August 2012

Wolters Kluwer Law & Business Briefing

Special Report

Medicare and Medicaid Programs Continue Changes As Result of Reform Law

Highlights

- ✔ States react to Medicaid portion of U.S. Supreme Court Decision
- ✔ Many new Medicare and Medicaid regulations already in effect
- ✔ Some ACA provisions not implemented or repealed

Inside

In the wake of the U.S. Supreme Court's decision in ***National Federation of Independent Business, et al. v. Sebelius*** *(No. 11-393, June 28, 2012) much attention has been focused on how different states are reacting to the Court's decision. The Court limited the penalties a state faces if it doesn't expand its Medicaid program as provided under the Patient Protection and Affordable Care Act (P.L. 111-148) (ACA). In the first few days after the Court decision was announced governors in at least 11 states publicly raised doubt as to whether they will participate in the Medicaid expansion. Currently, governors in only 10 states have affirmatively pledged to expand Medicaid, which leaves nearly two-thirds of the states in question.*

Republicans in the House of Representatives have voted again to repeal the law. The House Appropriations Committee also approved legislation that would stop funding for implementation of most ACA provisions.

While much of the media attention on the law in the wake of the Supreme Court decision has focused on changes in the private health insurance market, many of which do not go into effect until 2014, it's important to remember that the law has been in effect for two years, and different federal agencies have been busy issuing new regulations and guidance on the law.

ACA has almost 500 provisions adding to or amending existing Medicare and Medicaid laws. Since the law was enacted in March 2010, about 50 final rules have been issued to implement different parts of the law.

This briefing focuses just on the Medicare and Medicaid changes that have been implemented so far. The summaries are arranged topically; the paragraph numbers at the top of each summary are keyed to the explanation paragraphs that appear in ***CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act (LEA),*** *published in March 2010. A summary of the original law appears in italics and is followed by updates on that section since the law was passed, with citations to new documents linked.*

Providers

Federally Qualified Health Centers

[LEA ¶1578]

The HHS Secretary must develop a new prospective payment system (PPS) for services furnished by federally qualified health centers (FQHCs). Payment under the new PPS will be made for cost reporting periods on or after October 1, 2014. (ACA §10501(i)(3)(A))

CMS has issued a billing guide for FQHCs and rural health centers (RHCs) explaining (1) that FQHCs submitting bills to Medicare on or after January 1, 2011, must report all services provided during a visit by the

Wolters Kluwer
Law & Business

appropriate Healthcare Common Procedure Coding System code, and (2) how RHCs should bill for their services in accordance with ACA. For example, coinsurance and deductibles are not applicable for the initial preventive physical examination furnished by RHCs on or after January 1, 2011. [*MLN Matters Article*, *No. SE1039*, December 30, 2010.]

Inpatient Hospital Services

[LEA ¶1035]

Reclassifications of hospitals for the purpose of adjusting payment rates based on differences in hospital wage levels were extended to September 30, 2010. The Secretary of HHS must restore the reclassification thresholds used to determine hospital reclassifications to the percentages used in fiscal year (FY) 2009 starting in FY 2011, until the first fiscal year that is on or after the date the Secretary submits a report to Congress on reforming the wage index system. (ACA §3137)

This extension has been further changed by subsequent legislation, most recently by the Middle Class Tax Relief and Job Creation Act of 2012 (*P.L. 112-96*), which changed the end of the extension to March 31, 2012.

[LEA ¶749]

Beginning in FY 2012, inpatient prospective payment system (IPPS) hospital payments will be adjusted based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for the three conditions with risk adjusted readmission measures that are currently endorsed by the National Quality Forum. (ACA §3025)

CMS implemented this program via Final rule, and provided guidelines for these hospital risk-standardized readmission measures: acute myocardial infarction, heart failure, and pneumonia. For 2012, the focus is on (i) those aspects of the Hospital Readmissions Reduction Program that relate to the conditions and readmissions to which the Hospital Readmissions Reduction Program will apply for the first program year beginning October 1, 2012; (ii) the readmission measures and related methodology used for those measures, as well as the calculation of the readmission rates; and (iii) public reporting of the readmission data. [Final rule, *76 FR 51476*, August 18, 2011.]

[LEA ¶705]

A value-based purchasing program for hospitals participating in Medicare will launch in FY 2013. This program will link Medicare payments more closely to health care quality. A percentage of hospital payment will be tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care. Quality measures included in the program will be developed and chosen with input from external stakeholders. (ACA §3001)

Under Soc. Sec. Act §1886(b)(3)(B)(viii), for payments beginning with FY 2013, each measure specified by the Secretary must be endorsed by a consensus entity that has a contract with the Secretary under Soc. Sec. Act §1890(a) (currently the National Quality Forum), except in certain circumstances. Specifically, in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the consensus entity, the Secretary may specify a measure that is not endorsed by the consensus entity if due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. CMS will report data from the Hospital Inpatient Quality Reporting Program as soon as it is feasible on CMS Web sites such as the *Hospital Compare Web site* after a 30-day preview period. [Final rule, *76 FR 51476*, August 18, 2011.]

All providers participating in Medicare or Medicaid must undergo screening before initial enrollment.

The Hospital Inpatient Value-Based Purchasing (VBP) program, which starts October 1, 2012, will provide value-based incentive payments to hospitals that meet specific performance standards in a given year. In FY 2013, an estimated $850 million will be allocated to hospitals based on their overall performance on a set of quality measures that have been shown to improve clinical processes of care and patient satisfaction. The Final rule includes a list of 13 measures where hospitals will have to demonstrate that they have followed best clinical practices and enhanced patients' experiences of care to qualify to receive incentive payments. The list includes 12 clinical process of care measures, as well as the requirement that hospitals collect data through the

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience of care survey. [Final rule, *76 FR 26490*, May 6, 2011.]

Residents

[LEA ¶¶1579, 1581, 1583, 1585]

The Department of Health and Human Services (HHS) is directed to redistribute residency positions that have been unfilled for the prior three cost reports; the redistributed slots would go to training primary care physicians. HHS also will be required to redistribute residency slots from closed hospitals to other hospitals in the same state. (ACA §5503)

Hospitals can receive indirect medical education (IME) and direct graduate medical education (DGME) funding for residents who train in a nonprovider setting so that any time spent by the resident in a nonprovider setting will be counted toward hospital reimbursement for medical education if the hospital incurs the costs of the stipends and fringe benefits. (ACA §5504)

Current law is modified to allow hospitals to count resident time spent in teaching conferences toward IME costs in the teaching hospital setting and toward DGME in the nonprovider (non-hospital) setting. (ACA §§5505, 10501(j))

To redistribute unused medical resident positions, the Secretary of HHS must establish a process to increase the resident limit for one or more hospitals located in a state when a hospital with an approved medical residency program in the state closes within the two-year period before the date of the enactment of this Act. (ACA §5506)

Changes to the policies regarding counting residents for both IME and DGME payment purposes as a result of the implementation of ACA §§5503 through 5506 were issued in a Final rule published at *75 FR 71800*, November 24, 2010.

Cancer Hospitals

[LEA ¶1040]

The Secretary of HHS is required to study whether existing cancer hospitals that are exempt from IPPS have costs under the outpatient prospective payment system (OPPS) that exceed costs of other hospitals, and to make an appropriate payment adjustment under OPPS based on that analysis. (ACA §§3138, 10304(b))

After conducting the study, CMS determined that outpatient costs incurred by 11 specified cancer hospitals were greater than the costs incurred by other OPPS hospitals. CMS proposed in 2010 to increase payments to cancer hospitals by 41.2 percent for CY 2011. Because of the large number of comments received, CMS did not implement any changes in cancer hospital reimbursement for 2011. For 2012, however, CMS is providing the CY 2012 cancer hospital payment adjustment to cancer hospitals in the form of an aggregate payment at cost report settlement instead of through an increased adjustment to ambulatory payment classification payments on a claims basis, as was proposed. CMS has also proposed continuing these payments for CY 2013. [Final rule with comment period, *76 FR 74122*, November 30, 2011.]

Skilled Nursing Facilities

[LEA ¶1640]

The Nursing Home Compare website must include staffing data based on collected information. Summary information on complaints filed against skilled nursing facilities (SNFs) and nursing facilities (NFs) also will be made available. (ACA §§6103, 6106)

CMS provided a list of key elements for state website development for states to qualify for federal funding. The costs for development of the websites and operation are allowable expenses for reimbursement through a combination of Medicaid, Medicare survey and certification, and state-only funds under standard cost- allocation procedures. [*CMS Memorandum to State Survey and Certification Agencies*, *No. S&C-11-41*, September 30, 2011.]

[LEA ¶1680]

The administrator of a nursing facility that is preparing to close must provide written notification to residents and other parties and prepare a plan for closing that ensures the safe transfer of residents to new facilities. (ACA §6113)

When a long-term care (LTC) facility plans to close, the administrator of the nursing facility must provide written notification of the impending closure to the HHS Secretary, the state's LTC ombudsman, residents of the facility and their legal representatives, and other responsible parties. [Interim final rule with comment period, *76 FR 9503*, February 18, 2011.]

[LEA ¶¶1635, 1805]

SNFs and NFs must implement a compliance and ethics program and all employees and agents must follow the program within 36 months of enactment. The compliance and ethics programs will help prevent and

detect criminal, civil, and administrative violations. The Secretary of HHS is required to evaluate the SNF programs and report to Congress its findings. (ACA §§6102, 1304, 10603)

New and existing providers of medical or other items or services and suppliers participating in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) will be subject to new enrollment and revalidation requirements. (ACA §§1304, 10603)

All providers participating in Medicare, Medicaid or CHIP must undergo screening before initial enrollment and revalidate their compliance with enrollment requirements every five years (every three years for suppliers of durable medical equipment, prosthetics, orthotics and supplies). [Final rule with comment period, *76 FR 5862*, February 2, 2011.]

