



So.... Anything new Happen in Healthcare Law Recently?

A Discussion of PPACA and its Rural Health Impacts



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How Did We Get Here?

- 11/7/09 Houses passes its reform bill by vote of 220-215, including public option
- 12/24/09 Senate passes its reform bill by vote of 60-39, without public option
- 1/19/10 Scott Brown wins Mass. Election 
- 3/21/10 House approves reconciliation bill
- 3/23/10 President signs PPACA
- 3/25/10 Senate passes reconciliation bill
- 3/30/10 President signs HCERA 

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Leaving Us With

- Patient Protection and Affordable Care Act
 - HR 3590
 - 906 pages single spaced
 - Later sections amend earlier sections
- Health Care and Education Reconciliation Act of 2010
 - HR 4872
 - 148 pages double spaced
 - Amends some of PPACA, including some of PPACA's amendments to PPACA....



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■ ■ ■ Table of Contents

- PPACA Titles
 - Quality Affordable HC for All Americans
 - Role of Public Programs
 - Improving the Quality & Efficiency of HC
 - Prevention of Chronic Disease & Improving Public Health
 - HC Workforce
 - Transparency & Program Integrity
 - Improving Access to Innovative Medical Therapies
 - CLASS Act
 - Revenue Provisions
 - Strengthening Quality, Affordable HC for All Americans

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■ ■ ■ What We Will Cover

- Introduction to HC Reform Law
- Overview of Some Provisions Affecting All HC Providers
 - Employer Provisions
 - Individual Mandate
 - Hospital 501(c)(3) Requirements
- Provisions of Particular Interest to Rural HC
 - Medicaid expansions
 - 340B Expansions
 - Rural Medicare Changes (CAHs, etc.)
 - RHC/FQHC Items, and more....



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■ ■ ■ What We Will Not Cover

- Health Insurance Market Reforms
- Revenue/Tax Provisions
- Packer Draft Picks
- Tax Credits/Subsidies to
 - Individuals and
 - Small Businesses
- Demonstration Projects (unless rural specific)
- Other Stuff We Didn't Figure Out Yet



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High(laugh)lights???

- "Improving Payment Accuracy" – 3131 - 3143
- Excise tax on indoor tanning services - 9007
- Nutrition Labeling of Standard Menu Items at Chain Restaurants – 4205
- "Prohibitions on false statements and representations" - 6601
- Federal coordinating council for comparative effectiveness research – 6032
- Insurance mandate N/A if you are in jail
- All these changes get you depressed?
 - Grants for Centers for Excellence for Depression



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H.R. 3590 at 30,000 feet

- Cong. Budget Office Projections over 10 years:
 - Gross cost at nearly approximately \$940 billion
 - But Reducing budget deficit by \$124 billion due to
 - \$1.064 trillion of spending cuts and new taxes:
 - About 50% spending cuts, including:
 - \$155 billion for hospitals
 - \$150 billion for Medicare Advantage Plans
 - About 50% new taxes, including:
 - \$210 billion high income Medicare taxes
 - \$60 billion fee on health insurers
- BUT: CBO Assumes NO SGR FIX (\$250 billion)



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H.R. 3590 at 30,000 feet

- CBO projects that by 2019 the bill will
 - Reduce the number of uninsured by 32 million
 - From 15% to 5% of population
 - 16 million of those will be Medicaid covered
 - 24 million receiving subsidies via exchanges
 - 23 million nonelderly Americans remaining uninsured → 94% of the nonelderly population



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H.R. 3590 at 30,000 feet

- Individual mandate
- Health Benefit Exchanges
 - premium and cost-sharing credits available to individuals & families between 133-400% of the federal poverty level (the poverty level is \$18,310 for a family of three in 2009)
 - small businesses can also purchase coverage.
- Employer penalties if no health insurance
- Health insurance market reforms
- Expands Medicaid to 133% of the federal poverty level.



