to consult with a review panel composed of relevant experts appointed by the Comptroller General of the Government Accountability Office (GAO). When determining which states and localities will be awarded funds, the HHS Secretary consults with the Review Panel. Nominations will be solicited from the public for individuals to serve on the review panel. At least 9 but not more than 13, highly qualified and knowledgeable individuals will serve on the review panel; those individuals are to be from relevant stakeholders, including "health care providers and health care organizations." The Comptroller General, or an individual within the GAO designated by the Comptroller General, will be appointed the Chairperson.

The HHS Secretary is to make these funds available for five years, beginning in FY2011, subject to Congress appropriating the $50 million that was authorized under the PPACA. While the law is not explicit, it is presumed that the Agency for Healthcare Quality and Research (AHRQ) will be the HHS agency to implement the PPACA medical liability reform grants.

What will the impact likely be on internists and their patients?

We do not know the exact impact on internists, as the impact on each state will be different, depending on how the demonstration project is constructed. It is our belief that each demonstration project selected for funding would be assessed according to its capacity for lowering liability insurance premiums or reducing the frequency and severity of malpractice claims without denying injured patients appropriate redress for physician negligence. We believe medical professional liability reforms should result in speedier and more equitable damage awards and discourage frivolous or non-meritorious claims. We also hope that liability reforms would bring stability and predictability into the professional liability insurance market.

Do these medical liability reforms enacted under the PPACA infringe upon the rights of the states?

No. These reforms under the PPACA do not supersede the State's ability to enact legislation awarding non-economic damages on malpractice suits, nor do these reforms supersede any State's ability to enact prior, present or future alternatives to tort reform.

What other trusted sources are available to help them better understand the impact of this provision on their practices?

- AHRQ website on medical liability grants: http://www.ahrq.gov/qual/liability/
- Spotlight on Malpractice Reform (January 2010), Robert Wood Johnson Foundation, http://www.rwjf.org/pr/product.jsp?id=53988

Is there another initiative underway at the federal level regarding medical liability reform, outside the PPACA?

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In October 2009, in response to President Obama's September 17 directive for HHS Secretary Kathleen Sebelius to launch a new medical liability demonstration project, AHRQ issued the request for applications for "planning grants" and "demonstration projects" from States and health care systems for patient safety and medical liability innovations that put patient safety first and work to reduce preventable injuries; foster better communication between doctors and their patients; ensure that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits; and reduce liability premiums. More information can be found at: http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-10-022.html (planning grants) and http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-10-021.html (demonstration projects). Applications were due on January 20, 2010 for both grants, and on July 11, HHS awarded $23 million in grand funding, including seven three-year demonstration projects and thirteen one-year planning grants. More information about the grant recipients can be found at http://www.hhs.gov/news/press/2010pres/06/20100611a.html.

President Obama is using money in the existing AHRQ budget to fund these planning grants and demonstration projects.

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IV. 2012 Reforms

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Quality Reporting Requirements for Group and Individual Insurers

No later than March 2012, the federal government, in consultation with health care stakeholders, will develop quality reporting requirements for group and individual market insurers that disclose health plan benefits and reimbursement structures intended to improve the quality of care provided to beneficiaries. Health plans will be required to submit to the federal government and plan enrollees on an annual basis a report outlining how benefits and reimbursement structures promote quality care.

What will insurers have to report?

Insurers will have to report that the coverage they provide satisfies the following goals:

- Improve health outcomes through delivery system initiatives such as quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives and use of the medical home model.
- Include initiatives designed to reduce hospital readmissions, including patient-centered education and counseling and comprehensive discharge planning.
- Improve patient safety and health outcomes through use of best clinical practices, evidence-based medicine, and health information technology.
- Promote use of wellness and prevention services such as smoking cessation programs, weight management, physical fitness and nutrition.

What happens if an insurer fails to report or doesn't satisfy the quality coverage requirements?

The Secretary of the Department of Health & Human Services (HHS) is able to penalize any health insurer that fails to meet the quality reporting requirement. Certain health insurers deemed by the Secretary to be "substantially" meeting the above goals may be granted an exception from the reporting requirement.

Will the insurer's quality reports be made public?

Yes, the federal government will make the reports available through the Internet.

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Medicare Shared Savings (Accountable Care) Program

The Patient Protection and Affordable Care Act (PPACA) instructs the Secretary of Health and Human Services (HHS) to implement, no later than January 1, 2012, a voluntary shared savings program that promotes accountability for services delivered to a defined Medicare fee-for-service (FFS) patient population with the goals of increasing the quality and efficiency of services delivered.

Who may participate in this Medicare Shared Savings Program?

Eligible participants consist of groups of providers, referred to as Accountable Care Organizations (ACOs), which have established a mechanism for shared governance and take joint responsibility for the quality and efficiency of the services delivered to a defined population. These provider groups can consist of physician group practice arrangements, networks of individual practices, partnerships and joint-ventures between hospitals and other providers, hospitals employing physicians and other professionals, and other arrangements determined appropriate by the Secretary of HHS.

What requirements will ACOs have to meet to qualify for the Medicare Shared Savings program?

A qualifying ACO will have to meet a number of criteria, including:

- A willingness to become accountable for the quality, cost, and overall care of the Medicare FFS beneficiaries assigned to it.
- A willingness to participate in the program for not less than three years.
- A formal legal structure that allows the organization to receive and distribute payments for shared savings to participating providers.
- A sufficient number of primary care physicians and other healthcare professionals to provide services to the number of beneficiaries assigned to the ACO.
- A Medicare FFS population of at least 5000 beneficiaries.
- A leadership and management structure that includes clinical and administrative systems.
- A set of defined processes to promote evidence-based medicine, patient engagement, care coordination and to report on quality and cost measures.
- An ability to demonstrate that it meets patient-centeredness criteria specified by the Secretary of HHS.

How will Medicare payments be made to providers participating in the ACO?

In general, payments will continue to be made to providers participating in an ACO under the original Medicare FFS program in the same manner as they would otherwise be made except that a participating ACO is eligible to receive an additional payment for shared savings if specific criteria are achieved. This additional payment will be distributed among the providers within the ACO. The PPACA also provides the Secretary of HHS with the option to explore additional ACO payment structures, including capitation.

What criteria does the ACO have to achieve in order to receive the additional shared savings payment?

The ACOs will be required to meet both quality and Medicare (total of Parts A and B) expenditure savings requirements in order to receive a share of any Medicare savings accrued as a result of the project. The ACOs will have to perform above a defined quality threshold (to be determined by the Secretary of HHS) composed of measures assessing clinical processes and outcomes, patient and caregiver experience of care, and rates of unnecessary care utilization. In addition, the average per capita Medicare expenditures for an ACO's defined patient population would have to be a percentage (to be determined by the Secretary of HHS) below a risk adjusted expenditure benchmark based on the total Medicare spending in the most recent three-year period for beneficiaries attributed to the ACO, and an amount equal to the risk-adjusted average expenditure growth for

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beneficiaries nationally. The Secretary of HHS shall establish limits on the total amount of shared savings that may be paid to an ACO.

Is ACP engaged in any activities to help members learn about the ACO structure and payment model and participate in local ACO opportunities?

Yes. The College is engaging in a number of activities to inform members about the model and assist members interested in participating in local ACO opportunities. The College has approved a set of principles to be used within ACO projects that facilitate the effective participation of physician practices within these organizations—these principles are available at http://www.acponline.org/advocacy/where_we_stand/policy/aco.pdf. The College is also attempting to broaden the acceptance of these or similar ACO principles in collaboration with the American Academy of Family Physicians, the American Academy of Pediatrics and the American Osteopathic Association. The College is also in the process of developing information briefs about the model, and plans on developing additional educational opportunities and tools to assist practices interested in participating in ACO efforts. These will be available through the ACP website at http://www.acponline.org/running_practice/.