ACA §6102(c) requires CMS to promulgate a new Quality Assurance and Performance Improvement (QAPI) regulation, which will include the requirement that all homes must submit to HHS a plan for the facility to meet QAPI standards and implement QAPI best practices, including how to coordinate the implementation of a QAPI plan with Quality Assurance and Assessment activities conducted under existing regulations. The Affordable Care Act permits CMS time to develop resource materials prior to promulgation of the new regulation. [*CMS Letter to State Survey and Certification Agencies*, *No. S&C-11-22*, April 8, 2011.]

[LEA ¶820]

Physician assistants working in collaboration with a physician are authorized to certify the medical necessity for post-hospital skilled nursing care services. (ACA §3108)

Effective with services furnished on or after January 1, 2011, physician assistants can perform the required initial certification and periodic recertifications of a beneficiary's need for an SNF level of care. [*Medicare Benefit Policy Manual*, Pub. 100-02, *Transmittal No. 155*, April 20, 2012.]

[LEA ¶1655]

SNFs and NFs must electronically report staffing information in a uniform format based on payroll data, including information on agency or contract staff. (ACA §6106)

CMS extended the timeline for the design and implementation of this system for quarterly electronic collection of staffing information in nursing homes past the March 23, 2012, deadline identified in the ACA. Such a system requires a considerable investment in information systems, and an informational infrastructure must be capable of collecting and processing large amounts of information from 15,800 nursing homes each quarter, and rendering the information on CMS' Nursing Home Compare website. It must also support quarterly calculation of measures and data for use in CMS' Five-Star Quality Rating System. [*CMS Letter to State Survey Agency Directors*, *S&C-12-12-ALL*, December 9, 2011.]

[LEA ¶1665]

SNFs and NFs must conduct dementia management and abuse prevention training for employees before employment. Ongoing training may be required at the Secretary's discretion. (ACA §6121)

Interpretive Guidelines have been revised for the in-service training. CMS is developing a regulation to mandate these topics and training materials that nursing homes may use to train staff. [*Letter to State Survey Agency Directors*, *No. S&C-11-35-NH*, August 12, 2011.]

Rural Hospitals

[LEA ¶925]

The Medicare inpatient hospital payment adjustment for low-volume, rural hospitals is increased temporarily FYs 2011 and 2012, and the low-volume hospital eligibility requirements for FY 2011 and FY 2012 are modified. (ACA §§3125, 10314)

The revised provision specifies that, for FYs 2011 and 2012, a hospital qualifies as a low-volume hospital if it is "more than 15 road miles from another subsection (d) hospital and has less than 1,600 discharges of individuals entitled to, or enrolled for, benefits under Part A during the fiscal year." CMS estimated that 514 out of the 529 hospitals in its database that qualified as a low-volume hospital for FY 2011 will continue to meet the Medicare discharges criterion to qualify as a low-volume hospital for FY 2012. CMS identified an additional 86 hospitals in its database that meet the Medicare discharges criterion to qualify as a low-volume hospital for FY 2012. The changes made by these ACA sections are effective only for discharges occurring during FYs 2011 and 2012. Beginning with FY 2013, the preexisting low-volume hospital payment adjustment and qualifying criteria, as implemented in FY 2005, will resume. [Final rule, *76 FR 51476*, August 18, 2011.]

Home Health

[LEA ¶1839]

Before a physician may certify a patient for home health services or durable medical equipment, the physician must have a face-to-face (or telehealth) encounter with the patient. The Secretary has the discretionary authority to expand this requirement to other areas if the Secretary determines that the extension would help reduce waste, fraud, and abuse. (ACA §§6407, 10605)

Face-to-face encounter provisions were revised for starts of care beginning January 1, 2012, and later. The revised regulations (1) remove "attending" from the regulatory language and add language to describe physicians who qualify as the physician who cared for the patient in an acute or post-acute facility; (2) provide that the certifying physician's documentation of the face-to-face encounter clearly states that either the certifying physician himself or herself, the allowed nonphysician practitioner (NPP), or, for patients admitted to home health immediately after an acute or post-acute stay, a physician who cared for the patient in an acute or post-acute facility, has had a face-to-face encounter with the patient; and (3) address scenarios where the physician who cared for the patient in an acute or post-acute facility performing the face-to-face encounter is also the certifying physician. Also, the NPP or the physician who cared for the patient in an acute or post-acute facility performing the face-to-face encounter must communicate the clinical findings of the encounter to the certifying physician, unless the physician who cared for the patient in an acute or post-acute facility is also the certifying physician. [Final rule, *76 FR 68526*, November 4, 2011.]

Hospice

[LEA ¶1010]

Additional data and information will be collected for use with revising payments for hospice care. Prior to October 1, 2013, revisions based on this new data and information will be implemented into a new hospice payment methodology. Hospice recertifications will also require a nurse practitioner or hospice physician to have a face-to-face encounter with the beneficiary to determine continued eligibility. (ACA §3132)

The statute requires that for hospice recertifications occurring on or after January 1, 2011, a face-to-face encounter take place before the 180th-day recertification. CMS decided that the 180th-day recertification and subsequent benefit periods corresponded to the recertification for a patient's third or subsequent benefit period. Any hospice physician may perform the face-to-face encounter regardless of whether that same physician recertifies the patient's terminal illness and composes the recertification narrative. At this time, physician assistants, clinical nurse specialists, community physicians, and nurse practitioners may not perform the face-to-face encounter. [Final rule, *76 FR 47302*, August 4, 2011; Final rule, *75 FR 70372*, November 17, 2010.]

Medicare productivity adjustments will not be sustainable in the long range.

Productivity Adjustments to Market Basket Increases

[LEA ¶¶1305, 1310, 1315, 1320, 1325, 1330, 1335, 1340, 1345, 1350, 1355, 1360, 1365, 1370]

The ACA included provisions applying a productivity adjustment to the market basket update of payments for various providers reimbursed by Medicare. The ACA mandated that all of these payment updates be reduced by the percentage increase in the 10-year moving average of private nonfarm business multifactor productivity beginning as early as 2011. Providers and services affected include inpatient hospitals, skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities, home health agencies, psychiatric hospitals, hospices, end-stage renal facilities, outpatient services, ambulatory surgical centers, laboratory rates, ambulance services, DME, prosthetics, orthotics, and other miscellaneous services.

The productivity adjustments under the ACA apply automatically to payment updates for all future years. These update reductions cannot be modified or rescinded except through new legislation.

A letter from the CMS Actuary in 2012 noted that the productivity adjustments will not be sustainable in the long range. "Based on the historical evidence of health sector productivity gains, the labor-intensive nature of health care services, and presumed limits on

the extent of current excess costs and waste that could be removed from the system, actual health provider productivity is very unlikely to achieve improvements equal to the economy as a whole over sustained periods." The CMS Actuary concluded that "projections based on the permanent application of this new component of current law are likely to seriously understate actual Medicare costs in the long-range future." [CMS Letter from the Office of the Actuary, *May 18, 2012*.]

Graduate Nurse Education Demonstration

[LEA ¶1590]

A demonstration program will be created to increase graduate nurse education training under Medicare. (ACA §5509)

The *GNE Demonstration* is a four-year demonstration, under which eligible hospitals (which includes critical access hospitals) may receive reimbursement for the reasonable cost of providing clinical training to advanced practiced registered nurse (APRN) students. Participating eligible hospitals will coordinate with academic and provider entities to provide clinical training for students in the following four APRN specialties: (1) clinical nurse specialist (CNS); (2) nurse practitioner (NP); (3) certified registered nurse anesthetist (CRNA); and (4) certified nurse midwife (CNM). [*CMS Demonstration*, March 21, 2012.]

CMS has solicited eligible hospitals and individuals as participants in the demonstration. [Notice, *77 FR 29647*, May 18, 2012.]

Physicians

Preventive Services

[LEA ¶1417]

Medicare beneficiaries are entitled to personalized preventive plan services to be performed no more than once per year, and no deductible or coinsurance is required. (ACA §§4103, 10402)

Although the annual wellness visit was effective on January 1, 2011, ACA §4103 provided the Secretary additional time to establish guidelines for health risk assessments (HRAs) after consulting with relevant groups and entities. A technology assessment from the Agency for Healthcare Research and Quality was commissioned to describe key features of HRAs, to examine which features were associated with successful HRAs, and to discuss the applicability of HRAs to the Medicare population. The finalized technology assessment was posted on *July 6, 2011*. [Final rule with comment period, *76 FR 73026*, November 28, 2011.]

[LEA ¶1419]

A definition for "preventive services" is created and coinsurance and deductible amounts are waived for most covered preventive services provided to Medicare beneficiaries. (ACA §§4104, 10406, 10501)

Effective for dates of service on or after January 1, 2011, Medicare provides 100 percent payment (in other words, waives any deductible, coinsurance or copayment) for many Medicare-covered preventive services. CMS provided an article with a quick reference for the changes to deductibles, copayments, or coinsurances for these services. [MLN Matters, *No. SE1129*, October 21, 2011.]

