ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

Patient Protection and Affordable Health Care Act
Supplemental Details
April 28, 2010

Mammography and Women's Preventive Health Coverage

- Required of all plans
- No cost sharing or deductibles
- Women's preventive care and screenings included in comprehensive guidelines supported by HRSA, even if beyond those recommended by CDC and USPSTF
- Breast cancer screening, mammography, and prevention services are covered as if the USPSTF November 2009 did not exist.

State Prohibitions on Discriminating Against Health Care Providers

- Affects state any willing provider laws.
- Beginning January 1, 2014, group health plans and health insurers offering group or individual health insurance may not discriminate in terms of participation or coverage against any health care provider acting within the scope of their state license.
- May establish varied payment rates based on quality or performance measures
- May effectively require a plan to reimburse covered items and services provided by any provider authorized by the state and willing to accept the health plan payment rates.
- But plans are not required to contract with all health providers willing to abide by the terms and conditions.
- So plans may have to cover the items and services, but don't have to contract with the provider.

Grandfathered Plans

- Must comply with restrictions on:
  - Waiting periods
  - Lifetime limits
  - Rescissions
  - Extension of dependent coverage
  - Uniform explanation of coverage
  - Loss ratio reports and premium rebates
- Group grandfather plans must also comply with restrictions on:
  - Annual limits
  - Pre-existing conditions

Essential Benefits Package, Including Scope Of Maternity And Newborn Care

- Dept of Labor is required to survey employer sponsored plans to determine the scope of benefits provided in a typical plan, and report to the Secretary of HHS.

Abortion Coverage

- Restrictions apply only to plans in the Exchange and only to abortion services beyond Hyde (rape, incest, or endangerment to the mother's life)
- Provider and facility discrimination prohibition applies only to providers and facilities unwilling to provide abortions

- A State may pass a law outlawing any abortion coverage in the Exchange.

Medicaid Coverage of Free Standing Birth Center Services

- Pre-HCR law authorized payments to hospitals and other facilities operated by and under the supervision of a physician, no payment for services of an ambulatory center lawfully operated by other health professionals.
- This law allows Medicaid payments to free standing birth centers not operated by or under the supervision of a physician.

New Optional Coverage for Family Planning

- Allows coverage of family planning for individuals of childbearing age who are not pregnant, with incomes up to the limits currently applied to pregnant women under Medicaid.
- Presumptive eligibility
- State can count only the individual's income, and disregard the income of others in the household, including a spouse or parent
- Medicaid payments to primary care physicians for family planning services
    - Brings family med, internal med, and peds up to 100% of Medicare payment rates in 2013 and 2014 at full federal match.

Postpartum Depression

- NIMH is encouraged (not required) to conduct a longitudinal study from 2010 – 2019 on the mental health consequences, positive and negative, on women of resolving pregnancies, both intended and unintended, in various ways.

Personal Responsibility Education

- From 2010 – 2014, each state will receive funds for personal responsibility education programs targeted to reducing pregnancy rates in youths.
- Educational programs must include both abstinence and contraception
- And three or more adulthood preparation subjects.

Restoration of Abstinence Only Education Funding

- Funding is extended through 2014

Physician Fee Schedule Value-Based Payment Modifier

- Budget neutral payment system to reallocate Medicare payment among physicians, higher payments for high quality, low cost physicians.
- Begins with 2015 Medicare payments.
- Applies only to physicians in 2015. Other health professionals in 2017.

Improvements to the Physician Quality Reporting System (PQRI)

- Beginning in 2012, PQRI participation becomes a meaningful use qualifier for EHR grants.
- In 2011- 2014, physicians who complete the MOC are eligible for an additional one percent bonus in 2011 and 0.5% bonus in 2012 to 2014.
    - Data on the physician's quality measures would be submitted on the physician's behalf by the MOC program.
- After 2014, the Secretary can add MOC completion to the quality measures used for the value-based payment modifier.

New Center for Medicare and Medicaid Innovation to Test New Payment Models

- Models to be selected may include:
    - Patient centered medical homes
    - Encouraging physicians to transition from fee-for-service to salary-based payment
    - State all payer payment systems.
- All models must be budget neutral or reduce costs.

