Summary of Health Care Reform Provisions Affecting Home Care

January 1, 2010 (proposed extension to January 1, 2011 by regulation)	**Sec. 6407. Face to face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare; Sec. 10605 of Manager's Amendment. Certain other providers permitted to conduct face to face encounter for home health services.** Face-to-face physician encounter requirement (including telehealth encounter) with patients within a reasonable timeframe as determined by the Secretary; nurse practitioners, advanced practice nurses, and physician assistants may substitute for physicians to meet the face-to-face encounter requirement.
January 1, 2010	**Sec. 6406. Requirement for Physicians to Provide Documentation on Referrals to Programs at High Risk of Waste and Abuse.** Physician must maintain and provide access to documentation on Medicare home health referrals if requested. Home health agencies must maintain and provide access to documentation of certification of Medicare home health services if requested.
April 1, 2010	**Sec. 3131. Payment Adjustment for Home Health Care Sec. 3131(c). Application of the Medicare Rural Home Health Add-on Policy.** 3% rural add-on for episodes and visits ending on or after April 1, 2010 and before January 1, 2016.
July 1, 2010 (regulation out July 6)	**Sec. 6405 Physicians who order items or services required to be Medicare enrolled physicians or eligible professionals; Sec. 10604 of Manager's Amendment. Technical Correction to Section 6405.** Medicare enrolled physician requirement regarding care plan certification
September 30, 2010	**Sec. 5101. National Health Care Workforce Commission.** Establishes commission to review health care workforce and projected workforce needs.

October 1, 2010	**Sec. 2401. Community First Choice Option.** Expanded Medicaid home care through agencies and self-directed care.
October 1, 2010	**Sec. 2402. Removal of barriers to Home and Community based Services.** Expanded rebalancing requirements and waiver authority and removal of restrictions on waivers.
October 1, 2010	**Sec. 2403. Money Follows the Person Rebalancing Demonstration.** Extension through September 2016.
2010	**Sec. 6401. Provider Screening and other enrollment requirements under Medicare, Medicaid, and CHIP.** Require background screening and credentialing of provider and supplier owners and managers, require compliance plans, gives CMS the authority to impose a temporary moratorium on new providers
2010	**Sec. 3502. Establish Community Health Teams to Support Patient-Centered Medical Home.** Grants to community-based interdisciplinary, interprofessional teams to support primary care practices; includes chronic care management.
2010	**Sec. 6201. Nationwide program for National and State background checks on direct patient access employees of long-term care facilities and providers.** Extends existing pilot program for background checks on direct patient access employees of long-term care facilities and providers to a nationwide program (based on individual state choice of participation). Definition of long-term care facility or provider includes providers of home care.
2010 - 2014	**Sec. 4201. Community Transformation Grants** Competitive grants to State and local governmental agencies and community based organizations for the implementation, evaluation and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities and develop a stronger evidence-base of effective prevention programming. Authorized

	appropriations for 2010 – 2014.
2010	**Sec. 10501. National Diabetes Prevention Program** Grants to entities determined by the Secretary for community-based diabetes prevention programs.
2010 - 2014	**Sec. 4202. Healthy Aging, Living Well; Evaluation of Community-Based Prevention and Wellness Programs for Medicare Beneficiaries** Grants to state or local health departments and Indian tribes to carry out 5-year pilot programs to provide public health community interventions, screenings, and clinical referrals for individuals between 55 and 64.
2010	**Sec. 4204. Demonstration Program to Improve Immunization Coverage.** Demonstration program awarding grants to states to improve the provision of recommended immunizations through the use of evidence-based, population-based interventions for high-risk populations.
2010 - 2015	**Sec. 2951. Grants for Early Childhood Home Visitation.** Grants to states to establish quantifiable and measurable 3 and 5 year benchmarks to demonstrate improvements in maternal and newborn health, prevention of child injuries and abuse, improvements in family economic self-sufficiency and school readiness/achievement, and improvements in coordination and referrals between other community resources.
2010 (authorized for five years, with option of additional five years)	**Sec. 2601. Medicaid Waiver Demonstration Projects for Dual Eligibles.** Medicaid waivers for coordinating care for dual eligible beneficiaries.
January 1, 2011	**Sec. 2703. Health Homes for Chronically Ill Patients** Planning grants to states to develop a new state plan option to permit Medicaid enrollees with at least two chronic conditions,