Primary Care Incentive Payment Program

[LEA ¶1577]

Primary care practitioners and general surgeons practicing in health professional shortage areas will be provided with a 10 percent Medicare payment bonus for five years. (ACA §§5501, 10501(h))

CMS issued a series of FAQs on the program, focusing on updating beneficiary information with the coordination of benefits contractor; preventive services educational resources for health care professionals; and the 2012 Electronic Prescribing (eRx) payment adjustment. [*MLN Matters*, *No. SE1205*, February 10, 2012; *MLN Matters*, *No. SE1142*, December 15, 2011; *MLN Matters*, *No. SE1109*, March 22, 2011.]

Physician Fee Schedule

[LEA ¶¶709, 710, 713]

The Secretary of HHS is required to develop and implement a budget-neutral payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver. Quality and cost measures will be risk-adjusted and geographically standardized. The Secretary will phase in the new payment system over a two-year period beginning in 2015. (ACA §3007)

Medicare's physician resource use feedback program will be expanded to provide for development of individualized reports by 2012. Reports will compare the per capita utilization of physicians (or groups of physicians) to other physicians who see similar patients. Reports will be risk-

adjusted and standardized to take into account local health care costs. (ACA §3003)

Payments under the Physician Quality Reporting Initiative (PQRI) are extended through 2014. The program provides incentives to physicians who report quality data to Medicare. Beginning in 2014, physicians who do not submit measures to PQRI will have their Medicare payments reduced. (ACA §§3002, 10327)

CMS' goal is to have Medicare physicians receive a confidential feedback report prior to implementation of the value-based payment modifier. CMS views these two provisions as complementary and expects that the work done for the Physician Feedback Program will inform implementation of the value-based payment modifier. The approach used for performance assessment in the confidential feedback reports will serve as the foundation for implementing the value-based payment modifier. Specifically, throughout future phases of reports under the Physician Feedback Program, CMS will continue to enhance the measures and methods and improve the content of the reports based on both research and the feedback of stakeholders before the value-based payment modifier begins to affect physician payments in 2015. [Final rule, *75 FR 73170*, November 29, 2010.]

[LEA ¶805]

The floor on geographic adjustments to the work portion of the Medicare physician fee schedule was extended through the end of 2010, with the effect of increasing practitioner fees in rural areas. Immediate relief is provided to areas negatively impacted by the geographic adjustment for practice expenses. (ACA §§3102, 10324(c))

CMS is applying several changes to the geographic practice cost indices (GPCIs) as a result of additional analyses conducted both in accordance with ACA §3102(b) and commitments made in the CY 2011 final rule with comment period. For CY 2012, CMS will use the Bureau of Labor Statistics Occupational Employment Statistics specific to physicians to calculate the practice expenses (PE) employee wage index. In addition, CMS is replacing the U.S Department of Housing and Urban Development rental data as the proxy for physician office rent with rent data from the 2006-2008 American Community Survey. Lastly, CMS is creating a purchased service index to account for the labor-related industries within the "all other services" and "other professional expenses" Medicare Economic Index (MEI) categories. These changes result in very little change to the GPCIs and indicate that the data CMS has used to adjust for geographic variation is consistent and accurate. [*Medicare Claims Processing Manual*, Pub. 100-04, *Transmittal No. 2379*, January 18, 2012.]

[LEA ¶840]

To increase access to women's health services for Medicare beneficiaries, the reimbursement for certified nurse midwife (CNM) services is increased from 65 to 100 percent of the payment amount for the same service provided by a physician, effective for services on or after January 1, 2011. (ACA §3114)

Since Soc. Sec. Act §1833(a)(1)(K) (as amended by ACA §3114) requires that payment for services provided by a CNM be paid at 100 percent of the physician fee schedule (PFS) amount, this specialty will no longer be excluded from the ratesetting calculation under the PFS. [Final rule with comment period, *76 FR 73026*, November 28, 2011.]

Medicare now provides 100 percent payment for many preventive services.

CMS finalized regulations to increase the Medicare Part B payment amount for CNM services, with the clarification that the amount paid to a CNM may not exceed 100 percent of the PFS amount that would be paid to a physician for the same service furnished on or after January 1, 2011. [Final rule, *75 FR 73170*, November 29, 2010.]

[LEA ¶1020]

The Secretary is required to regularly review fee schedule rates for physician services paid for by Medicare, including services that have experienced high growth rates. The Secretary's authority is strengthened to adjust fees schedule rates that are found to be misvalued or inaccurate. (ACA §3134)

CMS is still in the process of soliciting comments on data sources and possible methodologies for developing a system-wide validation system. [Final rule with comment period, *76 FR 73026*, November 28, 2011; Final rule, *75 FR 73170*, November 29, 2010.]

General

[LEA ¶1615]

An additional requirement is added to the in-office ancillary exception that requires the referring physician to inform the patient in writing that the patient may obtain certain specified imaging services from (1) a person other than the referring physician, (2) a physician who is a member of the same group practice as the referring physician, or (3) an individual who is directly supervised by the physician or by another physician in the group practice. The referring physician also must provide the patient with a written list of suppliers who furnish such services in the area in which the patient resides. (ACA §6003)

CMS finalized regulations implementing this part of ACA, including application of the disclosure requirement to advanced imaging services only; the general disclosure requirements that the notice should be written in a manner sufficient to be reasonably understood by all patients and be given to the patient at the time of the referral; the list must include the requisite number of suppliers; the information about these suppliers must include name, address, and phone number; and that these suppliers are to be located within a 25-mile radius of the physician's office location at the time of the referral. [Final rule, *75 FR 73170*, November 29, 2010.]

Medicare Advantage

[LEA ¶1145]

For plan years starting on or after January 1, 2011, Medicare Advantage (MA) beneficiaries who need: (1) chemotherapy administration services, (2) renal dialysis services, (3) skilled nursing care, and (4) other services that the HHS Secretary determines appropriate will not be subjected to higher cost-sharing for these services than traditional fee-for-service (FFS) Medicare (Medicare Parts A and B) beneficiaries pay. (ACA §3202)

CMS finalized regulations to implement this section and extended these protections to section 1876 cost contracts. [Final rule, *76 FR 21432*, April 15, 2011.]

[LEA ¶1160]

Beginning on January 1, 2011, specialized MA plans for special needs individuals may enroll people only during annual, coordinated open enrollment periods or at the time of diagnosis. The special needs program will be extended for two years, through 2014. The Secretary of HHS is to develop plans to transition certain enrollees from special need plans (SNPs) to regular MA plans. An alternate funding scheme is proposed for frail adults in a SNP. (ACA §3205)

A dual eligible special needs plan (D-SNP) must meet the following criteria in order to be considered a fully integrated D-SNP: enroll special needs individuals entitled to medical assistance under a Medicaid state plan; provide dual eligible beneficiaries access to Medicare and Medicaid benefits under a single managed care organization (MCO); have a capitated contract with a state Medicaid agency that includes coverage of specified primary, acute and long-term care benefits and services, consistent with state policy; coordinate the delivery of covered Medicare and Medicaid health and long-term care services, using aligned care management and specialty care network methods for high-risk beneficiaries; and employ policies and procedures approved by CMS and the state to coordinate or integrate member materials, enrollment, communications, grievance and appeals, and quality improvement. [Final rule, *76 FR 21432*, April 15, 2011.]

[LEA ¶1175]

Certain MA plans may be approved to provide primary care services for residents in continuing care retirement communities on site, as well as transportation services for beneficiaries to specialty providers outside of the facility. (ACA §3208)

The definition of new coordinated care plan types is amended to include "senior housing facility plan." A senior housing facility plan must otherwise meet all requirements applicable to MA organizations. MA senior housing facility plans must restrict enrollment in these plans to residents of continuing care retirement communities, and individuals enrolled in such plans must meet all other MA eligibility requirements in order to be eligible to enroll. In addition, an MA senior housing facility plan must verify the eligibility of each individual enrolling in its plan using a CMS-approved process. [Final rule, *76 FR 21432*, April 15, 2011.]

Medicare Part D

[LEA ¶¶1220, 1225, 1245, 1290]

MA rebates and increases related to the grandfathering of supplemental benefits for current enrollees have been excluded from the MA-prescription drug plan (PDP) premium amount when calculating the regional low-income subsidy (LIS) benchmark. Medicare Part D plans that bid a nominal amount above the regional LIS

benchmark to absorb the cost of the difference between their bid and the LIS benchmark will remain $0 LIS plans. The Medicare Part D premium subsidy for beneficiaries with incomes above the Part B income thresholds will be reduced. Drugs provided to patients by AIDS Drug Assistance Programs or various Indian health services to count toward the patients' true out-of-pocket (TrOOP) costs, helping these beneficiaries reach their catastrophic coverage more quickly. (ACA §§3302(b), 3303, 3308, 3314)

Regulations incorporating these changes were issued by CMS. [Final rule, *76 FR 21432*, April 15, 2011.]

[LEA ¶1250]

Cost-sharing is eliminated under the Medicare Part D prescription drug program for people who receive care under a home- and community-based waiver who would otherwise require institutional care in a facility for the mentally retarded. (ACA §3309)

The regulations provide for a definition of an individual receiving home- and community-based services (HCBS), and for zero cost-sharing for Medicare Part D prescriptions filled by full-benefit dual eligible beneficiaries receiving such services. In order to implement ACA §3309, CMS needs data from states identifying full benefit dual eligible individuals who are receiving HCBS through one of the authorities listed in §3309. States are to report these data through an additional value in the Institutional Indicator field of the Medicare Modernization Act (MMA) file report. The new value will be "H" for HCBS. This new code now appears in the MMA File Specifications and Data Dictionary. Beginning no later than January 1, 2012, states must identify their full dual beneficiaries who are receiving HCBS and code these individuals "H" for HCBS in the Institutional Indicator field of the MMA file report. [Final rule, *76 FR 21432*, April 15, 2011; *CMCS Informational Bulletin*, October 31, 2011.]