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Simplifying Administrative Requirements the Health Care System Imposes on Physicians - 2012

The health care system, and its multiple payers, imposes significant burdens on physician practices. A typical physician practice has a contract with 12 or more health plans in addition to participating in Medicare and Medicaid and must follow each payer's requirements for contracting, credentialing, preauthorizing, coding, billing, and reimbursing. It is estimated that nearly 14 percent of physician practice revenue is consumed by billing and insurance-related functions. Further, studies by the Medical Group Management Association calculate the annual cost of administrative tasks, many of which are of dubious value, at around $25,000 per year per physician. In addition to being costly and frustrating to physicians, administrative burdens are unnecessarily limiting physicians' ability to provide patient care.

The Patient Protection and Affordable Care Act (PPACA) includes numerous provisions, beginning in 2012, that aim to reduce administrative burdens. PPACA generally assigns the responsibility for implementation of the administrative simplification provisions to the Secretary of the Department of Health and Human Services (HHS), often referred to as "the Secretary." Many implementation activities will be handled by the Centers for Medicare and Medicaid Services (CMS), an agency component of HHS.

What health reform law-mandated efforts to streamline administrative requirements take effect in 2012?

<u>Study to Identify Specific Administrative Transactions for Which Standard Processes Reduce Administrative Burdens</u>

PPACA establishes a timeline for accelerating the development, adoption and implementation of a set of operating rules for specific health care administrative transactions. The law defines operating rules as "the necessary business rules and guidelines for the electronic exchange of information…" Operating rules for different administrative transactions have different establishment and effective dates. The requirements for each type of transactional element are described throughout this guide.

The law also provides the HHS Secretary discretion to establish and implement standards and operating rules for additional administrative transactions, specifically requiring the Secretary to solicit input on the need for standards and rules for certain transactions. By January 1, 2012, the Secretary must seek input as to whether:

- The process by which physicians and other providers enroll to participate in a health plan can be made standard and electronic, including whether a uniform application form is viable. The intent is to make it easier for physicians to go through the process of being credentialed by multiple insurers. Consideration of this administrative transaction aims to assess whether the concept promoted through an initiative led by an organization established by large private payers to simplify administrative requirements imposed on physicians can be expanded. This organization, the Council for Affordable Quality Healthcare, has worked with ACP and a wide range of other stakeholders to establish a database of physician-provided credentialing information from which health plans can extract the information they need. This initiative enables physicians to provide credentialing information once instead of providing it, or a variation of it, to multiple individual insurers. While this effort is helpful, its overall impact is limited as it does not include all private payers nor does it include Medicare.
- There could be: more consistency in the process by which health plans develop the edits they include in their claim processing system that determine when to flag a claim for more information or outright deny payment for a claim; and greater transparency of the edits used by plans. Medicare develops its claim processing system edits at a national level with input from ACP and other physician organizations and makes the edits it uses publically available. Most edits maintained by private payers, however, are considered proprietary. Increased standardization in the edits used by each payer and availability of those edits would improve the ability of physician practices to be appropriately paid for claims.
- Health plans should be required to publish their rules about the timeliness with which they pay claims. While it is likely that many health plans have nuanced claim payment rules, e.g. whether a submission is

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a "clean" claim that officially enters the processing system, increased availability of rules may provide payers incentive to ensure their rules are reasonable.

Establishment of System that Assigns a Unique, Single Identification Number to Each Health Plan

PPACA requires the Secretary to establish a system that provides a unique identification number for each health plan that is effective by October 1, 2012. Ensuring that each health plan has only a single identification number should improve the ability of physician practices to manage their administration interactions with health plans.

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V. 2013 Reforms

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Enhanced Medicaid Reimbursement Rates for Primary Care Services

To prepare the primary care workforce for the influx of new Medicaid-eligible patients, the Patient Protection and Affordable Care Act (PPACA) increases payment rates for certain primary care services to the level of Medicare. The provision was included because primary care physicians, including general internists, will be particularly affected by the Medicaid expansion since millions of new patients will enter the health care system and many will have complex health care needs. Primary care physicians and subspecialists are not required to participate in Medicaid, and many practices do not accept Medicaid patients because reimbursement rates are relatively low and the administrative barriers are significant. Further, people who are currently eligible for Medicaid but not enrolled will likely enroll in Medicaid coverage to comply with the individual mandate, adding more beneficiaries to the program. Many of these new Medicaid patients will be adults who seek care from internists.

Why is a payment increase necessary?

In difficult economic times when the need for Medicaid is greatest, states are often forced to trim physician payment rates to maintain program solvency and/or balance state budgets. Physician reimbursement cuts may hinder patient access as the cost of providing care to patients exceeds the Medicaid pay rate, forcing doctors to limit the number of Medicaid patients they see. According to a survey conducted by The Physician's Foundation, declining reimbursement rates are the most "significant impediment to patient care delivery in today's practice environment by a large margin." Enhanced payment rates may induce more physicians to participate in Medicaid. According to a survey conducted by United Healthcare, half of primary care physicians would increase their Medicaid case load if Medicaid payment rates were increased to the level of Medicare pay rates.

How will primary care physicians benefit?

To help promote primary care physician participation, the PPACA increases Medicaid reimbursements for evaluation and management and immunization services to 100 percent of Medicare reimbursement in 2013 and 2014. The increase will apply to both fee-for-service and managed care Medicaid plans. The positive financial impact for physicians treating Medicaid patients is significant as Medicaid in most states pays primary care physicians at rates that are well below Medicare (and private insurance). In 2008, average Medicaid payment rates for primary care services were 66 percent of Medicare rates. Pay rates vary widely across states; in 2008, Wyoming's rates for primary care services were the highest in the nation (excluding Alaska) at 67 percent above the national average of fee-for-service Medicaid fees, while Rhode Island's rates were the lowest at 57 percent of the average. The increased revenue derived from payment at least equivalent to Medicare rates for evaluation and management and immunization is intended to entice primary care physicians to expand the number of Medicaid patients they treat.

How will the pay increase be implemented?

The exact nature of how state Medicaid programs will make this provision operational has yet to be determined. While Congress' intent seems clear and implementation seems relatively straightforward, the federal government and the states likely will have to address at least a few nuances. Whether a state Medicaid program is required to pay at least the Medicare rate for a Medicaid-covered service explicitly not covered by Medicare provides an example. Medicare typically publishes a value for a service in the Resource Based Relative Value Scale that can be used to determine a Medicare payment amount even when the program declines to pay for the service.

How much will this cost?

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The federal government is fully funding the cost of the 2013-2014 increased payments to primary care physicians for evaluation and management and immunization services. Beyond the 2014 date, states are permitted to continue funding Medicaid primary care reimbursement rates at or above Medicare levels. Congress could reauthorize the program beyond 2014 but this would require new legislation and would increase the cost of the program. The non-partisan Congressional Budget Office estimates that the provision will cost the federal government $4.9 billion from 2010-2014.

An earlier version of this provision was intended to ensure that Medicaid payments for evaluation and management and immunization services were at least equal to Medicare for all physicians regardless of their specialty. The provision included in the final law was narrowed to provide payment parity for primary care physicians, defined as general internists, pediatricians, and family physicians, primarily to limit the overall cost.

Additional Resources

- *Statehealthfacts.org, Medicaid-to-Medicare Fee Index;* Provides information on state Medicaid reimbursement in relation to Medicare payment.

  http://statehealthfacts.org/comparetable.jsp?ind=196&cat=4

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National Pilot Program on Payment Bundling

The Patient Protection and Affordable Care Act (PPACA) instructs the Secretary of Health and Human Services (HHS) to implement, no later than January 1, 2013, a voluntary national pilot program focused on payment bundling that aligns incentives to promote integrated care and joint responsibility among providers across the continuum during an episode of hospitalization under fee-for-service Medicare for a defined set of conditions. The goal of the pilot is to improve the coordination, quality, and efficiency of health care services within the system.