Establishing Community Health Teams to Support the Patient-Centered Medical Home

- Grants and contracts for local interdisciplinary teams to support services and provide capitated payments to primary care providers including ob-gyns.
- Primary care providers in this program function as medical homes, and are responsible for addressing patient personal health care needs. The team links the medical home to community support services for those patients.
- Ob-gyns can also be members of the team, providing support services to medical homes.

Improved Access for Nurse Midwife Services

- Medicare payments are increased from 65 to 100% of the payment amount for the same services provided by a physician.
- Effective January 1, 2011.

Misvalued Codes Under the Physician Fee Schedule

- Effective immediately, the Secretary has the authority to change relative values, and payments, for services, with special attention to
    - Services with high growth rates
    - Where there has been substantial changes in the practice expense or work components
    - Where new technology has reduced the cost of services
    - Where Multiple codes are frequently billed for a single service
    - Codes which have not be reviewed since implementation of the RBRVS.
- Secretary can increase and decrease cost values.

Independent Medicare Advisory Board

- Purpose: to reduce the per capital rate of growth in Medicare spending.
- First, the CMS Actuary determines if the rate of growth is above a predicted rate.
- If that determination is found:
    - The Board submits a proposal to Congress with ways to reduce spending to the expected rate.
    - The proposal cannot include rationing, raising revenues or premiums, increasing beneficiary cost-sharing, restricting benefits, or modifying eligibility criteria.
    - Recommendations submitted before 2018 cannot include payment cuts for providers already scheduled for cuts, as with the SGR.
    - Recommendations must all be Medicare-related, no outside sources of revenue.

    - Recommendations must reduce costs while maintaining or enhancing beneficiary access to quality care.
- The law sets out a very explicit legislative procedure for Congressional consideration of the Board's recommendations
    - Prohibition of filibuster.
    - Any changes to this part of the law requires 3/5 vote in the Senate.
    - Any Congressional changes to the Board's recommendations must accomplish as least the same cost reduction goals and adhere to the same recommendation requirements.
    - No extraneous amendments.
    - Congressional Committees have to mark up and report out the Board's recommendation by April 1 of each year. If the Committee(s) don't meet the deadline, the Board's recommendations go straight to the floors.
    - Strict limits in statute on debate time limits.
- The Secretary is required to implement the recommendations, either as submitted by the Board or as appropriately amended by Congress, on August 15 of each year.
    - And can use interim final rulemaking power to implement the recommendations.
    - No administrative or judicial review of the Secretary's implementation.
- Congress may only discontinue the Board by a joint resolution introduced before February 1, 2017.
    - No filibuster.
    - 3/5 majority of both Houses.
- Board members
    - Majority must be not involved in providing care.
    - Must not be working or engaged in business or vocation outside the Board.
    - 6 year terms.
    - May only be removed by the President for neglect of duty or malfeasance.

Breast-Health Awareness in Young Women

- NIH will conduct research to develop and test screening measures for prevention and early detection of breast cancer in women ages 15 to 44.

National Health Care Workforce Commission

- By April 1, 2011 and annually thereafter, the Commission reports to Congress on ways to align Medicare and Medicaid GME policies with national workforce goals which emphasize primary care.

Assessment of the Health Care Workforce

- Creates a new National Center for Health Workforce Analysis that collects labor and workforce statistical information and provides analyses and reports.
- To provide comprehensive information to Congress about how best to align existing federal health care workforce resources with national needs, including more primary care.
- Includes an advisory committee on primary care and one on GME.

In-Office Ancillary Services Exception for Certain Imaging Services

- Disclosure requirements apply to MRI, CT, PET, and any other designated imaging the Secretary deems appropriate, and can include ultrasound at her discretion.

Provider Screening and Other Enrollment Requires Under Medicare, Medicaid, and CHIP

- The Secretary will establish screening procedures, and levels of screening will vary according to risk of fraud in that health care sector.

- Screening must include criminal background checks, fingerprinting, unscheduled and unannounced site visits, and database checks.
- Screening takes place upon enrollment and revalidation of enrollment in these programs.
- New physicians screening begins on March 23, 2011.
- Existing physicians screening begins on March 23, 2012.
- Physicians will pay a $200 screening fee in 2010, increasing in 2011 and thereafter by the consumer price index (CPI).
- The Secretary can waive the fee for Medicaid providers if the fee is a barrier to beneficiary access.
- New providers will be subject to a provisional period of between 30 days and one year of enhanced oversight, including prepayment review and payment caps.