[LEA ¶1260]

Effective January 1, 2012, Medicare Part D plans must develop drug dispensing techniques to reduce prescription drug waste in long-term care facilities. (ACA §3310)

Part D sponsors are required to collect and report to CMS the method of dispensing technique used for each dispensing event and on the nature and quantity of unused brand and generic drugs. [Final rule, *76 FR 21432*, April 15, 2011.]

[LEA ¶1265]

The Secretary must develop and maintain a plan complaint system to handle complaints concerning Medicare Advantage and Part D prescription drug plans or their sponsors. (ACA §3311)

CMS developed a model electronic complaint form at *Medicare.gov* and on the website of the *Medicare Beneficiary Ombudsman,* as of December 2010. [Final rule, *76 FR 21432*, April 15, 2011.]

Medicare Advantage plans' in-network cost sharing charges will be no greater than under original Medicare.

[LEA ¶1270]

Medicare Part D prescription drug plans must use a single, uniform exceptions and appeals process that is instantly accessible by enrollees. (ACA §3312)

At a minimum, plans as of January 1, 2012, must have a process for allowing an enrollee to initiate a coverage determination or appeal request by sending a secure e-mail to an e-mail address that is prominently displayed on the plan's website. In response to such requests, plans must provide notice of decisions in a timely manner. [Final rule, *76 FR 21432*, April 15, 2011.]

[LEA ¶1280]

The Office of Inspector General must conduct a study comparing prescription drug prices paid under the Medicare Part D program to those paid under state Medicaid programs. (ACA §3313.)

The OIG found that Part D sponsors and state Medicaid agencies paid pharmacies similar amounts for most brand-name drugs under review. However, statutorily defined Medicaid unit rebate amounts for brand-name drugs exceeded Part D unit rebate amounts by a substantial margin. As a result, Medicaid collected nearly two-thirds as much as Part D in rebates for the 100 brand-name drugs ($2.9 billion vs. $4.5 billion), despite having only about one-fourth of the expenditure

($6.4 billion vs. $24 billion). [*OIG Report*, *No. OEI-03-10-00320*, August 1, 2011.]

[LEA ¶1155]

CMS, MA plans, and Part D prescription drug plans will have an extra week to process enrollment paperwork during annual enrollment periods. Each MA beneficiary may disenroll from a MA plan and return to traditional FFS Medicare program from January 1 to March 15 of each year. (ACA §3204)

CMS issued regulations to do the following: provide for the new disenrollment opportunity and clarify that the open enrollment period ended after 2010; specify the effective date for disenrollment requests submitted during the new 45-day disenrollment period; allow individuals who disenrolled from an MA plan between January 1 through February 14th to enroll in a standalone PDP; and specify the enrollment effective dates for individuals who enroll in a stand-alone Medicare prescription drug plan after disenrolling from MA during the 45-day period. [Final rule, *76 FR 21432*, April 15, 2011.]

[LEA ¶¶1205, 1215, 1255, 1625]

In order for prescription drugs dispensed on or after January 1, 2011, to be covered under Medicare Part D, a drug manufacturer must participate in a new coverage gap discount program that provides a 50 percent discount on applicable drugs provided to applicable beneficiaries that fall into the coverage gap know as the "donut hole." The program will require a manufacturer to provide beneficiaries discounted prices for applicable drugs at the pharmacy or by the mail order service at the point-of-sale.

The "donut hole" coverage gap was partially closed in 2010 by a $250 rebate for individuals enrolled in a Medicare prescription drug plan (PDP) or a MA prescription drug plan (MA-PD) who, as of the end of a calendar quarter in 2010, had incurred costs for covered Part D drugs exceeding the initial coverage limit. (ACA §3301)

Each Medicare Part D sponsor must establish a drug utilization management program, quality assurance (QA) measures and systems, and a medication therapy management program (MTMP). (ACA §10328(a))

A health benefits plan or a pharmacy benefit manager (PBM) that manages prescription drug coverage under a contract with a Medicare Part D drug plan or a qualified health benefits plan offered through an insurance Exchange established by a state must share information with the Secretary of HHS with respect to services provided during a contract year. (ACA §6005)

This Final rule implements new regulations relating to the MA program and PDB program to strengthen beneficiary protections; exclude plan participants that perform poorly; improve program efficiencies; and clarify program requirements. [Final rule with comment period, *77 FR 22072*, April 12, 2012; Final rule, *76 FR 21432*, April 15, 2011.]

This notice with comment period contains a draft model agreement for use by the Secretary and manufacturers under the Medicare Coverage Gap Discount Program. Under the agreement, manufacturers of covered Part D drugs must provide discounts to Medicare beneficiaries for covered Part D drugs while in the coverage gap beginning in 2011. [Notice, *75 FR 29555*, May 26, 2010.]

The number of ACOs currently participating in the Shared Savings Program is 154.

Part D sponsors are required to offer Comprehensive Medication Reviews (CMRs) to all targeted beneficiaries, including those in LTC settings. Sponsors remain subject to the requirement to furnish MTM services to all targeted beneficiaries. Thus, services required for MTM, such as offering a CMR, which must include an interactive, person-to-person, or telehealth consultation, are required for all targeted beneficiaries, including those in LTC settings. [Final rule with comment period, *77 FR 22072*, April 12, 2012.]

ACA §6005 created new Soc. Sec. Act §1150A, which directs qualified health plan issuers and sponsors of certain Part D plans to provide data on the cost and distribution of prescription drugs covered by the plan. Disclosure of this data is limited. CMS codified these standards in a Final rule. [Final rule, *77 FR 18310*, March 27, 2012.]

[LEA ¶1230]

The surviving spouse of a LIS-eligible individual will be able to delay LIS redetermination for one year after the death of a spouse. (ACA §3304)

The Final rule changes the way the Social Security Administration accounts for income and resources when determining eligibility for the Medicare Part D prescription drug subsidy provided by the low-income subsidy

(Extra Help) program; removes certain items from those counted as income and resources; and extends the effective date of a determination or redetermination of an Extra Help subsidy when there is a death of a spouse. [Final rule, *77 FR 2446*, January 18, 2012; Final rule, *75 FR 81843*, December 29, 2010.]

Medicare Fraud and Abuse

Physician-Owned Hospitals

[LEA ¶1605]

Physician-owned hospitals that do not have a provider agreement prior to December 31, 2010, are prohibited from participating in Medicare. Such hospitals that have a provider agreement prior to December 31, 2010, may continue to participate in Medicare under certain requirements addressing conflict of interest, bona fide investments, patient safety issues, and expansion limitations. Inpatient acute care hospitals have new requirements to qualify under either the rural provider or hospital ownership exceptions to the kind of physician ownership or investment interest that would result in prohibition of referrals by the physician to that entity. (ACA §§6001, 10601, and Health Care and Education Reconciliation Act of 2010, §1106)

CMS implemented this provision in the OPPS update for calendar year 2011 Final rule (*75 FR 71800*), November 24, 2010.

General

[LEA ¶1843]

Within six months of enactment, the Secretary of HHS, in cooperation with the HHS Office of Inspector General, will be required to establish a self-referral disclosure protocol (SRDP) to enable health care providers and suppliers to disclose actual or potential violations of the physician self-referral law. (ACA §6409)

The SRDP was issued and has been revised at least once. The most recent update was in *May 2011*. CMS also has posted several settlements related to the SRDP on its website at *https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Self-Referral-Disclosure-Protocol-Settlements.html.*

[LEA ¶1670]

The HHS Secretary is given the authority to reduce civil money penalties (CMPs) from the level that they would otherwise be by 50 percent for skilled nursing facilities and nursing facilities that self-report and promptly correct deficiencies within 10 calendar days of imposition. For CMPs that are due to actual harm, widespread harm, immediate jeopardy, or death of a resident, the 50 percent reduction will not be available. Nor will the reduction be available if the facility already had a penalty reduced in a preceding year with respect to a repeated deficiency. (ACA §6111)

The Final rule revises and expands current Medicare and Medicaid regulations regarding the imposition and collection of civil money penalties by CMS when nursing homes are not in compliance with federal participation requirements. [Final rule, *76 FR 15106*, March 18, 2011.]

This memorandum provides interim advanced guidance regarding the federal requirements for the independent informal dispute resolution (IDR) process for nursing homes. [*CMS Letter to State Survey and Certification Agencies*, *No. S&C-10-23-NH*, July 12, 2010.]

[LEA ¶1835]

Physicians who order DME or home health services that are billable to Medicare must be Medicare-enrolled physicians or eligible professionals. The Secretary has the discretion to expand this requirement to other areas if the Secretary determines that this extension of this requirement would help reduce waste, fraud, and abuse. (ACA §§6405(a), (b), 10604)

The Final rule requires health care providers and suppliers to include their National Provider Identifier (NPI) on all claims and must ensure that their NPI is in their Medicare enrollment record. The rule expands expand these requirements to clinical laboratory and imaging services. [Final rule, *77 FR 25284*, April 27, 2012.]

[LEA ¶1837]

Physicians and suppliers must maintain and provide, upon request of the Secretary, documentation related to written orders or requests for payment for DME, certifications for home health services, or referrals for other items or services as specified by the Secretary. (ACA §6406)

The Final rule clarifies the penalties that physicians and supplier face for failure to retain and/or disclose documentation of orders and referrals. [Final rule, *77 FR 25284*, April 27, 2012.]