	one condition and risk of developing another, or at least a serious and persistent mental health condition to select a designated provider (could include a home health agency), a team of healthcare professionals operating with such a provider, or a health team as the individual's health home for purposes of providing the individual with health home services. States taking up option provided with 90 percent of FMAP for two years for home health related services, including care management, care coordination, and health promotion.
January 1, 2011	**Sec. 3021. Establish a Center for Medicare and Medicaid Innovation within CMS.** Opportunities for chronic care and other initiatives includes funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams (xiv). Telehealth advancement opportunities through new CMS Innovations Center but no guarantee.
January 1, 2011	**Sec. 3026. Community Based Transitions Program** Funding for hospitals with high admission rates and community-based organizations that improve care transition services for high risk Medicare beneficiaries. ($500 million total.)
January 1, 2011	**Sec. 3131. Payment Adjustment for Home Health Care Sec. 3131(b). Program Specific Outlier Cap.** Beginning in 2011, cap total outliers at 2.5%; impose individual agency outlier cap of 10%.
January 1, 2011	**Sec. 3401 Revision of certain market basket updates and incorporation of productivity improvements into market basket updates that do not already incorporate such improvements.; Sec. 10319 of Manager's Amendment. Revisions to market basket adjustments.** Reduce home health market basket update by 1 percentage point in 2011, 2012, and 2013.
October 1, 2011	**Sec. 3006. Plans for a Value-Based Purchasing Program for Skilled Nursing Facilities and Home Health Agencies.** Secretary of HHS shall submit plan for value—based purchasing program for home health agencies to Congress by Oct. 1, 2011.

2011 (enroll) 2016 (coverage begins)	**Sec. 8001. Community Living Assistance Services and Supports Act (CLASS Act).** Establish voluntary national home and community-based long term care insurance program. Beneficiaries vest after 5 years paying premiums.
January 1, 2012	**Sec. 3024. Independence at Home demonstration program.** Tests a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams.
January 1, 2012 – December 31, 2016	**Sec. 2704. Bundled Payments Medicaid.** Medicaid demonstration project in 8 states to pay bundled payments to hospitals for episodes of care that include hospitalizations.
January 1, 2012	**Sec. 3022. Accountable Care Organizations.** Establishes a shared savings program that rewards Accountable Care Organizations (ACO) that take responsibility for the costs and quality of care. ACO's may include groups of health care providers.
October 1, 2012	**Sec. 3025. Hospital Readmissions and Reductions Program.** Reduce hospital payments for readmissions.
January 1, 2013	**Sec. 3023. National Pilot Program on Payment Bundling.** Directs HHS Secretary to develop a national, voluntary pilot program encouraging bundled payment models for hospitals, doctors, and post-acute care providers. Entities including a hospital, a physician group, a SNF and a home health agency may apply to participate. Requires the Secretary to establish this program by January 1, 2013 for a period of five years. Before January 1, 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will result in improving the quality of patient care and reducing spending.
January 1, 2014	**Sec. 3131. Payment Adjustment for Home Health Care; Sec. 10315 of Manager's Amendment. Revisions to Home Health Provisions.** Rebase starting in 2014 phasing in through 2017; rebasing adjustment limited to no more than 3.5% reduction per year.

January 1, 2014 – December 31, 2018	**Sec. 2404. Protection for Recipients of Home and Community Based Services Against Spousal Impoverishment.** Spousal impoverishment protection for home care eligibility.
January 1, 2014	**Sec. 1513. Shared Responsibility for Employers.** Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. (Effective January 1, 2014) Exempt employers with 50 or fewer employees from any of the above penalties.
January 1, 2014	**Sec. 10108. Free Choice Vouchers.** Require employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400% FPL who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange. (Effective January 1, 2014) The term 'full-time employee' means an employee who is employed on average at least 30 hours of service per week.
January 15, 2014	**Sec. 3403. Independent Medicare Advisory Board; Sec. 10320 of Manager's Amendment. Expansion of the Scope of, and additional improvements to, the Independent Medicare Advisory Board.** Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning January 15, 2014, in years when Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or

	cost-sharing standards.
March 1, 2014	**Sec. 3131(d). Study and Report on the Developments of the Home Health Payment Reforms In Order to Ensure Access to Care and Quality Services.** By March 1, 2014, HHS Secretary must report on home health rebasing and impact on access and quality.
March 1, 2014	**Sec. 10315 (b). Revisions to Home Health Care Provisions.** HHS Study and Report: By March 1, 2014, HHS must report results of a study with recommendations for legislative and administrative action, regarding home health agency costs for care provided to low-income beneficiaries or those in medically underserved areas, and those with varying levels of severity.
2014	**Sec. 1302. Essential Health Benefits Requirements** Secretary shall define essential health benefits with respect to any health plan; provides for notice and opportunity for public comment.
January 1, 2015	**Sec. 3131(2)(B). MedPAC Study and Report.** MedPAC shall report by Jan. 1, 2015, on impact of rebasing.
January 1, 2015	**Sec. 3401. Revision of Certain Market Basket Updates and Incorporation of Productivity Improvements into Market Basket Updates That Do Not Already Incorporate Such Improvements.** Annual productivity adjustment (estimated 1 percentage point reduction) beginning 2015.
January 1, 2015	**Sec. 10315 (b) Revisions to Home Health Care Provisions.** Medicare Demonstration Project: HHS Secretary may provide for a four-year (beginning no later than January 1, 2015) $500M demonstration project to test whether making payment adjustments based on the study substantially improve access to care for patients with high severity levels of illness or for low-income or underserved Medicare beneficiaries.