Who can participate in this voluntary National Pilot Program on Payment Bundling?

Entities seeking approval by the Secretary of HHS to participate must be comprised of groups of providers including a hospital, a physician group, a skilled-nursing facility (SNF) and a home health agency (HHA) that are willing to take responsibility to provide services during an episode of hospitalization, defined as the period that a patient stays in a hospital plus the first 30 days following discharge. The Secretary of HHS will define a set of specific medical conditions, which will be eligible for payment under this pilot.

What services will be expected from approved entities under the National Pilot Program on Payment Bundling?

Approved entities will be required to provide all the following services during a defined episode of hospitalization: acute care inpatient services; physicians' services delivered in and outside of an acute care hospital setting; outpatient hospital services, including emergency department services; and post-acute care services, including home health services, skilled nursing services, inpatient rehabilitation services, and inpatient hospital services furnished by a long-term care hospital. The approved entity will also be expected to furnish such services as care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities as determined appropriate by the Secretary of HHS.

How will payments be made under this pilot program and what is the incentive for physician participation in this voluntary pilot?

The Secretary of HHS is required to develop provider payment methods that could include bundled payments and bids from entities for episodes of care. The payment is to cover the costs of all applicable services. Approved entities would be able to "profit" from the difference between the bundled fee paid and their cost to provide the bundled care.

What authority does the Secretary of HHS have to expand the program?

The pilot program will be conducted initially for five years. However, at any point after January 1, 2016, if it is determined that expanding the pilot program will either maintain or improve quality and reduce costs, the Secretary of HHS can extend its duration and scope indefinitely.

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Prescription Drug Discounts and Medicare - 2013

The Patient Protection and Affordable Care Act (PPACA) continues to make changes to the Medicare Part D Prescription Drug Program in 2013, having built upon changes made in 2011 and 2010.

To recap the background and primary changes made in 2010 and 2011, the standard Medicare Part D benefit (as of 2010) includes a $310 deductible and a 25 percent coinsurance until the enrollee reaches $2,830 in total covered drug spending. After this initial coverage limit is reached, there is a gap in coverage in which the enrollee is responsible for the full cost of the drugs (often called the "donut hole") until total costs hit the catastrophic threshold, $6,440. It is estimated that about 25 percent of beneficiaries reach the coverage gap in a given year. Once reaching the catastrophic threshold, beneficiaries are covered for at least 95 percent of their drug expenses for the rest of the year.

- In 2010, beneficiaries who reach the coverage gap will receive a $250 rebate. This rebate is only in effect for 2010.
- In 2011, the PPACA requires that drug manufacturers provide a 50 percent discount on brand name prescriptions while the beneficiary is in the coverage gap. In addition, Medicare total cost calculations will include the non-discount price of the drugs; thus beneficiaries will be able to reach the catastrophic threshold more quickly while benefiting from decreased out-of-pocket spending.
- In 2011, a federal subsidy is phased in for generic drugs so that the coinsurance is reduced from 100 percent to 25 percent within the coverage gap by 2020. The specifics of the phase-in however are not provided in the language of the law.

Beginning in 2013, additional federal subsidies to Medicare Part D beneficiaries will be gradually phased-in for brand-name drugs in the Part D coverage gap reducing the beneficiary co-insurance rate in the gap from 100 percent to 25 percent by 2020 – in addition to the 50 percent manufacturer brand discount that began in 2011.

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Simplifying Administrative Requirements the Health Care System Imposes on Physicians - 2013

The Patient Protection and Affordable Care Act (PPACA) includes numerous provisions in 2013 that aim to reduce administrative burdens on physicians. These provisions in 2013 build on other administrative simplification provisions that became effective in 2012. PPACA generally assigns the responsibility for implementation of the administrative simplification provisions to the Secretary of the Department of Health and Human Services (HHS), often referred to as "the Secretary." Many implementation activities will be handled by the Centers for Medicare and Medicaid Services (CMS), an agency component of HHS.

How significant are administrative burdens on physicians?

The health system, and its multiple payers, imposes significant burdens on physician practices. A typical physician practice has a contract with 12 or more health plans in addition to participating in Medicare and Medicaid and must follow each payer's requirements for contracting, credentialing, preauthorizing, coding, billing, and reimbursing. It is estimated that nearly 14 percent of physician practice revenue is consumed by billing and insurance-related functions. Further, studies by the Medical Group Management Association calculate the annual cost of administrative tasks, many of which are of dubious value, at around $25,000 per year per physician. In addition to being costly and frustrating to physicians, administrative burdens are unnecessarily limiting physicians' ability to provide patient care.

What health reform law-mandated efforts to streamline administrative requirements take effect in 2013?

Standard Process for Verifying Patient Insurance Eligibility and Checking on Status of Claim for Payment

By January 1, 2013, the Secretary must implement a standard set of rules that facilitate electronic transactions that enable physician practices to verify patient health insurance coverage eligibility and obtain the status of claims submitted to bill for services. The Secretary must establish these operating rules by July 1, 2011, allowing stakeholders time to prepare for the January 2013 effective date. The rules as they pertain to patient eligibility are to facilitate the ability of a physician to determine: the insurance product that covers the patient, whether a specific service is covered, and any patient financial responsibility. The physician practice is to be able to access this information prior to or at the time of the patient encounter. The rules that pertain to claim status are to facilitate timely practice access to whether the insurer received the claim submitted and the status of an accepted claim in the processing cycle. The rules are also to promote physician access to insurer claims processing cycle details, including how a determination is made whether to pay a claim and how to appeal adverse determinations. The provision states that these rules allow for use of a machine readable identification card.

The Secretary must develop the operating rules in consultation with a broad range of health care stakeholders, including physicians. The Secretary is to use a rigorous process by which health plans demonstrate their compliance with the rules, with financial penalties imposed on plans that fail to comply. The rules apply to all payers.

This provision aims to expand on the concept promoted through an initiative led by an organization established by large private payers to simplify administrative requirements imposed on physicians. This organization, the Council for Affordable Quality Healthcare, is working with ACP and a wide range of other stakeholders to provide physician practices with real-time access to patient eligibility and benefits information through a single electronic portal that contains information on patients covered by all participating payers. While this still-evolving effort is helpful, its overall impact is limited as it does not include all private payers nor does it include Medicare. That the rules will apply to all payers should maximize the benefit derived from this provision.

Standard Mapping of International Classification of Diseases, Clinical Modification, Ninth Revision (ICD-9), Diagnosis Codes to those in More Expansive ICD-10 Code Set

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The PPACA requires HHS to maintain a crosswalk that translates how current ICD-9 diagnosis codes map to the ICD-10 diagnosis code set that physicians are required to use October 1, 2013. Diagnosis codes are included on the claim form to indicate the reason the physician preformed the service for which he/she billed. These codes are also used to track morbidity and mortality.

The ICD-10 code set, which is more granular, contains roughly five times the number of diagnosis codes maintained in ICD-9. The law requires HHS to solicit stakeholder comment on its initial ICD-9 to ICD-10 crosswalk effort and make changes prior to the October 2013 effective date. The revised crosswalk will be considered a standard mapping that facilitates the adoption of ICD-10 by enabling physician practices to update their systems and promoting health plan standardization in the diagnosis requirements that trigger payment of claims.

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VI. 2014 Reforms

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Health Insurance Exchanges

The Patient Protection and Affordable Care Act (PPACA) will make shopping and purchasing insurance more consumer-friendly by establishing state-based health insurance exchanges. These health insurance marketplaces will make available information about health plan's premiums and copayments, physician and other health care practitioner participation, and benefits, among other important information.