[LEA ¶1809]

CMS will include claims and payment data from various programs in its integrated data repository to combat fraud

Key ACA Sections Repealed or Not Implemented

[LEA ¶¶ 2105; 2125; 2130; 2145]

Community Living Assistance Services and Supports (CLASS). This program was designed as a federally administered, voluntary insurance program to help working adults cover some costs of their long-term-care (LTC) services and supports. In October 2011, HHS effectively announced it would not implement the program because it could not figure out an actuarially sound benefit plan as laid out by the law.

[LEA ¶1017]

RUG-IV for skilled nursing facilities. *The Secretary of HHS may not implement the use of Resource Utilization Groups, Version IV (RUG-IV) in the skilled nursing facility prospective payment system until October 1, 2011. (PPACA §10325)*

This provision was subsequently repealed by section 202 of the Medicare and Medicaid Extenders Act of 2010 (*P.L. 111-309*), enacted December 15, 2010.

[LEA ¶1850]

Exclusion from Medicaid participation. *State Medicaid agencies that certify compliance with conditions of participation must exclude from Medicaid participation any individual or entity that owns, controls or manages, or is owned, controlled or managed by, an individual or entity: (1) with unpaid, delinquent overpayments under the Medicaid Act; (2) that is excluded or suspended from Medicaid participation; or (3) whose Medicaid participation has been terminated. The state agency also must exclude any entity or individual that is affiliated with any individual or entity that has been suspended or excluded from Medicaid participation or whose participation has been terminated. (PPACA §6502)*

This was repealed by the Medicare and Medicaid Extenders Act of 2010 (*P.L. 111-309*).

and abuse, in addition to overpayment and identifier requirements to enhance program integrity. (ACA §6402(a))

The provider agreement between a state agency and each provider delivering services under the state Medicaid plan must include a requirement that the provider furnish to the state agency its NPI; and include its NPI on all claims submitted under the Medicaid program. States are required to comply with the provider screening, oversight, and reporting requirements outlined in Soc. Sec. Act §1902(kk) including the process for screening providers. [Final rule, *77 FR 25284*, April 27, 2012.]

Although the NPI requirements in ACA §6402(a) did not extend to CHIP providers, ACA §6401 does apply equally to CHIP, and the proposed requirement for ordering and referring physicians or other professionals under the Medicaid program apply equally under CHIP. [Final rule with comment period, *76 FR 5862*, February 2, 2011.]

The Final rule requires all providers of medical or other items or services and suppliers that qualify for a NPI to include their NPI on all applications to enroll in the Medicare and Medicaid programs and on all claims for payment submitted under the Medicare and Medicaid programs. Physicians and eligible professionals who order and refer covered items and services for Medicare beneficiaries must be enrolled in Medicare. [Interim final rule with comment period, *75 FR 24437*, May 5, 2010.]

Medicare (Miscellaneous)

Accountable Care Organizations

[LEA ¶743]

A shared savings program has been created to promote accountability for a patient population, coordinate items and services under Parts A and B, and encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Accountable care organizations (ACOs), composed of a group of providers, will be rewarded with a share of this savings program for providing high quality of care and/or care at lower costs relative to a spending benchmark. (ACA §§3022, 10307)

The number of ACOs participating in the Shared Savings Program as of July 2012 is 154. Additional ACOs may be selected annually through an application process and begin their participation in January. Applications to participate in the program beginning January 1, 2013, will be accepted from August 1 through September 6, 2012. The requirements and application materials are available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Application.html*.

The Final rule implements regulations relating to Medicare payments to providers of services and suppliers

participating in ACOs. Under these provisions, providers of services and suppliers can continue to receive traditional Medicare FFS payments under Parts A and B, and be eligible for additional payments if they meet specified quality and savings requirements. [Final rule, *76 FR 67802*, November 2, 2011.]

CMS and OIG announced this Interim final rule providing for waivers of certain fraud and abuse laws for those providers participating in Shared Savings. There are five waivers; three of them are waivers of the Physician Self-Referral Law, the federal anti-kickback statute, and the Gainsharing CMP law. The other two waivers include: (1) compliance with the Physician Self-Referral Law waiver, which is a waiver of the Gainsharing CMP and the anti-kickback statute for ACO arrangements that implicate the Physician Self-Referral Law and already fit under an existing exception; and (2) patient incentive waiver of the Beneficiary Inducements CMP and anti-kickback statute for medically related incentives offered by ACOs to encourage beneficiaries to follow treatment recommendations and obtain preventive care. Those ACOs participating in Shared Savings, including those participating in the Advance Payment Initiative, will be eligible for these waivers, and need only fit one waiver to be protected. [Final rule, *76 FR 67992*, November 2, 2011.]

The Departments of Justice (DOJ) and the Federal Trade Commission (FTC) have issued a policy where ACOs may need to undergo an expedited review to determine if they are in violation of anti-trust statutes and regulations. Safety zones are created where an ACO will not have to undergo an expedited review to determine if it is in compliance with the anti-trust laws and regulations. For an ACO to fall within the safety zone, each participant in the ACO that provides the same service must have a combined share of 30 percent or less of each common service in each participant's primary service area (PSA). [Notice with comment period, *76 FR 21894*, April 19, 2011.]

This notice with comment period describes and solicits public input regarding possible waivers of the application of the Physician Self-Referral Law, the federal anti-kickback statute, and certain CMP law provisions to specified financial arrangements involving ACOs. In addition, Soc. Sec. Act §1115(d)(1) authorizes the Secretary to waive the same fraud and abuse laws, among others, as necessary solely for the purposes of carrying out the provisions of Soc. Sec. Act §1115A with respect to the testing of certain innovative payment and service delivery models by the Center for Medicare and Medicaid Innovation. [Notice, *76 FR 19655*, April 7, 2011.]

Independent Medicare Advisory Board

[LEA ¶1385]

The Independent Medicare Advisory Board (IMAB) is established to reduce the per capita rate of growth in Medicare spending and to make recommendations to Congress on how changes should be implemented to maintain or enhance beneficiary health care access. (ACA §§3403, 10320(a))

In March 2012, the House of Representatives approved and sent to the Senate *HR 5*, which would repeal the IMAB. The Senate has not taken up the legislation. In July 2012, the House Ways and Means Appropriations Subcommittee approved a spending bill for fiscal year 2013 that would defund much of the ACA, including funding for this Board. The Senate was not expected to approve this legislation.

Community Mental Health Services

[LEA ¶917]

Community mental health centers (CMHCs) that provide Medicare partial hospitalization services must provide a significant share of their services to individuals who are not eligible for benefits under Medicare. (HCERA §1301)

The regulations were updated to implement this provision, as part of the annual update of the OPPS. CMS amended the description of a partial hospitalization program (PHP) to specify that the program must be a distinct and organized intensive ambulatory treatment program offering less than 24-hour daily care "other than in an individual's home or in an inpatient or residential setting." CMS also established four separate PHP APC per diem payment rates, two for CMHCs (for Level I and Level II services) and two for hospital-based PHPs (for Level I and Level II services). [Final rule, *75 FR 71800*, November 24, 2010; Final rule with comment period, *76 FR 74122*, November 30, 2011.]

After publication of the OPPS regulations in 2010, a CMHC and one of its patients filed an application for a preliminary injunction, challenging the OPPS rates for PHP services provided by CMHCs in 2011. The plaintiffs challenged CMS' use of cost data derived from both hospitals and CMHCs (in determining the relative payment weights for the OPPS rates for PHP services furnished by CMHCs), alleging that Soc. Sec. Act §1833(t)(2)(C) requires that such relative payment weights be based on cost data derived solely from hospitals. Both a district court and court of appeals agreed that CMS' determination of the 2011 payment rates for PHP using

both hospital costs and CMHC costs in OPPS does not violate a clear statutory mandate. [*Paladin Community Mental Health Center v. Sebelius*, U.S. Court of Appeals, Fifth Circuit, No. 11–50682, June 15, 2012.]

General

[LEA ¶737]

Non-patient identifiable claims data under Medicare Parts A, B, and D will be made available to qualified public or private entities, as determined by the HHS Secretary, to evaluate the performance of providers and suppliers on measures of quality efficiency, effectiveness, and resource use. (ACA §10332)

This Final rule requires qualified employers, insurance groups, and consumer groups to be able to utilize Medicare data to create report cards to measure the quality standards of physicians and hospitals. [Final rule, 76 FR 76542, December 7, 2011.]

Certain qualified entities, which may include existing community collaboratives, that meet certain requirements for performance measurement and reporting can access beneficiary identifiable claims data for the purposes of evaluating the performance of providers and suppliers on measures of quality, efficiency, effectiveness, and resource use. [Final rule, *76 FR 67802*, November 2, 2011.]

The Secretary of HHS must establish a process to allow for the use of standardized extracts of Medicare Parts A, B, and D claims data by Qualified Entities to evaluate and report on the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use. [*Notice*, *76 FR 65196*, October 20, 2011.]

[LEA ¶747]

A new demonstration program has been created to test the use of home-based primary care teams for chronically ill Medicare beneficiaries in an effort to reduce expenditures and improve health outcomes. (ACA §§3024, 10308(b))

In April 2012, the CMS Innovation Center selected 16 practices to participate in this demonstration. [*Fact sheet, April 2012*.]