Individual Mandate

- 2014 must have Minimum Essential Coverage, unless:
 - Hardship (to be defined)
 - Indian tribe members, unlawful aliens
 - Incarcerated
 - Religious objections/HC Sharing Ministry
- Penalty – tax only – no right to insurance
 - 2014 - > of \$ 95 or 1% of income
 - 2015 - > of \$325 or 2% of income
 - 2016 - > of \$695 or 2.5% income
 - Tax applied on monthly basis



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Individual Mandate

- MEC defined as:
 - Medicare, Medicaid, or CHIP
 - Employer Sponsored Plans
 - Individual plan
 - Other to be defined, including high risk plans, etc
- Minimal definition of actual coverage requirements for MEC
- Refundable HC premium income tax credit
 - Household income between 100%- 400% poverty line
 - Sliding scale – AGI, standard monthly premium



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Increased Coverage - Medicaid

Medicaid coverage for lowest income populations

- New mandatory Medicaid eligibility category
 - Individuals with income ≤ 133% of FPL
 - Not otherwise covered (e.g., infants, children, pregnant women)
- Mandatory Medicaid income eligibility level for children (6 to 19) changes from 100 percent FPL to 133 percent FP
- States have option to provide Medicaid coverage to all non-elderly above 133 percent of FPL
- Begins January 1, 2014

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Increased Coverage - Medicaid

Community First Choice Option

- New optional Medicaid benefit
- Attendant services/supports for Medicaid beneficiaries
 - with disabilities
 - that would otherwise require hospital, nursing facility, or ICF/MR
- Includes
 - "Home or community based" services to assist in daily living tasks
- Excludes
 - room and board, assistive devices, DME, home mods
- Income
 - <= 150% FPL, or State plan income level for eligible patients
- "Agency" (contract) or "Other" (e.g., voucher) Models
- Begins October 1, 2010

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Increased Coverage - Medicaid

State option - Health homes for enrollees with chronic conditions

- State option to enroll Medicaid beneficiaries with chronic conditions into a "health home."
 - Health Homes - Team of health professionals that provide comprehensive set of medical services and care coordination
- FMAP – 90%

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HC Providers as Employers

- Extension of dependent coverage to age 26
 - Unmarried adult child of covered parent
 - Effective plan years beginning after 9/23/10
- Report value of HC benefits on W-2s
 - Effective for benefits in calendar year 2011
- Notice to new hires and current employees
 - Availability of exchanges
 - If employer share is <60% of cost, eligibility for premium tax credit
 - If employee purchases through exchange will lose employer contribution
 - Effective 3/1/2013

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HC Providers as Employers

- No mandate, but in 2014, if >50 FTEs then penalty applies if:
 - Fail to offer minimum essential coverage, or
 - 1+ FTE eligible for premium tax credit (if employer pays <60% of cost)
- Penalty = \$2,000/employee after 1st 30
 - Pro rated monthly
- Full time count =
 - Employees averaging 30+ hours/week
 - Convert part time to FTE using 30/week
 - Average on business days in prior calendar year
 - Exceptions for seasonal workers

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HC Providers as Employers

- 2014 must file new Information Return:
 - Whether full time employees and dependents offered MEC
 - Length of any waiting period
 - Monthly premium for lowest cost option
 - Employer's share of costs
 - Number of full time employees for each month
 - Name, address and SSN of each full time employee and months covered
- If > 200 FTEs automatic enrollment in plan
 - For full time employees
 - Must provide adequate notice to opt out

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Health Insurance Market Reforms

- Bans on denials for pre-existing conditions
- New health plans cover preventive services
- Bans on rescission practices and lifetime limits
- Reporting on medical loss ratios
- Insurance Exchanges – CO-OPs

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Increased Medicare Coverage

Medicare coverage of annual wellness visit

- Annual wellness visit & personalized prevention plan services covered
 - Includes a comprehensive health risk assessment. "May" include:
 - Family history, vitals, detection of cognitive impairment, 5 to 10 year screening schedule, list of risk factors (and list of treatment options with risks/benefits), and others (with more to be listed by HHS)
 - Guidelines to be published
 - Web-based assessment methodology to be developed
 - Payable under PFS (not APCs)
 - No copay or deductible
 - Begins January 1, 2011



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Increased Medicare Coverage

Removal of barriers to preventive services in Medicare

- Coverage of Screening and Preventive Services
 - Pneumonia/flu/Hep B vaccine
 - Mammography
 - OB preventive
 - Colorectal screening
 - Diabetes Training
 - And more
- Fee schedule payments
- No copay or deductible for certain of the covered preventive services
- Begins January 1, 2011



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Community Living Assistance Services and Supports

- **CLASS Act**
- **Voluntary insurance program**
 - For Activities of Daily Living (ADLs)
 - Eating, toileting, transferring, bathing, dressing, continence
- **Benefits**
 - Cash for non-medical services & supports
 - Minimum \$50/month
 - No lifetime limits