HEALTH EXCHANGES:

People who do not have access to health insurance through their employer must seek insurance on their own in a market that is largely unregulated, expensive, and difficult to navigate. Small businesses often have the same problems, since they do not have the negotiating power of large employers and may face a significant increase in premiums if an employee gets sick.

To help address the cumbersome nature of health insurance decision-making for individuals and small businesses, the PPACA directs states to establish "health insurance exchanges." A health insurance exchange is a virtual marketplace where a person or small business can access objective, easy-to-understand information to help them find health coverage to fit their needs. Exchanges will also help Medicaid- and Children's Health Insurance Program-eligible people enroll.

In 2014, each state will establish a health insurance exchange and eventually, states will have the ability to band together to form regional exchanges. If states fail to establish an exchange that meets the standards outlined in the law, the federal government will create and operate the state's exchange. Beginning in 2011, states will receive funding to help establish the exchanges, but by 2015 they must be self-sufficient. An example of an existing health insurance exchange is Massachusetts' Commonwealth Connector.

Who would be able to purchase insurance through exchanges? The exchanges are open to:

- Individuals who receive tax credits to buy coverage through a qualified health plan.
- Small businesses with up to 100 employees who want to purchase qualified health insurance for their employees.

What kind of insurance will be made available?

All insurance plans offered through an Exchange must be qualified health plans, meaning they must abide by insurance regulations, copayment and deductible limits, and adhere to a number of other rules that protect consumers. The Exchange will rate qualified health plans on the basis of quality and price to help consumers compare plans. Plans offered in the exchange will reflect the four benefit tiers established in the law – from a Bronze plan, which has higher co-payments, to a Premium plan, which has lower co-payments.

- Qualified health plans must provide at least the essential benefits package that includes ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness and chronic disease management, and pediatric services.
- The Secretary of the Department of Health and Human Services (HHS) will determine covered services within these benefit categories, which will generally reflect the scope of benefits provided by a typical employer-based health insurance plan.
- Health plans are permitted to cover services in addition to the essential benefit package. States can require coverage of additional services as long as they provide funding.
- The Secretary of HHS is required to give notice to the public regarding decisions relevant to the essential health benefits package and provide for public comment.

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- Qualified health plans must also disclose information such as claims payment policy and practices, premium rating practices, claims denials, and policies related to out-of-network cost-sharing.
- Exchange-based health plans must also meet certain marketing requirements, ensure that an adequate number of providers can be accessed by enrollees, and they must meet clinical quality standards.

What else will the Exchanges do?

- Review health plan premium increases.
- Maintain a toll-free hotline to assist customers.
- Apply a rating to health plans reflecting the quality and cost of benefits.
- Make available an online calculator to determine if a person is eligible for premium and cost-sharing assistance.

Exchange-eligible individuals and businesses may also have the option of enrolling in other innovative plans such as:

- *Consumer Oriented and Operated Plan (CO-OP)*: Some people may have access to a CO-OP insurance plan, a member-run, non-profit insurance plan where a board of members decides on issues involving benefits, premiums, and other important plan features. A CO-OP cannot be operated by an existing insurer and any profits must be directed towards lowering premiums and other consumer costs. The PPACA distributes grants for the creation of CO-OP plans and grant applicants offering a state-wide qualified health plan, an emphasis on integrated health care, and those that have significant private support will be prioritized. CO-OP programs may offer qualified health plans outside of the Exchange as well.

- *Multi-State Qualified Health Plans (MSQHP)*: Each Exchange in each state will have available at least two MSQHPs, insurance plans made available nationally that are contracted with the Office of Personnel Management (OPM), the same federal entity that administers health insurance for Members of Congress. MSQHP will negotiate with OPM on factors such as premiums, the percentage of a premium that is devoted to medical care, and other terms. The benefits package would have to be at least as generous as other QHPs, but states could require additional benefits as long as they provide funding. Of the two plans that must be made available, one is required to be a non-profit insurer and the other cannot provide abortion coverage beyond the services mandated by federal law.

- *Basic Health Plan (BHP):* States have the option of creating a Basic Health Plan for Exchange-eligible people with incomes between $14,404 and $21,660 (based on 2009 figures) for individuals and $29,327 and $44,100 for a family of four. Instead of receiving health coverage through an Exchange-based plan, the federal government would direct credits to the BHP to provide coverage. The Basic Health Plan coverage will be provided through one or more state-contracted health insurance plans (likely health maintenance organizations) that provides at least the minimum benefit package required of Exchange-based plans and adheres to premium and cost-sharing limits. States would negotiate with health plans on premium and cost-sharing levels, care coordination and preventive care availability, and whether the plan would use certain performance and quality measures for physicians and other health practitioners.

Additional Resources

- *Massachusetts Commonwealth Connector; P*rovides an example of an existing health insurance exchange.

  https://www.mahealthconnector.org/portal/site/connector

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- *Kaiser Family Foundation*: *Questions About Health Insurance Exchanges;* Answers popular questions on how the health insurance exchange will operate

  http://www.kff.org/healthreform/upload/7908-02.pdf

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Health Insurance Tax Credits for Individuals and Families

The Patient Protection and Affordable Care Act (PPACA) seeks to make insurance more affordable for uninsured individuals by providing tax credits towards the purchase of comprehensive health coverage. Most people receive health insurance through their employers or through public programs like Medicare or Medicaid, but nearly 50 million people are uninsured (2009 figures). Beginning in 2014, the PPACA will provide tax credits to assist U.S. citizens and legal residents who do not have access to comprehensive, affordable health insurance purchase coverage through state-based health insurance exchanges.

Who qualifies? Sliding scale premium tax credits will be made available to people with incomes between 133 percent and 400 percent of the Federal Poverty Level:

- Individuals with incomes between $14,404 and $43,320 (in 2009 dollars).
- Families depending on income and family size. A family of four, for instance, would be eligible if their income is between $29,327 and $88,200 (in 2009 dollars—actual income amounts to be updated by 2014).
- Individuals whose required contribution to their employer-based insurance exceeds 9.5 percent of their annual income.
- People covered by employer-based insurance that is deemed incomprehensive. Coverage is considered incomprehensive if it does not have an actuarial value of at least 60 percent. An actuarial value is a measure of an insurance plan's generosity – plans that have a high actuarial value have lower cost-sharing requirements.

Is anyone ineligible for the credits?

- In general, a person is ineligible for insurance credits if they are offered comprehensive, affordable health insurance through their employer or a public program such as Medicare.
- Generally, individuals with incomes below $14,404 will be made eligible for the Medicaid program, although some legal residents with incomes between $10,830 and $14,404 (2009 dollars—actual income amounts to be updated by 2014) who are ineligible for Medicaid (because they are required to wait 5 years prior to enrolling) will be eligible for premium credits.
    - Individuals who apply for premium credits and are determined to be eligible for Medicaid coverage will be enrolled in the Medicaid program.

How do the credits work?

- The premium credits reduce the cost of insurance and ensure that the cost of coverage does not exceed a certain percentage of an individual's income.
    - The amount of credit varies with income and is based on purchase of a Silver plan with a 70 percent actuarial value. A less-comprehensive Bronze plan (with 60 percent actuarial value) will have a lower premium than a Silver-level plan. People who receive tax credits are able to purchase a more generous Gold or Platinum-level plan, but will have to pay the difference.
    - Age and geographic area, among other factors, affect premium cost. Premiums for younger individuals are lower than that for older enrollees. An older individual living in a high-cost area would receive a larger tax credit to compensate for the higher premium cost than a young person living in a low-cost area.
    - The Kaiser Family Foundation provides the following example: a 45-year old person with an income of $28,735 would be eligible for a credit that would reduce the premium cost of a Silver-level health plan (valued at $5,733) to about 8 percent of their income, or $2,313.
    - A family of four earning an income of about $80,000 purchasing a Silver-level health plan with a premium cost of $9,435 would receive a credit of $1,835.