[LEA ¶790]

The Government Accountability Office (GAO) is required to conduct a study of providers of dialysis services ability to safely provide oral drug access for Medicare beneficiaries, especially end-stage renal disease (ESRD) beneficiaries. (ACA §10336)

GAO recommends that CMS assess payment adequacy when oral-only ESRD drugs are included in the bundled payment and ensure availability of reliable data for monitoring treatment of mineral and bone disorder. [*GAO Report*, *GAO-11-365*, March 23, 2011.]

[LEA ¶855]

Bonus payments made by Medicare for ground and air ambulance services in rural areas were extended through the end of 2010. This will result in rural ambulance firms continuing to receiving 3 percent more than they otherwise would without this legislation. (ACA §§3105, 10311)

This provision was further extended by §106 of the *Medicare* and Medicaid Extenders Act of 2010 (*P.L. 111–309*), by §306 of the Temporary Payroll Tax Cut Continuation Act of 2011 (*P.L. 112-78*), and §3007 of the Middle Class Tax Relief and Job Creation Act of 2012 (*P.L. 112-96*). The bonus payments now will continue to the end of 2012.

Medicare and Medicaid

[LEA ¶561]

The Secretary of Health and Human Services is required to establish a federal Coordinated Health Care Office (CHCO) within CMS. The purpose of the CHCO is to bring together officials of the Medicare and Medicaid programs to: (1) more effectively integrate benefits under those programs, and (2) improve the coordination between the federal and state governments for individuals eligible for benefits under both Medicare and Medicaid (dual eligibles) to ensure that dual eligibles have full access to the items and services to which they are entitled. (ACA §2602)

The Medicare-Medicaid Coordination Office is charged with making the two programs work together more effectively to improve care and lower costs. Specifically, pursuant to ACA §2602(c), the Office is focused on improving quality and access to care for Medicare-Medicaid enrollees; simplifying processes; and eliminating regulatory conflicts and cost-shifting that occurs between the Medicare and Medicaid programs, states, and the federal government. [*CMS Letter to State Medicaid Directors*, *No. SMDL 11-008*, July 8, 2011.]

The Office is undertaking an initiative to identify and address conflicting requirements between Medicaid and Medicare that potentially create barriers to high quality, seamless, and cost-effective care for dual eligible ben-

eficiaries. The goal is to create and implement solutions in line with the CMS three-part aim, which includes solutions that advance better care for the individual, better health for populations, and lower costs through improvement. [Notice, *76 FR 28196*, May 16, 2011.]

Part F of the Statement of Organization, Functions, and Delegations of Authority for HHS is being amended to change the title of the Office of Executive Operations and Regulatory Affairs; it will now be known as the Office of Strategic Operations and Regulatory Affairs. This change reflects the creation of a new federal Coordinated Health Care office. [Notice, *75 FR 82405*, December 30, 2010.]

Medicaid

Eligibility

[LEA ¶¶505, 506, 507, 534, 536, 563, 580]

Beginning January 1, 2014, state Medicaid programs may choose to cover individuals under age 65 with incomes greater than 133 percent of the federal poverty level (FPL) but not exceeding the limit in the state Medicaid plan or waiver. The U.S. Supreme Court clarified in its opinion that the federal government may not penalize states that do not expand their programs by withholding federal funding for all Medicaid beneficiaries in that state. States must establish income eligibility thresholds for populations to be eligible for Medicaid using standards that are not less than the income eligibility levels in effect under the state plan as of the date of ACA's enactment (March 23, 2010).

Certain states will receive 100 percent reimbursement from January 1, 2014, through December 31, 2016, for expenditures for assistance for the newly eligible group: childless, nonpregnant adults. All states, except expansion states, will receive 100 percent federal reimbursement for their Medicaid expenditures for the new mandatory eligibility group of nonpregnant, childless adults from January 1, 2014, through December 31, 2016. States that require political subdivisions to contribute a higher percentage of the non-federal share of their Medicaid expenditures than they did on December 31, 2009, will not receive the increases. (ACA §§2001; 2002(b), (c); 2101; 10201; 10203; 2201)

This Final rule codified policy and procedural changes to the Medicaid and CHIP related to eligibility, enrollment, renewals, public availability of program information and coordination across insurance affordability programs. These regulations are effective January 1, 2014. [*Final rule, 77 FR 17144*, March 23, 2012.]

The new Soc. Sec. Act. §1905(cc) added by ACA §10201(c)(6) states that, to comply with the political subdivision provision, the maximum percentage contributions that political subdivisions are required to contribute in any quarter must reflect "the requirements of the Medicaid state plan, or state law, as provided by this subsection" as of September 30, 2008. CMS interprets this language to mean that, if the state plan or state law in effect on September 30, 2008, provided for changes in the percentage contributions or dollar amount contributions by political subdivisions, those changes must be given effect as applicable to the current period. The final phrase in the first sentence of Soc. Sec. Act §1905(cc) refers to determining the required percentage contribution by the state "without regard to any such increase," referring to the increase in Federal Medicaid Assistance Percentage (FMAP). CMS interprets this language as meaning that the required contribution by a political subdivision in the period at issue must be measured as a percentage of the non-federal share that would apply if there were no increased FMAP. In determining compliance with the political subdivision provisions, states must take into account the effect of the provisions of Soc. Sec. Act §1905(cc). [*CMS Letter to State Medicaid Directors*, *No. SMDL 10-023*, November 9, 2010, reiterated by *Final rule*, *76 FR 21950*, April 19, 2011.]

The CMS Innovation Center has selected 16 practices to participate in a demonstration for home-based care for chronically ill Medicare beneficiaries.

Children's Health Insurance Plan (CHIP)

[LEA ¶566]

CHIP is reauthorized for an additional two years, through FY 2015. States' allotments will be rebased in FY 2013. Appropriations have been increased, and funds allocated to bonus payments in the future are redirected. (ACA §10203)

The Final rule provides methodologies and procedures for determining states' fiscal years 2009 through 2015

allotments and payments under Medicaid and CHIP. [Final rule, *76 FR 9233*, February 17, 2011.]

[LEA ¶521]

Children receiving Medicaid or coverage under CHIP who have been diagnosed with a terminal illness may receive both hospice care and treatment for the terminal illness concurrently. (ACA §2302)

State Medicaid directors are advised that Medicaid programs that cover hospice services must provide it to eligible terminally ill children without requiring them to give up curative treatment. [*CMS Letter to State Medicaid Directors*, *No. SMDL 10-18*, September 9, 2010.] CMS then provided states with a "draft template" to be used when submitting revised pages to a state plan amendment. States are now required to amend state plans as necessary to add the hospice concurrent care legislation requirement. [*CMCS Informational Bulletin*, *May 27, 2011*.]

[LEA ¶564]

Qualified plans to be offered through the health insurance exchanges will be evaluated to determine whether they are at least comparable to plans offered by a state's CHIP. The Secretary will certify the comparable qualified plans in each state. The Secretary must evaluate all plans on each state exchange to determine which plans are at least comparable to the state's CHIP plan by April 1, 2015. (ACA §§2101(b) and 10203)

The methodology for calculating the CHIP allotments to the states, District of Columbia, and Territories has been finalized. [Final rule, *76 FR 9233*, February 17, 2011; Notice, *77 FR 43290*, July 24, 2012.]

Coverage

[LEA ¶519]

State Medicaid programs may cover the services of freestanding birth centers in connection with labor and delivery and other ambulatory services that are otherwise covered under the state plan. (ACA §2301)

States will need to submit amendments to their Medicaid state plans that specify coverage and separate reimbursement of freestanding birth center facility services and professional services in order to comply with this provision. [*Center on Medicaid, CHIP and State Operations Informational Bulletin*, *March 25, 2011*.]

[LEA ¶523]

States may choose to offer family planning services to a new group, specifically, individuals of childbearing age who are not pregnant, with incomes up to the limits currently applied to pregnant women under their Medicaid or CHIP plans. States may choose to provide family planning services during a period of presumptive eligibility. (ACA §2303)

States may amend their Medicaid plans to cover family planning and related services for individuals who are not eligible for Medicaid under any other category. The eligible group may include individuals with incomes up to the state's income limit for pregnant women under Medicaid and CHIP. The benefits available to individuals in this group are limited to family planning services and related services. States will be reimbursed at the 90 percent rate for family planning services and at their ordinary rate for the related services. [*CMS Letter to State Medicaid Directors*, No. *SMDL 10-013*, July 2, 2010.]

Many states are considering not expanding their Medicaid programs.

[LEA ¶1425]

Counseling and drug therapy for smoking cessation is a required Medicaid benefit for pregnant women. The required services and supplies include diagnostic, therapy and counseling services and prescription and nonprescription drugs that are approved by the Food and Drug Administration and are used for the purpose of cessation of tobacco use by pregnant women who either use or are being treated for use of tobacco. (ACA §4107)

CMS provided further guidance to state Medicaid agencies on this new coverage. [*CMS Letter to State Medicaid Directors*, *No. SDL 11-007*, June 24, 2011.]

Pharmaceutical Coverage

[LEA ¶543]

Rebates paid by drug manufacturers to state Medicaid programs are increased. Drug manufacturers are required to pay rebates for drugs dispensed to Medicaid beneficiaries

who receive care from a Medicaid managed care organization. Total rebate liability is limited to 100 percent of the average manufacturer price. (ACA §2501)

As of March 23, 2010, all covered outpatient drugs provided by Medicaid MCOs must be eligible for the rebates. Medicaid MCOs must report the utilization of covered outpatient drugs to the state Medicaid agency, and the state agency must submit claims for rebates. CMS will "offset" the difference between the former rebate percentage and the new percentage, subtracting that amount from the federal matching funds payable to the states. [*CMS Letter to State Medicaid Directors*, *No. SMDL 10-006*, April 22, 2010.]