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Community Living Assistance Services and Supports

- **Benefit Triggers**
 - Deemed unable to perform minimum number of ADLs
- **Eligible Beneficiary**
 - Paid enrollment premiums for 60 months
 - Substantial Premium Reductions for
 - Students
 - FPL

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New 501(c)(3) Requirements for Hospitals

- Not treated as 501(c)(3) unless satisfy new requirements for:
 - Community Health Needs Assessment
 - Financial Assistance Policy
 - Limitations on Charges
 - Billing & Collection practices
- Penalties for failure to meet:
 - New excise tax of \$50,000 per tax year
 - Loss of exemption ?
 - Immediate – "not treated as ... (c)(3)"
 - Eventually ?



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■ ■ ■ New 501(c)(3) Requirements for Hospitals

- Applies for tax years beginning after 3/23/10
 - CHNA 2 years later
 - So FYEs ending 3/31/11 (2013 for CHNA) or later
- Applies to organizations operating
 - Facility licensed, registered or similarly recognized as a hospital under state law
 - Any other organizations IRS determines has the provision of hospital care as principal function
 - If >1 hospital facility in entity then new requirements apply separately to each facility
- Narrower than tax definition of "hospital"
 - Can include clinics and some SNFs

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■ ■ ■ New 501(c)(3) Requirements for Hospitals

- Community Health Needs Assessment
 - Must conduct at least once every 3 years
 - Must adopt implementation strategy
- CHNA Must
 - Take into account input from persons who represent the broad interests of the community served, including those with special knowledge or expertise in public health
 - Be made widely available to public
 - (including strategy?)



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■ ■ ■ New 501(c)(3) Requirements for Hospitals

- Financial Assistance Policy (written)
 - Eligibility criteria
 - Whether it includes fee or discounted care
 - Basis for calculating charges
 - Method for applying for financial assistance
 - If no separate billing & collection policy then explain actions take for non-payment
 - Measures to widely publicize the policy with the community served
 - Written policy requiring emergency medical care w/o discrimination regardless of eligibility for FAP



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■ ■ ■ New 501(c)(3) Requirements for Hospitals

■ Limitation on Charges

- Limits amounts charged for emergency or other medically necessary care provided to individuals eligible under FAP to:
 - "not more than the lowest amounts charged to individuals who have insurance covering such care, and
 - Prohibits the use of gross charges"



■ Billing & Collection Requirements

- Organization cannot
 - "engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the FAP"



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■ ■ ■ Medicare Payment Changes/Fixes

■ CAH Method II Election Fix

- Election to receive:
 - Cost for TC and
 - 115% of PC for physician services in CAH O/P space
- In FFY 2010 Final Rule CMS changed regulation to state CAHs electing Method II for cost reporting periods beginning on or after 10/1/09 would be paid 100% of costs not 101%
 - Based on statutory interpretation
 - FIs should not have implemented



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■ ■ ■ Medicare Payment Changes/Fixes

■ PPACA 3128 changes statute to clarify 101% CAHs paid for both Method I and II

- Effective retroactively as if included in MMA-2003
- CAHs that rescinded may wish to ask FI about changing back and rebilling

■ Annual election by cost report year

- in writing at least 30 days before beginning of cost-report year
- NOTE – proposed rule for FFY 2011 would change this to one time election that carries over to subsequent years
 - unless revoked by CAH 30 days before start of next cost reporting period
 - Effective for cost reporting periods beginning after 10/1/10



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Medicare Payment Changes/Fixes

Special Status - MDHs

- Payment Advantages
 - 75% of increase from DRG to Hospital Specific Rate
 - HSR based on > of 1982, 1987, 2002
 - Volume Adjustment same as SCH
 - No cap on DSH
- Does NOT get following that SCHs do:
 - Proximity exemption for wage index Reclass
 - 7.1% APC add-on
 - 2% on clinical lab
- Sec. 3124 PPACA. Extension of MDH program
 - Extends the MDH program through October 1, 2012.
 - Previously, ended October 1, 2011

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Medicare Payment Changes/Fixes

Extension of Medicare reasonable costs payments - clinical diagnostic lab tests furnished to hospital patients in certain rural areas

- Reasonable cost reimbursement for Part B clinical diagnostic laboratory services "furnished by"
 - Hospitals with < 50 beds
 - In a rural area
 - July 1, 2010 to July 1, 2011.

