The Patient Protection and Affordable Care Act
All CMS Provisions -- As of December 10, 2010

Section of the Law	Subject	Implementing Document	Release Date
1001 (1of9)	**Amendments to the Public Health Service Act -- *2711 -- No lifetime or annual limits*** – Prohibits all loans from establishing lifetime or unreasonable annual limits on the dollar value of benefits. With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits as determined by the Secretary. Requires plans to provide a summary of coverage to applicants and policyholders or certificate holders, as well as to enrollees. ***RB -- 2301 -- Insurance Reforms --*** Extends the prohibition of lifetime limits and a requirement to provide coverage for non-dependent children up to age 26 to all existing health insurance plans starting six months after enactment. For group health plans, prohibits pre-existing condition exclusions in 2014, restricts annual limits beginning six months after enactment, and prohibits them starting in 2014.	Regulation-Omnibus Health Insurance Market Interim Final Rule (Preventive Services) Guidance	**6-22-10** **5-10-10**

RB = Reconciliation bill

The Patient Protection and Affordable Care Act
All CMS Provisions -- As of December 10, 2010

Section of the Law	Subject	Implementing Document	Release Date
1001 (2of9)	**Amendments to the Public Health Service Act – *2712 --Prohibition on rescissions*** -- Prohibits all plans from rescinding coverage except in instances of fraud or misrepresentation. ***RB -- 2301 -- Insurance Reforms*** -- Extends the prohibition on rescissions and a requirement to provide coverage for non-dependent children up to age 26 to all existing health insurance plans starting six months after enactment.	Regulation-Omnibus Health Insurance Market Interim Final Rule (Preventive Services) Guidance	**6-22-10** **5-10-10**
1001 (3of9)	**Amendments to the Public Health Service Act -- *2713 -- Coverage of preventive health services*** -- Requires all plans to cover preventive services and immunizations recommended by the U.S. Preventive Services Task Force and the CDC, and certain child preventive services recommended by the Health Resources and Services Administration, without any cost-sharing.	Regulation-Omnibus Health Insurance Market Interim Final Rule (Preventive Services) Guidance	**7-14-10** **5-10-10**
1001 (4of9)	**Amendments to the Public Health Service Act -- *2714 -- Extension of dependent coverage*** -- Requires all plans offering dependent coverage to allow unmarried individuals until age 26 to remain on their parents' health insurance. ***RB -- 1004 -- Income definitions*** -- Extends the exclusion from gross income for employer provided health coverage for adult children up to age 26.	Regulation-Omnibus Health Insurance Market Interim Final Rule (Coverage Up to Age 26) Guidance	**5-10-10** **5-10-10**
1001 (5of9)	**Amendments to the Public Health Service Act -- *2715 --Development and utilization of uniform explanation of coverage documents and standardized definitions*** -- Requires the Secretary to develop standards for use by health insurers in compiling and providing an accurate summary of benefits and explanation of coverage. The standards must be in a uniform format, using	Regulation-Omnibus Health Insurance Market Interim Final Rule (Coverage Up to Age 26)	**5-10-10** **5-10-10**

RB = Reconciliation bill

Section of the Law	Subject	Implementing Document	Release Date
	language that is easily understood by the average enrollee, and must include uniform definitions of standard insurance and medical terms. The explanation must also describe any cost-sharing, exceptions, reductions, and limitations on coverage, and examples to illustrate common benefits scenarios.	Guidance	
1001 (6of9)	**Amendments to the Public Health Service Act – 2716** -- ***Prohibition on discrimination in favor of highly compensated individuals*** **--** Employers that provide health coverage will be prohibited from limiting eligibility for coverage based on the wages or salaries of full-time employees. Also, prohibits the required collection of data from employees (specifically gun ownership).	Regulation-Omnibus Health Insurance Market Interim Final Rule (Coverage Up to Age 26) Guidance	**5-10-10** **5-10-10**
1001 (7of9)	**Amendments to the Public Health Service Act -- *2717 -- Ensuring quality of care* --** Requires the Secretary to develop guidelines for use by health insurers to report information on initiatives and programs that improve health outcomes through the use of care coordination and chronic disease management, prevent hospital readmissions and improve patient safety, and promote wellness and health.	Regulation-Omnibus Health Insurance Market Interim Final Rule (Preventive Services) Guidance	**7-14-10** **5-10-10**
1001 (8of9)	**Amendments to the Public Health Service Act -- *2718 -- Bringing down the cost of health care coverage*** -- Requires the Secretary promulgate regulations for enforcing the provisions under this section. Health insurance companies will be required to report publicly the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums including the percentage of total premium revenue that is expended on clinical services, and quality rather than administrative costs. Health insurance companies will be required to refund each enrollee by the amount by which premium revenue expended by the health insurer for non-claims costs exceeds 20 percent in the	Regulation-Omnibus Health Insurance Market Interim Final Rule (Coverage Up to Age 26) Notice--Request for Information on Medical Loss Ratio	**5-10-10** **4-12-10**