Another CMS letter revises the previous instructions concerning the federal offset of Medicaid prescription drug rebates and further specifies the process CMS will use for the estimation and collection of these offsets. [*CMS Letter to State Medicaid Directors*, *No. SMDL 10-019*, September 28, 2010.]

[LEA ¶545]

Smoking cessation drugs, barbiturates, and benzodiazepines are removed from Medicaid's excludable drug list beginning with drugs dispensed on January 1, 2014. (ACA §2502)

States will generally be required to cover these products to the extent that states provide coverage of prescribed drugs. Because Medicare Part D does not require the coverage of over-the-counter smoking cessation drugs, states are responsible for coverage of such drugs for Medicaid dual-eligible individuals, if the state provides a prescription drug benefit under its state plan for such Medicaid beneficiaries. [*CMS Letter to State Medicaid Directors*, *No. SMDL 10-019*, September 28, 2010.]

[LEA ¶547]

The Secretary of Health and Human Services is required to calculate the federal upper limit (FUL) as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer prices (AMP) for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies. (ACA §2503)

CMS plans to require manufacturers to report these units by the same unit type used to calculate the AMP and plans to use these units to calculate the weighted AMP-based FULs prices. CMS plans to have the data field necessary for manufacturers to report this data and will provide instructions to manufacturers regarding the reporting of units to facilitate timely reporting in advance of the deadline. [CMS Letter to State Medicaid Directors, *No. SMDL 10-019*, September 28, 2010.]

Fraud and Abuse

[LEA ¶1847]

States must contract with recovery audit contractors (RACs) by December 31, 2010. (ACA §6411)

Medicare has increased the maximum contingency fee paid to Recovery Auditors by 5 percent for the recovery of overpayments only for durable medical equipment claims (DME). [Notice, *77 FR 11127*, February 24, 2012.]

CMS now authorizes states to pay their respective Medicaid RACs a contingency fee up to 17.5 percent, the current highest contingency fee paid to Medicare RACs, for the recovery of improper payments made for "medical supplies, equipment and appliances suitable for use in the home" found within the home health services benefit. [*CPI-CMCS Informational Bulletin No. CPI-B 12-01*, December 30, 2011.]

Effective January 1, 2012, Medicaid RACs will be required to: (1) hire a minimum of one full-time medical director who is a doctor of medicine or doctor of osteopathy; (2) hire certified coders unless the state determines that certified coders are not required for the effective review of Medicaid claims; (3) educate providers, including notification to providers of audit policies and protocols; (4) require RACs to include customer service measures such as providing a toll-free customer service telephone number; (5) limit the look-back review to a three-year period; and (6) establish a limit on the number and frequency of records requested by a RAC. States are encouraged to adopt specific program elements that are part of the permanent Medicare RAC program. [Final rule, *76 FR 57808*, September 16, 2011.]

[LEA ¶1807]

Providers or suppliers of Medicaid services will have to conform to certain requirements and undergo screening, as well as pay a fee to cover the costs of the screening. (ACA §6401)

This provision was implemented by Final rule with comment period, *76 FR 5862*, February 2, 2011. The regulation establishes the same screening levels for Medicaid and CHIP providers. For those Medicaid and CHIP provider types that are also recognized provider or supplier types under Medicare, states must use the same screening levels as apply under Medicare. For those provider-types that are not recognized under Medicare, states must assess the risk of fraud, waste, and abuse

using similar criteria to those used in Medicare. [*CMCS Informational Bulletin*, *December 23, 2011*.]

[LEA ¶1853]

State Medicaid agencies must terminate the Medicaid participation of any individual or entity whose participation in Medicare or in another state's Medicaid program has been terminated. (ACA §6501)

This was implemented by Final rule with comment period, *76 FR 5862*, February 2, 2011. After the implementing regulations were issued, some states requested clarification regarding CMS's definition of "for cause" terminations. For example, some states consider providers who were terminated because they no longer maintain an active medical license in the state, regardless of the reason for the inactive license, e.g., the provider relocated to another state, as meeting the definition of a "for cause" termination. CMS does not consider this type of termination to be a "for cause" termination within the meaning of the Final rule. States do not have to share information regarding this type of termination with other states.

In addition, "for cause" does not include any voluntary action taken by the provider to end its participation in the Medicaid program, except where that "voluntary" action is taken to avoid sanction. Accordingly, CMS believes that providers who are terminated by states because they allow their medical license to expire due to relocation to another state does not qualify as a "for cause" termination and should not be reported or shared with other states. CMS believes that this type of termination is not within the spirit of the final rule and does not meet the definition of "for cause." "For cause" terminations that are shared with other states should be limited to terminations based upon fraud, integrity, or quality. [*Joint Informational Bulletin from Center for Medicaid and CHIP Services and Center for Program Integrity*, *No. CPI-B 12-02*, January 20, 2012.]

[LEA ¶1861]

In situations in which a state has discovered an overpayment due to fraud but no final determination of the amount of the overpayment has been made, the federal government will not adjust the payment to a state until 30 days after a final determination of the amount of the overpayment has made when the state is unable to recover an overpayment made to a person or entity due to fraud within one year of discovery. (ACA §6506)

The Final rule extends the deadline for states' repayment of the federal share of Medicaid overpayments a state has made to providers. [Final rule, *77 FR 31499*, May 29, 2012.]

Administration

[LEA ¶1863]

Effective for claims filed on or after October 1, 2010, state Medicaid agencies must incorporate the compatible methodologies of the Correct Coding Initiative (CCI) used in Medicare in order to receive the increased matching funds available for use of automated data systems in the administration of their programs. (ACA §6507)

CMS issued two guidance letters on implementation of this provision. [*CMS Letter to State Medicaid Directors*, No. SMDL 11-003, April 22, 2011; *CMS Letter to State Medicaid Directors*, *No. SMD 10-17*, September 1, 2010.]

Home- and Community-Based Services

[LEA ¶530]

The Community First Choice Option gives state Medicaid programs the option to offer community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require the level of care offered in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases. (ACA §2401)

The Final rule provides the requirements for state plan amendments adopting the optional Community First Choice benefit added by ACA §2402. [Final rule, *77 FR 26828*, May 7, 2012.]

The Government Accountability Office (GAO) closely examined home- and community-based services (HCBS) options. Of the four options discussed by the GAO, two were created as part of ACA. Three of the options provide states with financial incentives in the form of enhancements to the Medicaid matching rate that determines the federal share of the program's costs. The states reported considering several factors in deciding whether to pursue the ACA options, including potential effects on state budgets, staff availability, and interaction with existing state Medicaid efforts. GAO found that states were "attracted by the increased federal funding available under some of the options, but were concerned about their ability to contribute their share of funding.

Limited staff resources and competing priorities were also concerns." GAO also noted that broader Medicaid reform efforts, such as transitions to statewide managed care and the potential interaction with existing HCBS options were considerations that states were weighing. ["States' Plans to Pursue New and Revised Options for Home- and Community-Based Services," *GAO-12-649*, June 13, 2012.]

[LEA ¶533]

Barriers to providing HCBS are removed by giving states the option to provide more types of HCBS through a state plan amendment to individuals with higher levels of need, rather than through a waiver. States may also extend full Medicaid benefits to individuals receiving HCBS under a state plan amendment. (ACA §2402)

The requirements for state plan amendments adopting the optional Community First Choice (CFC) benefit added by ACA §2402 have been finalized. The benefit must include self-directed assistance with activities of daily living (ADLs), such as dressing, transferring or bathing, instrumental ADLs, such as meal preparation, and health-related tasks.

Assistance may include hands-on help, supervision or "cueing." States also must provide acquisition, maintenance or enhancement of skills necessary to perform ADLs, instrumental ADLs and health-related tasks and voluntary training in the management of the attendant. States also may cover certain one-time costs of transition from an institution to community-based care, including security deposits and the purchase of furniture, bedding and kitchen supplies, and assistive devices and home modifications that would replace covered human assistance.

The benefit must be available statewide to all beneficiaries who require the level of care available in a hospital, nursing facility, or intermediate care facility for the developmentally disabled. An assessment of the individual's needs and strengths must be used to develop the plan of services. The settings in which individuals may receive CFC have not yet been determined. An enhanced federal medical assistance percentage (FMAP) is available for the services. During the first year the benefit is offered, states must spend at least as much on long-term care as they did the previous year. [Final rule, *77 FR 26828*, May 7, 2012.]

Earlier guidance on the expansion of this benefit was provided by *CMS Letter to State Medicaid Directors*, *No. SMDL 10-015*, August 6, 2010 and *CMS Letter to State Medicaid Directors*, No. *SMDL 11-005*, June 6, 2011.

[LEA ¶590]

States may apply for incentive payments to add or increase their coverage of long-term care services at home or in the community as an alternative to nursing homes and facilities for individuals with mental retardation. Participating states must agree to implement structural changes to their Medicaid programs work toward increasing the percentage of long-term care expenditures made for home- and community-based care to a target rate. The incentive period runs from October 1, 2011, through September 30, 2015. Participating states will receive federal matching funds at an increased percentage. (ACA §10202)

CMS may approve waivers for Medicaid demonstration projects for a five-year term.