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Medicare Payment Changes/Fixes

Extension of payment for technical component of certain physician pathology services

- Independent labs providing services to "Covered Hospitals"
 - Agreement in effect as of July 22, 1999
- Can direct bill Medicare for Anatomic Pathology TC through 2010

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Medicare Payment Changes/Fixes

Elimination of reimbursement sunset for Part B services furnished by certain Indian hospitals and clinics

- Allows IHS or tribal-operated hospital/clinic services to continue to be reimbursed by Medicare Part B
- Effective January 1, 2010

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Medicare Payment Changes/Fixes

Extension of ambulance add-ons

- Extends ambulance fee schedule bonus payments for rural and other areas through the end of 2010.
 - Ground ambulance
 - Urban POP – 2%
 - Rural POP – 3%
- Effective January 1, 2010.

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Medicare Payment Changes/Fixes

"Improvement" [?] to Medicare DSH payments

- Medicare DSH payments reduced
 - To reflect lower uncompensated care costs.
 - DSHs to be paid 25% of otherwise calculated amount; PLUS
 - Amount = product of following three factors
 1. Difference between;
 - Original DSH payment amount; and
 - New DSH amount
 2. 1 minus % of uninsured who are under 65; and
 3. % factor that equals
 - Amount of uncompensated care; divided by
 - Aggregate of uncompensated care for all (d) hospitals
 - Starts FY 2014 - \$36 billion

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Enhanced Enforcement

- Some of cost savings come from enhanced fraud and abuse changes found in the PPACA including:
 - Amending the Federal Stark Law to limit expansion of existing physician-owned hospitals and to prevent future development of physician-owned hospitals unless already under construction.
 - Weakening the "intent" requirement under the criminal health care fraud statute and the federal Anti-Kickback statute (AKS) by establishing that a person need not have actual knowledge of the statutes nor specific intent to commit a violation (eliminating an important check on governmental powers under the laws).
 - Providing for the suspension of Medicare and Medicaid payments during an investigation of a credible allegation of fraud (unless Health and Human Services (HHS) determines there is good cause not to suspend payments).



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Enhanced Enforcement

- Effective 3/23/10 Medicare overpayments must be reported & returned by the later of:
 - 60 days after identification, or
 - Due date for any corresponding cost report.
- Overpayment =
 - "funds a person receives or retains from [Medicare or Medicaid] to which the person, after reconciliation, is not entitled"
 - Report/return to: DHHS, state, FI, carrier or contractor as appropriate.
- Failure to comply may be subject to False Claims



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Deadline for Submitting Medicare Claims

- Shortened to 1 year from date of service
- Applies to DOS on or after 1/1/2010
- For DOS prior to 1/1/2010 claim must be filed by 12/31/2010
- DHHS may specify exceptions



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Medical Education Funding

- Redistribution of FTE CAPs for Medicare DME and IME Payment beginning 7/1/11
 - 65% of unused cap taken away
 - Rural Hospitals <250 beds are exempt
 - Rural hospitals are 2nd tier preference to receive CAP increases
 - Estimates are 900 FTE slots will be reassigned
 - 30% reserved for rural hospitals, and
 - Hospitals in 10 states with highest HPSA % (not WI)

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340B Program Expansions

- 340B Program Benefits Access Expanded by Section 7101
- Compared to AMP (about 20% less than AWP – aka pharmacy sticker price) –
 - Minimum discount of 15.1% for drugs
 - 11% discount for generic and OTCs
 - Entitled to additional discount if price of the drug has increased faster than inflation



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340B Program Expansions

- Prime Vendor Program
 - Access to sub-340B pricing on covered drugs (type of GPO)
- Expansion of Covered Entities
 - Current (Among Others)
 - FQHC
 - "Subsection d" Hospitals
 - Government or Non-Profit with a contract with state or local government to provide care to non-Medicare/caid patient;
 - DSH Payment Percentage \geq 11.75%; and
 - Does not obtain drugs through GPO.