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- The premium credits are directed to the insurer that is chosen by the individual receiving the credit and are used to reduce the premium amount of the enrollee.
- The tax credits are *advanceable*, meaning the credit can be used when the coverage is purchased.
- The premium credits are also *refundable,* so people who do not pay income tax because of their low income can still use the credits to reduce the cost of health insurance.

In addition to premium credits, some individuals and families would also qualify for cost-sharing assistance to help with co-payments and out-of pocket expenses. Cost-sharing subsidies will be most generous for lower-income people and will phase-down as income increases. Cost-sharing subsidies increase the generosity of the insurance plan and limit the amount of out-of-pocket costs for eligible individuals. Out-of-pocket costs will also be limited for people receiving health benefits through the exchange.

What kind of insurance can an eligible person purchase with the tax credit?

Eligible individuals and families are required to purchase a "qualified health plan" through a health insurance exchange (see the previous section). Qualified health plans are required to abide by a number of regulations, including restrictions that prohibit insurers from basing premiums on a person's health status and excluding coverage of an individual's pre-existing condition. Qualified health plans c*an't* exclude persons with pre-existing conditions, rescind policies, or impose annual or lifetime limits, and they can only vary premiums based on age, where a person lives, family composition, and tobacco use. Insurers offering QHPs must offer at least one qualified Silver-level and Gold-level benefit package to include preventive services with no cost-sharing. Qualified health plans are also required to meet marketing rules, have adequate provider networks, and provide a minimum essential health benefit package (at either the Bronze, Silver, Gold, Platinum, or for individuals up to age 30, a catastrophic plan coverage levels), among other things.

Additional Resources

- *Kaiser Family Foundation: Health Reform Subsidy Calculator*; An online calculator that helps determine tax credit eligibility.

  http://healthreform.kff.org/SubsidyCalculator.aspx

- *Kaiser Family Foundation: Questions About Health Insurance Subsidies;* An overview of how premium credits and cost-sharing assistance work.

  http://www.kff.org/healthreform/upload/7962-02.pdf

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Small Business Tax Credits - 2014

The Patient Protection and Affordable Care Act (PPACA) provides financial assistance through tax credits to qualified small businesses towards the purchase of health insurance for their employees. Small businesses often have difficulty providing health insurance for their employees because they do not have the negotiating power of large businesses and corporations and are particularly vulnerable to cost increases if an employee gets sick. State efforts to regulate insurance for small businesses vary widely across the country, creating a confusing patchwork of rules and regulations that influence the content and cost of small business insurance plans.

How much is the tax credit?

Beginning in 2014 and subsequent years, the amount of the tax credit would be a maximum of 50 percent of the employer's contribution (35 percent for non-profit firms) towards their employees' health insurance premium. A smaller tax credit begins in 2010 and continues on a sliding scale through 2013. The credit is available for up to 6 years, from 2010 to 2013 and any two years after that.

To qualify, the employer:

- Would have to employ fewer than 25 full-time workers (different rules apply for part-time workers);
- Must have average annual wages of less than $50,000 per full-time employee;
- Must contribute at least 50 percent of the cost of their employees' health insurance premiums to qualify for the credit.

How do qualifying small business owners, e.g. physicians who qualify, claim the tax credit?

A tax credit is available in 2010 that pays eligible small businesses up to 35 percent of the employer's contribution to the premiums for health insurance purchased on behalf of their employees but this increases to 50 percent of the premium contribution in 2014. An employer can claim it on their annual income tax return. The Internal Revenue Service (IRS) is determining the process for tax-exempt firms. Business owners would not include their income in a calculation to determine eligibility or amount of the credit. This restriction would include a shareholder owning more than 2 percent of an "S" corporation, a sole proprietor, a partner in a partnership, an owner of more than 5 percent of other businesses, or a family member or dependent of such an individual. Additionally, an owner would not count as an employee when calculating the number of full-time employees. So, if a physician is also the owner of their practice, their salary would not be counted when determining if their firm qualifies for the small business tax credit. The salary of a physician employed by a practice would be considered if they do not meet the above criteria (e.g. partner in a partnership, sole proprietor, etc.). Employers (other than tax-exempt employers) with no taxable income for the year cannot use the credit for that year since it is applied to the employer's income tax liability. However, the IRS notes that an unused health insurance credit is considered a general business credit and can be applied to be carried back one year (excepting 2010 credits) and carried forward up to 20 years. It is unclear if physicians who claim business income as personal income for tax purposes will be eligible for the credit. Physicians are encouraged to consult their financial advisor to determine if their practice is eligible for the small business tax credit.

Additional Resources

- *Internal Revenue Service. Small Business Health Care Tax Credit: Frequently Asked Questions*; Provides detailed information on how to determine whether your business qualifies for the credit and what you need to do to claim the credit.

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http://www.irs.gov/newsroom/article/0,,id=220839,00.html

- *Internal Revenue Service: 3 Simple Steps for Employers to Qualify*; Worksheet to help determine if you qualify for the tax credit.

  http://www.irs.gov/pub/irs-utl/3_simple_steps.pdf

- *Small Business Majority. Health Insurance Premium Tax Credit Calculator;* Interactive calculator that helps you determine if your business may qualify for the tax credit and the amount you may be able to claim.

  http://smallbusinessmajority.org/tax-credit-calculator/

- *New York Times. How the Health Care Law Affects Your Business;* Features a number of questions and answers related to how the health care reform law will affect small businesses, including inquiries on the tax credit.

  http://boss.blogs.nytimes.com/2010/03/31/how-the-health-care-law-affects-your-business/

- *American Medical News: Tax Credits Help Offset Staff Insurance Costs;* Article regarding how physician's practices might be able to benefit from the small business tax credit. Includes a number of examples of how physician practices might benefit from the tax credit.

  http://www.ama-assn.org/amednews/2010/05/03/bica0503.htm

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Medicaid Coverage Expansion

Medicaid is a health coverage program for low-income individuals dually run by the federal government and the states. The program covers roughly 60 million people. Although the federal government establishes some requirements related to coverage and benefits, states are mostly free to tailor their programs as they see fit. All states are required to cover low-income children (and provide screening and diagnostic services, as well as any related treatment), low-income pregnant women, certain low-income parents, as well as seniors and those with a disability who receive supplemental assistance. Certain benefits are mandatory, such as acute hospital care and physician services, and most states cover so-called optional benefits like prescription drugs. In many states, childless adults – no matter how poor they are – cannot receive Medicaid coverage, although some states have on their own extended coverage to such persons

The Patient Protection and Affordable Care Act (PPACA) dramatically alters the Medicaid program by expanding mandatory coverage based solely on income, proving significant federal financing to states for the expansion cost, improving Medicaid reimbursement for primary care services, maintaining the existing Medicaid and CHIP eligibility requirements, and improving the Medicaid enrollment process.

MEDICAID COVERAGE EXPANSION:

Beginning in 2014, the PPACA expands Medicaid eligibility to all individuals with incomes at or below 133 percent of the federal poverty level ($14,404 for an individual and $29,327 for a family of four, 2009 dollars; actual income amounts to be updated by 2014). For the first time, qualified non-elderly childless adults and other traditionally ineligible low-income people would be able to enroll in the Medicaid program in all states.

This will result in a significant increase in the number of adults in the Medicaid program, since most low-income children already receive coverage through either Medicaid or the Children's Health Insurance Program (CHIP). The Kaiser Family Foundation estimates that over 17 million uninsured non-elderly adults earn incomes that would currently qualify them for Medicaid under the expansion. The Congressional Budget Office estimates that about 16 million individuals will enroll in the Medicaid and CHIP programs.