This letter provides a high-level overview of the Balancing Incentive Program, along with the required structural changes and timeframes for implementation. As described in more detail in the accompanying application, the funding authorized in ACA §10202 will provide an increased Federal Medical Assistance Percentage (FMAP) payment to states participating in the Balancing Incentive Program for non-institutional long-term social services and will be made available as a noncompetitive grant to states. This letter and the accompanying application serve as a notice of this funding opportunity. [*CMS Letter to State Medicaid Directors*, *No. SMDL 11-010*, September 12, 2011.]

Health Homes

[LEA ¶555]

States have the option of enrolling Medicaid beneficiaries with chronic conditions into a health home, starting January 1, 2011. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination. (ACA §2703)

The health home may be offered to individuals with a serious and persistent mental health condition or who are at risk of another of the following: substance use disorder, asthma, diabetes, heart disease or a body mass

index over 25. The health home is a provider or a group or team of providers working together, that coordinates care of the individual and follows up to assure that the individual receives the prescribed services and is taking any prescribed medication. Compensation may be tiered depending on the number and severity of a patient's conditions. States may submit letters of interest describing the proposed services and payment methodology and work with CMS on the development and implementation of their proposed state plan amendments. [*CMS Letter to State Medicaid Directors*, No. SMDL 10-024, November 16, 2010.]

Since individuals with HIV may also be experiencing mental health and/or substance use issues, this provision offers important coordinated care opportunities for supporting physical and behavioral health, as well as linkages to long-term supports, which are fundamental elements of a successful health home. However, a state cannot offer a health home to an individual solely on the basis of having an HIV diagnosis. Per statutory requirement, the individual must have two or more chronic conditions (as defined by the state and approved by CMS) or have one chronic condition and be at risk of another. [*CMS Letter to State Medicaid Directors*, No. SMDL 11-005, June 6, 2011.]

States that pursue the new health home option are required to consult and coordinate with the Substance Abuse and Mental Health Services Administration (SAMHSA) to address the prevention and treatment of mental and substance use disorders among Medicaid eligible individuals with chronic conditions. Given the complex health problems faced by children and youth in the child welfare system, health homes are one vehicle for improving the care they receive. [*Tri-Agency Memorandum to State Program Directors*, November 23, 2011.]

Personal Care Attendants

[LEA ¶2150]

States are required to provide an infrastructure to support the development of the personal care attendant workforce. The Secretary of Health and Human Services must further establish a Personal Care Attendants Workforce Advisory Panel to provide advice on issues affecting such workers, including wages and benefits. (ACA §8002)

The Panel will provide advice and guidance on issues related to the adequacy of the number of personal care attendant workers, the salaries, wages, and benefits, and access to the services provided by personal care attendant workers. [Notice, 75 FR 34140, June 16, 2010.]

School-Based Health Centers

[LEA ¶1413]

The Secretary of Health and Human Services must award grants for the establishment and operation of school-based health centers (SBHC), with preference for applicants that serve populations of children and adolescents eligible for Medicaid or child health assistance. Grant applicants must provide certain assurances, including that funds will not be used to provide any service not allowed by federal, state, or local law and that the SBHC will provide onsite access during the school day and 24-hour on-call coverage through backup health providers. (ACA §§4101, 10402)

Applicants can request a maximum amount of $500,000 per application, regardless of the type or number of projects proposed. [More information is available at *http://www.hrsa.gov/grants/apply/assistance/sbhcc/fy13sbhccappfaqs.pdf*.]

General

[LEA ¶255]

For plan years beginning in 2017, states are allowed to apply for a waiver for up to five years of requirements relating to qualified health plans, Health Insurance Exchanges, cost-sharing reductions, and tax credits as outlined in the Patient Protection and Affordable Care Act. (ACA §1332)

The Final rule implements a regulatory framework for the submission and review of initial applications for Waivers for State Innovation under Medicaid. [Final rule, 77 FR 11700, February 27, 2012.]

[LEA ¶783]

The HHS Secretary must publish regulations governing the application or renewal of any experimental, demonstration, or pilot project that would have any effect on the eligibility, enrollment, benefits, cost sharing, or financing with respect to a state Medicaid or CHIP. (ACA §10201(i))

The Final rule implements provisions that set forth transparency and public notice procedures for experimental, pilot, and demonstration projects approved under Soc. Sec. Act §1115 relating to Medicaid and CHIP. [Final rule, 77 FR 11678, February 27, 2012.]

[LEA ¶553]

The Secretary of the Department of Health and Human Services is required to develop a list of health care-acquired

conditions (HACs) for Medicaid based on those defined under Medicare and current state practices. Under these regulations, no Medicaid payments will be permitted for services related to health care-acquired conditions. (ACA §2702)

The Final rule directs the Secretary of Health and Human Services to issue Medicaid regulations effective as of July 1, 2011, prohibiting federal payments to states under Soc. Sec. Act §1903 for any amounts expended for providing medical assistance for health care-acquired conditions. [Final rule, *76 FR 32816*, June 6, 2011.]

[LEA ¶515]

The formula for computing the FMAP for disaster-recovery states is changed to avert a sharp decrease in funding that would otherwise occur in 2011. The adjustment does not apply to certain expenditures. States that require political subdivisions to contribute a higher percentage of the non-federal share of their Medicaid expenditures than they did on December 31, 2009, will not receive the FMAP increases. (ACA §§2006, 10201(c))

These letters clarify the treatment of voluntary contributions by political subdivisions to the non-federal share of Medicaid expenditures. [*CMS Letter to State Medicaid Directors*, *No. SMDL 10-023*, November 9, 2010; *CMS Letter to State Medicaid Directors*, *No. SMDL 10-010*, June 21, 2010.]

[LEA ¶557]

A Medicaid emergency psychiatric demonstration project is established in which participating states would be required to reimburse certain institutions for mental disease for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition. (ACA §2707)

Under the *Medicaid Emergency Psychiatric Demonstration,* states will receive only federal matching funds for Medicaid payments. Funds shall be allocated to eligible states on the basis of specific criteria, including a state's application and the availability of funds. In no case may the aggregate amount of payments made by the Secretary to eligible states for the demonstration exceed $75,000,000. The demonstration will end December 31, 2015.

[LEA ¶559]

Medicaid waivers for coordinating care for dual eligible beneficiaries may be authorized for up to five years. (ACA §2601)

State Medicaid directors are advised that CMS may, in its discretion, approve waivers for demonstration projects for a five-year term, as permitted by section ACA §2601. The projects must address the needs of dually eligible beneficiaries and provide delivery system options or services that could not ordinarily be provided to dually eligible individuals under the state plan. Projects that exclude dual eligibles and those that are inconsistent with ACA will not be approved. [*CMS Letter to State Medicaid Directors*, *No. SMDL 10-022*, November 9, 2010.]

Medicare data will be used to create report cards to measure the quality standards of physicians and hospitals.

[LEA ¶1821]

The HHS Secretary may suspend payments to a Medicare provider or supplier during a pending fraud investigation. Similarly, HHS may suspend payments to a Medicaid provider or supplier during a pending fraud investigation if a state fails to suspend such payments. (ACA §6402(h))

This was implemented by Final rule with comment period, *76 FR 5862*, February 2, 2011. Further guidance was provided by *CPI - CMCS Informational Bulletin*, *CPI-B 11-04*, March 25, 2011.

To avoid conflicts among investigating agencies, the New York State Medicaid Fraud Control Unit created a list of names associated with ongoing investigations. This list will be helpful in instituting the new payment suspension rules mandated by the ACA, which permit the state Medicaid agency to suspend payment in cases of suspected fraud identified by the Unit or by the Office of the Medicaid Inspector General. [*OIG Report*, *No. OEI-02-11-00440*, June 1, 2012.]

Quality Reporting

[LEA ¶717]

Quality reporting measuring programs will be implemented for long-term care hospitals, inpatient rehabilitation hospitals, hospice providers, and inpatient psychiatric hospitals. Providers who do not participate in the program will be

subject to a 2.0 percent reduction in their annual market basket update. (ACA §§3004, 10322)

Qualified employers, insurance groups, and consumer groups will be able to utilize Medicare data to create report cards to measure the quality standards of physicians and hospitals, pursuant to ACA §10332. By allowing qualified entities to access the CMS claims database, these organizations could identify high quality providers and assist consumer decision-making with online tools, increasing transparency and accountability in the health care system. The database contains information regarding approximately 47 million beneficiaries and every participating physician and hospital. Pursuant to a request by the American Medical Association, CMS will evaluate the analytical methods proposed by groups wanting to use the data before they are given access. Additionally, the organizations must pay an access fee and meet other requirements to qualify. [Final rule, *76 FR 76542*, December 7, 2011.]

CMS has issued several notices with specific forms that providers must use to provide this quality information. [Notice, *77 FR 32977*, June 4, 2012; Notice, *76 FR 81503*, December 28, 2011; Notice, *76 FR 73649*, November 29, 2011; Notice, *76 FR 54776*, September 2, 2011.

[LEA ¶733]

The Secretary of HHS has been provided $20 million for each of fiscal years 2010 through 2014 to support a consensus-based entity whose responsibility it will be to develop multi-stakeholder groups and facilitate the groups' input on the endorsement and use of endorsed and non-endorsed quality measures for reporting performance information to the public and in health care programs. (ACA §§3014, 10304, 10322(b))

HHS officials told the Government Accountability Office (GAO) that it planned to obligate approximately $10 million per year for the NQF contract, beginning in 2011, and that they may extend the contract through fiscal year 2014. [*GAO Report*, *GAO-12-136*, January 13, 2012.]