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340B Program Expansions

Expansion of Covered Entities to Include:

- Children's Hospitals (but must meet all requirements applicable to (d) hospitals)
- CAHs
 - Government or Non-Profit with a contract with state or local government to provide care to non-Medicare/caid patients
- SCHs or RRCs
 - Government or Non-Profit with a contract with state or local government to provide care to non-Medicare/caid patient; AND
 - DSH Payment Percentage \geq 8%



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340B Program Expansions

- Modification of GPO Purchasing Limitation
 - Covered outpatient drugs *may be purchased through GPO for new covered entities (but still not subsection (d) hospitals.);*
- Excludes "orphan drugs" for rare diseases purchased by Children's, Critical Access, Rural Referral and Sole Community hospitals.
- Effective: January 1, 2010
- Must apply to HRSA – Office of Pharmacy Affairs and obtain approval



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Quality, Cost and Payment

Hospital value-based purchasing program

- DRG multiplier.
 - Percentage of DRG payment tied to performance on quality measures related to common and high-cost conditions.
- Applies to subsection (d) hospitals.
- Conditions:
 - Acute MI
 - Heart Failure
 - Pneumonia
 - Surgical Infection
 - Healthcare-associated infection
- Applies to discharges on or after October 1, 2012.

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Quality, Cost and Payment

(CONT.) Hospital value-based purchasing program

- Efficiency measures included
 - Adjusted Medicare spending per beneficiary
 - After October 1, 2013
- Funding
 - DRG Payment Reductions
 - Sliding implementation scale
 - 1.0% 2013 up to 1.75% in 2016.
- Application to Rural Hospitals:
 - "The Secretary shall consult with small rural and urban hospitals..."

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Quality, Cost and Payment

Improvements to the PQRI

- Extends through 2014 PQRI program payments
 - Medicare physician quality data reporting incentive payments
- Was through 2010 (2010 incentive - 2% of PFS payments)
 - 2011 - 1.0%
 - 2012-14 - 0.5%
- Will integrate with EHR meaningful use reporting requirements

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Quality, Cost and Payment

Quality reporting for:

- 1) long-term care hospitals,
- 2) inpatient rehabilitation hospitals, and
- 3) hospice programs

- Will require long-term care hospitals, inpatient rehabilitation facilities, hospice and inpatient psych providers to report quality measures.
- Failure to report = 2% reduction in annual market basket update (even if update is 0)
- Beginning FY 2014
- Measures to be published by October 1, 2012

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Health Professional Shortage Area

Why do I care?

- National Health Service Corps LRP
 - Assigned professionals can only be sent to HPSAs
- FQHCs – MUPs
- RHCs
- 10% PFS Bonus Payments
- J-1 Waivers: Waiver of the "return home" requirement (2 year) in return for 3 year HPSA/MUA stay
- CMS proposing to score ALL existing MUA/HPSA upon publication of the Final Rule
- Consider "Governor's HPSA" – only RHC



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HPSA/PSA Bonuses

- Services in HPSA – 10% bonus
- Bonuses, including 115%, cumulative
 - $1.15 \times 1.10 \times 1.05 = 1.3285$
- What about remote physicians?
 - Tele-connections for reads
 - Location of doc or TC service?
 - Not clear – but reasonable position that TC location applies



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Think About HPSA

Criteria:						
State: Kentucky	Description: Primary Medical Care					
County: All Counties	Match: All					
Date of Last Update: All Dates	Status: Designated					
HPSA Score (lower limit): 0	Type: All					
Results: 154 records found.						
Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee. They are not listed separately.						
Search Name	ID	Status	Type	FTE: 1	# Short	Last Updated
001 – Adams County						
Law Income - Adam/Russell Service Area	12-1992190	Designated	Population Group	6	1	02/08/2007
003 – Allen County						
Law Income - Allen	12-1992193	Designated	Population Group	1	13	03/02/2018
005 – Anderson County no HPSAs matching your search were found in this county.						
007 – Ballard County						
Law Income	12-1007	Designated	Single County	2	0	06/12/2008
009 – Barren County no HPSAs matching your search were found in this county.						
011 – Bath County						
Law	12-1011	Designated	Single County	2	1	04/17/2007
Bath County Medical Clinic	12-1992110	Designated	Rural Health Clinic		0	10/07/2008
013 – Bell County						
Law Income	12-1992106	Designated	Rural Health Clinic		0	06/05/2008
015 – Boone County no HPSAs matching your search were found in this county.						
017 – Bourbon County						
Federal Correctional Institution - Ashland	12-1992130	Designated	Correctional Facility	2	21	02/08/2007
021 – Boyle County no HPSAs matching your search were found in this county.						
024 – Bracken County						
Law Income	12-1023	Designated	Single County	1	2	11/18/2008
Bracken County Family Medical Care	12-1992189	Designated	Rural Health Clinic		0	10/11/2008
025 – Breathitt County						
Law Income	12-1992147	Designated	Comprehensive Health Center	6	6	10/05/2002