How will the expansion be financed?

The federal government will provide most of the funding for the expansion population. From 2014 to 2016, the federal government will finance 100 percent of the expansion. In subsequent years, the federal share is phased down and states will be required to pay for a portion of the expansion.

- In 2017, the federal share is reduced to 95 percent of the expansion cost,
- In 2018 the federal government pays 94 percent of the expansion cost,
- In 2019 the federal government pays 93 percent
- In 2020 the federal share of the expansion cost is 90 percent

For individuals who are currently eligible for Medicaid but not enrolled, the existing federal reimbursement formula applies.

How will the expansion affect physicians?

Physicians, including internists, will be particularly affected by the Medicaid expansion since millions of new patients will enter the health care system and many will have complex health care needs. Physicians are not required to participate in Medicaid, and many practices do not accept Medicaid patients because reimbursement rates are relatively low and the administrative barriers are significant. Further, people who are currently eligible for Medicaid but not enrolled will likely enroll in Medicaid coverage to comply with the individual mandate, adding more beneficiaries to the program.

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To help promote physician participation, the PPACA increases Medicaid reimbursements for evaluation and management and immunization services to 100 percent of Medicare reimbursement in 2013 and 2014. The increase will apply to both fee-for-service and managed care Medicaid plans. Beyond the 2014 date, states will be permitted to continue funding Medicaid primary care reimbursement rates at or above Medicaid levels. Additionally, the PPACA provides increased funding for community health centers, a crucial link to care for Medicaid beneficiaries.

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New Requirements for Health Insurers - 2014

The Patient Protection and Affordable Care Act (PPACA) includes a variety of important insurance industry reforms that will help ensure patients have access to affordable, comprehensive insurance and establish uniformity in the volatile individual and small group insurance markets. The new regulations, most of which will be implemented in plans beginning on or after January 1, 2014, will require insurers to accept and renew insurance policies for all applicants, prevent discrimination against people with pre-existing conditions, require that a sufficient amount of premiums is directed towards medical costs, prohibit insurers from basing premiums on a person's health status, and limit waiting times for coverage, among other regulations. Lastly, insurance plans will be required to offer one or more of four benefit categories with varying cost-sharing requirements.

Guaranteed Issue and Renewability:

Beginning January 2014, new individual and group insurance plans (not including self-insured plans or plans that were established on or before March 23, 2010, also known as grandfathered plans) will be required to accept all applicants. Additionally, insurers would be required to renew policies for individuals or plan sponsors (e.g. employers) as requested.

Premiums Cannot be Based on Enrollee Health Status:

Beginning January 2014, individual and small group plans (those intended for small businesses) are prohibited from basing premiums on an enrollee's health status. This requirement does not apply to large group (except for large group insurance purchased through the Exchange, where applicable), self-insured, or grandfathered plans, which are those that existed on or prior to March 23, 2010. Individual and small group plans are permitted to vary premiums based on the following factors:

- An enrollee's age (limited to a ratio of 3 to 1 for adults)
- Whether the plan covers an individual or family
- Tobacco use (limited to a ratio of 1.5 to 1)
- Where the enrollee lives

Universal Prohibition on Pre-Existing Condition Exclusions:

Beginning January 2014, individual and group plans - including self-insured and grandfathered plans - are prohibited from imposing pre-existing condition exclusions on all enrollees. A pre-existing condition is a medical condition that was present prior to health plan enrollment, regardless of whether or not it was diagnosed or treated.

Universal Prohibition on Annual Dollar Limits on Coverage:

Beginning January 2014, individual and group plans – including grandfathered group and self-insured plans - are prohibited from imposing annual dollar limits on coverage (in 2010, insurers can impose annual dollar limits based on restrictions established by the Department of Health and Human Services).

Eliminate Coverage Waiting Periods:

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Some insurance plans delay coverage of enrollees after they've been accepted into the plan. Beginning in January 2014, group plans – including grandfathered group and self-insured plans as well as grandfathered individual plans – cannot impose a waiting period of more than 90 days.

Essential Benefits Package:

Beginning January 2014, qualified health plans (Exchange-based plans or those that meet the definition of "qualified"), individual and small group insurance plans (not including grandfathered or self-insured plans), are required to provide an essential benefit package to include the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness and chronic disease management, and pediatric services.

Limits on cost-sharing:

Beginning January 2014, individual and group health plans (it is unclear whether self-insured plans are included) must abide by annual cost-sharing limits that cap the amount of allowable yearly cost-sharing at those established for health savings accounts/high-deductible plans, which is $5,950 for individual and $11,900 for family plans in 2010; the limits are indexed in subsequent years. Deductibles for small group market plans (those sold to small businesses) offering the essential benefit package are limited to $2,000 for an individual and $4,000 for family coverage. Limits will be indexed in subsequent years based on premiums. Preventive services are exempt from the deductible.

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Tax Penalties for Individuals Who Do Not Purchase Coverage

The Patient Protection and Affordable Care Act (PPACA) includes provisions that would require individuals to have health insurance. While this element of the health reform law has generated significant controversy, Congress felts that such a requirement is crucial to ensuring that the reform law works as intended. Without a requirement to purchase insurance, healthy individuals would delay or decide not to purchase insurance, creating a risk pool comprised primarily of sick enrollees who would drive up the cost of coverage and destabilize the insurance market.

Beginning in January 2014, individuals will be required to have “minimum essential coverage.” This is defined as coverage provided through a public insurance plan such as Medicare, an employer-sponsored plan, a plan purchased in the individual market, or a plan established prior to March 23, 2010. Any individual who does not acquire coverage will have to pay a fine:

- The greater of $695 per year (up to three times that amount per family), or
- 2.5 percent of household income (in 2016).
- Prior to 2016, the flat fee fine is phased-in: $95 in 2014, $325 in 2015, and $695 in 2016 and the income percentage fine is phased in beginning with 1.0 percent of taxable income in 2014, 2.0 percent in taxable income in 2015, and 2.5 percent of taxable income in 2016. After that, the mandate penalty will be adjusted based on cost of living.

Some people will be exempt from the fine, including:

- Those with religious objections
- American Indians
- People who have been uninsured for less than 3 months
- Undocumented immigrants
- Incarcerated individuals
- People for whom the lowest-cost health plan in their area would exceed 8 percent of their income
- People whose income is below the tax filing threshold (in 2009 the threshold for those under age 65 was $9,350 for individuals and $18,700 for couples)

The law prohibits those who fail to pay the penalty from being criminally prosecuted.

Employer Assessment:

Also beginning in 2014, large employers who fail to provide affordable, comprehensive health insurance for their employees would be required to pay a penalty if they have at least one full-time employee receiving a premium tax credit.

Which employers will be required to pay the assessment?

- Large employers with at least 50 full time employees who do not provide affordable, comprehensive health insurance for their employees may have to pay an assessment.
- A full-time employee is defined as person who works an average of at least 30 hours per week.
    - Small businesses – those with less than 50 employees – would be exempt from the requirement.
    - There are also exemptions for employers who hire a high number of seasonal workers. In this case, an employer will not be considered to have more than 50 employees if they employ at least 50 full-time employees for 120 days or less and the excess employees during the 120 day period are seasonal workers.

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- Part-time employees are also counted to determine the size of an employer's workforce. The number is determined by dividing by 120 the aggregate number of hours worked by part-time employees in one month. The resulting number is added to the number of full-time employees.

How much will employers have to pay?