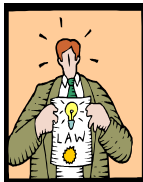
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Proposed HPSA Designation Criteria

■ Status

- 2/29/08 – Proposed MUP/HPSA Rule
- 6/2/08 – Comment period extended
- 6/23/08 – Due to volume of comments, HHS to issue new *Proposed* Rule for further comment prior to issuing the Final Rule
- **PPACA - Sec. 5602**
 - Negotiated rulemaking for development of HPSA/MUSA methodology and criteria by Secretary
 - Target date for publication of *final rule* - July 1, 2011



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Provider/Supplier Issues - Recruitment

Health care workforce loan repayment programs

- New pediatric specialty LRP (in addition to current LRP) – up to \$70,000 (2 years)
 - Pediatric surgery
 - \$30 million for 2010-14
 - Child/adolescent mental/behavioral health
 - \$20 million for 2010-13
- Must serve in HPSA, MUA or MUP
- Appears to be separate from NHSC LRP

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Provider/Supplier Issues - Recruitment

Allied health workforce recruitment and retention programs

- Allied Professional LRP
 - Non-RN
 - Non-PA
 - Non-Physician
 - With certificate or degree in health-care field
- HPSA, MUA, MUP
- Funding? Silent, though some general appropriations in the Bill likely to be used

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Provider/Supplier Issues - Recruitment

Funding for National Health Service Corps

Increases/extends appropriations for NHSC scholarship and loan repayment program:

- 2010 - \$320 million
- 2011 - \$414 million
- 2012 - \$530 million
- 2013 - \$690 million
- 2014 - \$890 million
- 2015 - \$1.15 billion
- 2016 (*and each subsequent year*) – Formula-based increase

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Provider/Supplier Issues - Recruitment

Additional NHSC LRP Funding increases elsewhere in the Bill (10503)

- 2011 - \$290 million (414+ 290 = 610)
- 2012 - \$295 million (530+ 295 = 709)
- 2013 - \$300 million (690+ 300 = 830)
- 2014 - \$305 million (890 + 305 = 995)
- 2015 - \$310 million (1,150 + 310 = 1,460)

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Practitioner Issues – Payment (General)

Expanding access to primary care and general surgery services

Primary Care

- 10% Medicare primary care service payment bonus
 - Eligible providers = Physician (family, internal, geriatric, peds), PA, Clinical nurse specialist who
 - Provided at least 60% primary care services in preceding TBD period;
 - "Primary Care Services" - defined by HCPCS codes
- **In addition to 10% HPSA physician bonus payment**
- NO RURAL REQUIREMENT
- Services between January 1, 2011 and January 1, 2016

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Practitioner Issues – Payment (Rural)

(Cont.) Expanding Access

General Surgery

- 10% Medicare primary care service payment bonus
- Eligible providers – Physician who
 - furnishes the payable service **in a HPSA**
 - Eligible procedures – procedures with 10 or 90 day global period
- In addition to 10% HPSA physician bonus payment
- Services between January 1, 2011 and January 1, 2016
- BNA – Thank your non-rural colleagues!

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Practitioner Issues – Payment (General)

Extension of physician fee schedule mental health add-on

- Increases psychiatric physician fee schedule payment rate by 5%
- Through December 31, 2010

Improved access for certified nurse-midwife services

- Increases payment rate for CNMs from 65% to 100% of PFS rate

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Practitioner Issues – Payment (General)

Extension of exceptions process for Medicare therapy caps

- Extends exception process (medically necessary) for OT/PT therapy cap (\$1,860) until December 31, 2010

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Practitioner Issues - General

Permitting PAs to order post-Hospital extended care services

- PAs will be permitted to order skilled nursing care services. Includes:
 - Inpatient Psych
 - SNF
 - Home Health
- Effective January 1, 2011



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Supplier Issues - DME

Exemption of certain pharmacies from DMEPOS accreditation requirements

- MIPPA –
 - All DMEPOS suppliers were to be accredited by October 1, 2009
 - Would include pharmacies providing DMEPOS, no matter how little
- Now –
 - Certain pharmacies exempt from this requirement:
 - < 5% revenues from DMEPOS
 - Enrolled as supplier for past 5 years
 - Among others
 - BUT Secretary of HHS *may develop pharmacy-specific standards*



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SNF/NF Accountability

Accountability requirements for SNF/NFs

- SNFs required to have in place compliance and ethics program
 - Detect and prevent Medicare compliance violations
 - Promote quality of care
 - Within 36 months of enactment
 - Bigger entities (5+ facilities) to have more strict requirements



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SNF/NF Accountability

(Cont.) Accountability requirements for SNF/NFs

- Required compliance/ethics program components - Must
 - Implement standards and procedures
 - Have specific high-level personnel responsible for compliance standards and procedures
 - Use due care not to delegate to someone "should have known" had a propensity to act criminally



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SNF/NF Accountability

(Cont.) Accountability requirements for SNF/NFs

- Required compliance/ethics program components – Must
 - Take steps to communicate standards effectively
 - Take steps to effectuate program (e.g., monitoring) Consistently enforce standards
 - Take reasonable steps once an offense is detected
 - Periodically reassess the compliance program
- Regulations forthcoming – about 2 years
 - Will 1 year be enough time to implement?



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SNF/NF Accountability

(Cont.) Accountability requirements for SNF/NFs

- HHS Secretary instructed to implement SNF QAPI program
 - By December 31, 2011
 - Direct care staffing information – electronic submission (based on payroll, etc.)
 - Data to include:
 - Category of work
 - Resident census data
 - Employee turnover and tenure
 - Hours of care



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SNF/NF Accountability

Standardized complaint form

- HHS Secretary to develop standardized complaint form
 - Must be available to-
 - Residents
 - Persons acting on residents behalf
 - States directed to establish complaint resolutions process
 - Effective 1 year from data of Enactment

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Rural Health Clinics

- **Location** - Both "rural" and "underserved"
 - **Underserved** – HPSA/MUA
- **Physical Plant** – No restrictions. May be a permanent or mobile location
- **Staffing** – Each RHC must have
 - One or more physicians; and
 - One or more PAs, NPs or CNMs (and on-site and available to see patients 50 percent of the time the clinic is open for patients)
- **Direct Services** - Must provide diagnostic and therapeutic services commonly furnished in physician's office
- **Emergency Services** - Rural Health Clinics must be able to provide "first response" services to common life-threatening injuries and acute illnesses
- **Payment – Per visit rate based on cost (subject to limit)**
- **No service scope limits (payment - not so for facility)**

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Hospital Based RHC

- Exempt from rate/visit if based to < 50 bed hospital
- RHC Services @ cost reimbursement – PC & TC
- Non-RHC services at site billed as hospital services (Facility/TC paid under APCs)
- Certain provider based rules N/A:
 - Name need not include hospital's
 - 35 miles
- Subject to same risk of losing RHC status
- Transfer (CHOW) may accelerate reassessment of RHC/HPSA criteria

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Federally Qualified Health Centers

- Must be located in a MUA
- FQHC must be controlled by board independent from employees and hospital
 - Effectively precludes hospital based status
- Paid same as RHC, but:
 - Eligible for some grant funding
 - Not eligible for HB'd exception to RPV like RHC



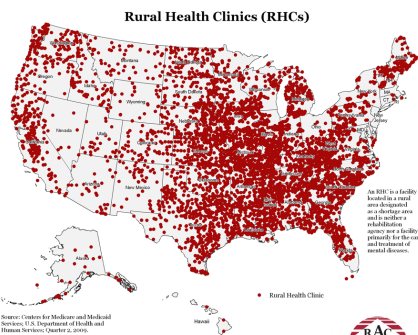
70

Federally Qualified Health Centers



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Federally Qualified Health Centers



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■ ■ ■ RHC/FQHC Changes In CoPs

■ Status

- February 28, 2000 – Proposed Rule
- December 24, 2003 – Final Rule
- September 22, 2006 – Suspended effective Final Rule
 - > 3 years before 2003 Rule was finalized
- June 28, 2008 Proposed Rule – "Re-implementing" December 2003 Final Rule



■ Will PPACA Drive Action... or slow it d o w n ?