- Eligible employers who do not offer insurance to their employees and have at least one full-time employee receiving a premium tax credit to purchase Exchange-based health care will have to pay $2,000 per full-time employee.
- Additionally, firms that do offer coverage but have at least one full-time employee receiving premium tax credits to purchase Exchange-based insurance will be required to pay the lesser of $3,000 for each credit-receiving employee or $2,000 for each full-time employee.
- In both cases, the first 30 employees are excluded from the assessment formula; for example, in a firm with 50 full-time employees, the firm would have to pay a fine for 20 employees.

Anything else required of employers?

- The law also requires large employers with over 200 employees to automatically enroll employees into the health insurance plans they offer. Employees are allowed to opt-out of their employer's coverage.
    - The intent of this provision is to increase the number of people with health coverage and to ensure that large employers currently offering coverage continue to do so, rather than drop coverage and choose to pay the employer assessment, which would increase the federal government's financial burden.

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Employer-Based Wellness Programs

A number of provisions in the Patient Protection and Affordable Care Act (PPACA) seek to emphasize illness prevention and healthy lifestyle. In addition to requiring many private insurers to cover certain preventive services rated with an "A" or "B" by the U.S. Preventive Services Task Force (USPSTF), the PPACA would encourage employers to develop preventive care and wellness programs for their employees. As chronic disease rates and health care costs continue to rise, many employers have established wellness programs for their employees. Wellness programs may include gym memberships, smoking cessation treatment, nutrition counseling and other incentives to push employees to adopt healthier lifestyles.

What do ratings "A" and "B" mean?

- An "A" rating means that the service is recommended and that there is a high level of certainty that it will yield substantial benefit to the patient.
- A "B" rating indicates that the service is recommended and that there is a high level of certainty that the services will yield at least a moderate benefit to the patient.

How does the PPACA incentivize wellness programs for employers and their employees?

Prior to enactment of the PPACA, insurers were permitted to provide a financial reward of up to 20 percent of the value of the insurance premium to enrollees who met certain health status standards. Beginning in 2014, the PPACA expands the allowable amount of the reward to 30 percent of the cost of coverage and if the Secretaries of Treasury, Health and Human Services (HHS), and Labor approve, the ceiling may be increased to 50 percent of the insurance premium.

Do any other rules apply?

In order for a wellness program to offer a reward based on meeting a health status standard, the program must have a reasonable chance of improving an enrollee's health status, cannot be overly burdensome, and cannot result in discriminating an enrollee based on health status, among other requirements. The PPACA also requires that insurers report on wellness and health promotion programs.

Additional Resources

- *Congressional Research Service report on wellness programs and other health reform law provisions:*

  http://www.aamc.org/reform/summary/ph.pdf

- *FAQs About the HIPAA Nondiscrimination requirements (for requirements established prior to health reform law):*

  http://www.dol.gov/ebsa/faqs/faq_hipaa_ND.html

- *Health Employment Council: Benefits and Wellness*

  http://healthcareemploymentcounsel.com/employee-benefits/federal-laws/health-care-reform-provides-support-for-wellness-programs/

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Income-Based Repayment for Student Loans

Income-Based Repayment (IBR) is a repayment plan option for borrowers of federal student loans. IBR is calculated on a sliding scale to determine how much you can afford to pay on your federal loans. If you earn below 150 percent of the poverty level for your family size, your required loan payment will be $0. If you earn more, your loan payment will be capped at 15 percent of whatever you earn above that amount. Your remaining debt, if any, will be forgiven after 25 years of qualifying payments.

Beginning in July 2014, the Patient Protection and Affordable Care Act (PPACA), instead of capping the annual repayment at 15 percent of income above 150 percent of the federal poverty guidelines for the applicable household size, the annual repayment will be capped at 10 percent.

In addition, a borrower will be eligible for loan forgiveness after 20 years of qualifying payments, rather than the current 25 years. As a result, monthly repayment amounts will be lower, and the duration that a borrower will have to repay their loans until the balance is forgiven will be shortened.

How do I apply for IBR?

To apply for Income-Based Repayment, contact your lender directly.

Additional information:

- *Income Based Repayment Questions & Answers; U.S. Department of Education*

  http://studentaid.ed.gov/students/attachments/siteresources/IBRQ&A_template_123109_FINAL.pdf

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Independent Payment Advisory Board

The Patient Protection and Affordable Care Act (PPACA) establishes an Independent Payment Advisory Board (IPAB), which must submit recommendations to Congress, beginning in 2014, to reduce the growth of Medicare expenditures while maintaining or improving the quality of care delivered. The Secretary of Health and Human Services (HHS) would be required to implement these recommendations unless Congress passed an alternative proposal that provided an equivalent amount of budgetary savings.

Why was the IPAB included within the healthcare reform legislation?

Medicare expenditures continue to grow much faster than the growth of the general economy. If these expenditures continued to grow at this accelerated rate, Medicare healthcare costs would comprise an excessive amount of the federal budget and the federal trust fund supporting the Medicare Hospital coverage program (Medicare Part A) could become insolvent before the end of this decade. It is believed that making difficult Medicare payment and budgetary decisions is very difficult within a political process with substantial lobbying pressures, and that an independent board serving this role would have some protection from this undue influence.

Who are the members of the IPAB?

The IPAB will consist of 15 members appointed by the President for a 6 year term with the advice and consent of the Senate. Initial appointments will be made on a staggered basis of 1, 3 and 6 years. Appointees are to include physicians and others with national recognition for their expertise in healthcare finance and delivery. Individuals directly involved in the delivery or management of health care services cannot constitute a majority of the Board. Although not clearly specified in the legislation, a call for Board nominations will likely be announced in 2011 or 2012.

When is the IPAB required to submit a recommendation to Congress?

Beginning in 2014, proposals for Medicare cost reductions from the Board would be required from IPAB for each year when Medicare costs are projected to increase faster than the 5-year average of the consumer price index (CPI). The targeted level of cost reduction would be the lesser of the level of anticipated excess spending or a defined level starting at .5 percent and increasing each year to 1.5 percent through 2018 and beyond. The Secretary of HHS would be required to implement the provisions included in the IPAB proposal, unless Congress passes an alternative proposal with an equivalent amount of budgetary savings. The Board can make recommendations in other years, but these would be advisory in nature. Beginning in 2019, the Board will be required to submit recommendations in those years in which per capita Medicare costs are projected to be greater than the Gross Domestic Product (GDP) plus 1 percent.

What are the types of recommendations that are excluded from IPAB consideration?

The IPAB proposals cannot include any recommendations to ration health care, raise revenues or Medicare beneficiary premiums, increase Medicare beneficiary cost sharing, or otherwise restrict benefits or modify eligibility criteria. In addition, recommendations for reductions in payments to several provider groups (e.g. hospitals, hospice) are excluded through 2019 from IPAB implementation since the PPACA already includes reductions in their annual updates during those years.

What legislative process is followed once the IPAB makes a required recommendation?

The PPACA outlines a "fast track" legislative procedure once the IPAB makes a required recommendation. The IPAB is required to provide the recommendation to Congress by January 15 of the given year. Congress has until April 1 of the given year to review the recommendation within their relevant Committees and until August

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15 of the given year to decide not to take any action—in which case the IPAB recommendation would be implemented—or enact alternative legislation that meets the required budgetary savings. If alternative legislation is passed, it can still be vetoed by the President. As a result, the IPAB recommendation will take place unless Congress over-rules the veto by a two-thirds majority in both Houses.

Is there any way Congress can remove the authority granted to this Board?

Yes. Congress can introduce a Joint Resolution to discontinue the Board. It must be introduced by January 31, 2017, with passage by August 15, 2017. Adoption of this Joint Resolution would require a three-fifths majority. If adopted, the board would not be able to submit proposals after January 16, 2018 and would terminate on August 16, 2018. Some legal experts believe, though, that a Congress cannot enact legislation that binds a future Congress from amending or repealing, by a simple majority vote, legislation adopted by the earlier Congress.