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■ ■ ■ Provider Issues – FQHC Services

Medicare FQHC improvements

- Expands scope of covered FQHC preventive services
- Now consistent with new Medicare covered services (e.g., colorectal screening).
- Effective January 1, 2011

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■ ■ ■ Provider Issues – FQHC PPS

(Cont.) Medicare FQHC improvements

- Requires implementation new FQHC PPS – Begins October 1, 2014
 - Payments at 100% of estimated then-current aggregate amount
 - Thereafter updated by
 - MEI – Year 1
 - FQHC Market Basket (or MEI if not available) - thereafter

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Provider Issues – FQHC Funding

Spending for FQHCs

- FQHC Grants Will be going UP (plus other funding - :
 - FY 2010 - \$2.98 Billion
 - FY 2011 - \$3.86 Billion
 - FY 2012 - \$4.99 Billion
 - FY 2013 - \$6.44 Billion
 - FY 2014 - \$7.33 Billion
 - FY 2015 - \$8.33 Billion

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Provider Issues – FQHC Funding

(Cont.) Spending for FQHCs

- Contracting with FQHCs for Provision of Services
 - FQHCs may contract with low volume hospital, CAH, SCH or MDH for delivery of certain primary care services and may pass through grant payments.
 - Requires
 - Nondiscrimination policies
 - Sliding fee scale

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Provider Issues – Other Health Centers

School-based health centers

- New grant program for the development of School-Based Health Clinics
 - \$50 million for FY 2010, 11, 12 and 13
- What is a school-based health center?
 - Located in or near a school facility;
 - Is organized through school, community, and health provider relationships;

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Provider Issues – Other Health Centers

(CONT.) School-based health centers

- What is a school-based health center?
 - Provides primary health services (e.g., basic physical care/referral mental health counseling/referral) to children; and
 - State-based requirements.
 - Is administered by a **sponsoring facility**;

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Provider Issues – Other Health Centers

(CONT.) School-based health centers

- What is a "Sponsoring Facility?"
 - Hospital
 - Community health center
 - Nonprofit health care agency
 - School or school system.
 - Program administered by IHS/BIA or operated a tribal organization
- Grant funded FQHCs not eligible to receive related grants.
 - No mentioned of look-alikes

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Provider Issues – Other Health Centers

Nurse-managed health clinics

- New \$50 million grant program to support nurse-managed health clinics
- Must provide FQHC primary services (e.g., prenatal, immunization, preventive dental, etc.)
- A "nurse-practice arrangement, management by advanced practice nurses" that is "associated" with
 - School, college, university or department of nursing, [FQHC], or independent nonprofit health or social services agency.

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■ ■ ■ Pilot Programs

- National pilot program on payment bundling
- Design and implementation of regionalized systems for emergency care
- Healthy aging, living well; evaluation of community-based prevention and wellness programs for Medicare beneficiaries
- Pilot testing pay-for-performance programs for certain Medicare providers



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■ ■ ■ Demonstration Programs

- Wellness Program
- Money Follows the Person Rebalancing
- 5-year period dual eligible beneficiary waivers
- Evaluation of integrated care around a hospitalization
- Medicaid global payment system
- Pediatric Accountable Care Organizations
- Medicaid emergency psychiatric demonstration



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■ ■ ■ Demonstration Programs

- Independence at home
- Extension of gainsharing
- Treatment of certain complex diagnostic lab tests
- **Extension of the Rural Community Hospital Demonstration Program**
- **Improvements to demonstration project on community health integration models in certain rural counties**
- Payment adjustments for home health care
- Medicare hospice concurrent care



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■ ■ ■ Demonstration Programs

- Making senior housing facility demonstration permanent
- Demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals
- Patient navigator program
- Oral healthcare prevention activities
- Immunizations
- Individualized wellness plans
- Funding for childhood obesity



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■ ■ ■ Demonstration Programs

- Alternative dental health care providers
- Grants for family nurse practitioner training programs
- Demonstration project to address health professions workforce needs; extension of family-to-family health information centers
- Graduate nurse education
- National independent monitor



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■ ■ ■ Demonstration Programs

- National demonstration projects on culture change and use of information technology in nursing homes
- Sense of the Senate regarding medical malpractice
- Access to affordable care
- State demonstration programs to evaluate alternatives to current medical tort litigation



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THE END

**A Discussion of PPACA and
its Rural Health Impacts**

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