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Simplifying Administrative Requirements the Health Care System Imposes on Physicians - 2014

The Patient Protection and Affordable Care Act (PPACA) includes numerous provisions in 2014 that aim to reduce administrative burdens on physicians, having built upon earlier administrative simplification provisions in 2013 and 2012. PPACA generally assigns the responsibility for implementation of the administrative simplification provisions to the Secretary of the Department of Health and Human Services (HHS), often referred to as "the Secretary." Many implementation activities will be handled by the Centers for Medicare and Medicaid Services (CMS), an agency component of HHS.

Reiterating what was stated earlier in this guide, the health system, and its multiple payers, imposes significant burdens on physician practices. A typical physician practice has a contract with 12 or more health plans in addition to participating in Medicare and Medicaid and must follow each payer's requirements for contracting, credentialing, preauthorizing, coding, billing, and reimbursing. It is estimated that nearly 14 percent of physician practice revenue is consumed by billing and insurance-related functions. Further, studies by the Medical Group Management Association calculate the annual cost of administrative tasks, many of which are of dubious value, at around $25,000 per year per physician. In addition to being costly and frustrating to physicians, administrative burdens are unnecessarily limiting physicians' ability to provide patient care.

What health reform law-mandated efforts to streamline administrative requirements take effect in 2014?

The PPACA administrative simplification provisions that come into play for 2014 pertain to the administrative transaction of electronic payment of claims—through a transfer of funds—and transaction that entails a health plan communicating its payment decision related to a claim—known as remittance advice.

Specifically, by January 1, 2014, the Secretary must:

- Implement a standard for electronic funds transfer (EFT) and implement a set of operating rules for use of that EFT standard; and
- Implement a standard set of rules that pertain to claims remittance/payment.

The Secretary is to establish the EFT standard by January 1, 2012 and the EFT operating rules by July 1, 2012, allowing stakeholders time to prepare for their January 2014 effective date. The EFT and claims remittance/payment operating rules must allow for automated reconciliation of the electronic payment the physician receives and the corresponding remittance advice that the health plan provides. The Secretary must develop both sets of operating rules in consultation with a broad range of health care stakeholders, including physicians. The Secretary is to use a rigorous process by which health plans demonstrate their compliance with these rules, with financial penalties imposed on plans that fail to comply. The rules apply to all payers. An EFT standard, and operating rules to facilitate standard EFT and claim remittance/payment, will increase the ability of physician practices to determine the precise payment determination for each claim submitted and to enhance their ability to collect payments.

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VII. 2015 Reforms and Beyond

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Payment Penalties under Medicare's Pay-for-Reporting Program

Beginning in 2015, the Patient Protection and Affordable Care Act (PPACA) requires that the Centers for Medicare and Medicaid Services (CMS) assess a payment penalty for a physician's failure to successfully participate in the Physician Quality Reporting Initiative (PQRI).

The Medicare pay-for-reporting program, known as PQRI, entails physicians reporting on how the care they furnish aligns with evidence-based clinical guidelines for a variety of medical conditions, e.g. diabetes, heart disease. Physicians report this information through quality measures. Physicians report by submitting specially designated quality measure billing codes when submitting the claim with the procedure code describing the associated service, e.g. an evaluation and management (E/M) service office visit, for which Medicare would make payment when the PQRI program started in July 2007. The options available for PQRI reporting have increased beyond this single approach as the program has evolved in subsequent years.

The PPACA establishes a penalty of 1.5 percent in 2015 and 2 percent in 2016 and each subsequent year for a physician's failure to successfully participate in the program. This payment penalty will be determined by applying the percentage in place for that performance year to your Medicare revenue for that year. CMS has yet to determine the operational manner in which it would assess the payment penalty. The agency will establish that process closer to the 2015 performance year payment penalty effective date.

Further, the availability of the 0.5 percent bonus payment amount for meeting requirements pertaining to Maintenance of Certification also ceases in 2014, meaning that it cannot be used to offset a payment penalty for failure to successfully report related to quality measures in 2015 and subsequent years.

The law, however, does allow CMS to incorporate successful completion of a MOCP as a component of its program that adjusts payments for individual physician based on how his or her quality and cost of care compares to peers beginning that begins in 2015. CMS has yet-to-determine how it will assess physician quality and cost.

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Simplifying Administrative Requirements the Health Care System Imposes on Physicians - 2016

The Patient Protection and Affordable Care Act (PPACA) includes numerous provisions in 2016 that aim to reduce administrative burdens on physicians. These provisions build on earlier administrative simplification provisions in 2014, 2013 and 2012. PPACA generally assigns the responsibility for implementation of the administrative simplification provisions to the Secretary of the Department of Health and Human Services (HHS), often referred to as "the Secretary." Many implementation activities will be handled by the Centers for Medicare and Medicaid Services (CMS), an agency component of HHS.

As mentioned earlier in this guide, the health system, and its multiple payers, imposes significant burdens on physician practices. A typical physician practice has a contract with 12 or more health plans in addition to participating in Medicare and Medicaid and must follow each payer's requirements for contracting, credentialing, preauthorizing, coding, billing, and reimbursing. It is estimated that nearly 14 percent of physician practice revenue is consumed by billing and insurance-related functions. Further, studies by the Medical Group Management Association calculate the annual cost of administrative tasks, many of which are of dubious value, at around $25,000 per year per physician. In addition to being costly and frustrating to physicians, administrative burdens are unnecessarily limiting physicians' ability to provide patient care.

What health reform law-mandated efforts to streamline administrative requirements take effect in 2016?

<u>Standard Process for Health Plan Approval of Referral to Other Physicians, Certification of Need for Service, and Authorization of Services</u>

By January 1, 2016, the Secretary must implement a standard set of rules for the administrative transactions: health claims; referral; certification; and authorization. The Secretary must establish these operating rules by July 1, 2014, allowing stakeholders time to prepare for the January 2016 effective date. Standardization related to these transactions will decrease the burden that comes with required use of different forms for different payers. The Secretary must develop the operating rules in consultation with a broad range of health care stakeholders, including physicians. The Secretary is to use a rigorous process by which health plans demonstrate their compliance with the rules, with financial penalties imposed on plans that fail to comply. The rules apply to all payers.

<u>Standard Process for Electronic Submission of Supporting Information Attached to Claim for Payment</u>

By January 1, 2016, PPACA requires the Secretary to implement a standard and associated set of operating rules that pertain to health claim attachments. The Secretary must establish the rules by January 1, 2014, allowing stakeholders time to prepare for the January 2016 effective date. Standardization in the processes by which physicians submit and payers receive claims attachments will reduce the hassle and associated cost of submitting additional clinical information, e.g. portion of patient's health record, to justify payment for a claim and enable physicians to receive payment more promptly. This standard and the associated operating rules apply to all payers.

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VIII. Conclusion

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The information in this guide was prepared by the American College of Physician's (ACP) Division of Governmental Affairs and Public Policy based on review of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148. This guide is not intended to substitute for specific advice from accountants, financial managers, and practice managers on the impact and options available to any individual practice.

Many of the details concerning implementation of the PPACA will not be known until federal agencies and state agencies issue guidelines on the new law and implementation begins. This guide will be updated as such information becomes available.

For more information, please visit the following ACP webpages:

Advocacy:
http://www.acponline.org/advocacy/

Running a Practice:
http://www.acponline.org/running_practice/

Patient Centered Medical Home:
http://www.acponline.org/running_practice/pcmh/

Medical Home Builder:
http://www.acponline.org/running_practice/pcmh/help.htm

Principles on Accountable Care Organizations:
http://www.acponline.org/advocacy/where_we_stand/policy/aco.pdf

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