Section of the Law	Subject	Implementing Document	Release Date
	group market and 25 percent in the individual market. The requirement to provide a refund expires on December 31, 2013, but the requirement to report percentages continues. Require the Secretary make reports received under this section available to the public on the HHS website.		
1101	**Immediate access to insurance for people with a preexisting condition --** Enacts a temporary insurance program with financial assistance for those who have been uninsured for several months and have a pre-existing condition. Ensures premium rate limits for the newly insured population. Provides up to $5 billion for this program, which terminates when the American Health Benefit Exchanges are operational in 2014. Also establishes a transition to the Exchanges for eligible individuals.	High Risk Pools; Interim Final Rule Guidance -- Letter to States	**5-10-10** **4-30-10**
1102	**Reinsurance for early retirees --** Establishes a temporary reinsurance program to provide reimbursement to participating employment-based plans for part of the cost of providing health benefits to retirees (age 55-64) and their families. The program reimburses participating employment-based plans for 80 percent of the cost of benefits provided per enrollee in excess of $15,000 and below $90,000. The plans are required to use the funds to lower costs borne directly by participants and beneficiaries, and the program incentivizes plans to implement programs and procedures to better manage chronic conditions. The act appropriates $5 billion for this fund and funds are available until expended.	Regulation -- Reinsurance Program for Retirees Interim Final Rule	**05-04-10**

Section of the Law	Subject	Implementing Document	Release Date
1003	**Ensuring that consumers get value for their dollars** -- For plan years beginning in 2010, the Secretary and States will establish a process for the annual review of increases in premiums for health insurance coverage. Requires States to make recommendations to their Exchanges about whether health insurance issuers should be excluded from participation in the Exchanges based on unjustified premium increases. Provides $250 million in funding to States from 2010 until 2014 to assist States in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage and in providing information and recommendations to the Secretary.	Regulation -- Omnibus Health Insurance Market Interim Final Rule(Part 1) Notice--Request for Information on Premium Rate Review Guidance	**5-10-10** **4-30-10** **4-30-10**
1103	**Immediate information that allows consumers to identify affordable coverage options --** Establishes an Internet portal for beneficiaries to easily access affordable and comprehensive coverage options. This information will include eligibility, availability, premium rates, cost sharing, and the percentage of total premium revenues spent on health care, rather than administrative expenses, by the issuer [(including Medicaid) in the State shall be available to small businesses and shall contain information on coverage options.] Clarifies that reinsurance for early retirees applies to plans sponsored by State and local governments for their employees.	Creation of Website Regulation -- Web Portal for Private Plan and Medicaid/CHIP Data Interim Final Rule with Comment	**7-1-10** **4-30-10**
1201 (4of8)	**Amendment to the Public Health Service Act** -- ***Sec. 2704 -- Prohibition of preexisting condition exclusions or other discrimination based on health status*** -- No group health plan or insurer offering group or individual coverage may impose any pre-existing condition exclusion or discriminate against those who have been sick in the past.	Regulation- Omnibus Health Insurance Market Interim Final Rule (Part1) Guidance	**5-10-10** **5-10-10**

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Section of the Law	Subject	Implementing Document	Release Date
1201 (5of8)	**Amendment to the Public Health Service Act -- *Sec. 2705 -- Prohibiting discrimination against individual participants and beneficiaries based on health status* --** No group health plan or insurer offering group or individual coverage may set eligibility rules based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability – including acts of domestic violence or disability. Permits employers to vary insurance premiums by as much as 30 percent for employee participation in certain health promotion and disease prevention programs. Authorizes a 10-State demonstration to apply such a program in the individual market.	Regulation- Omnibus Health Insurance Market Interim Final Rule (Part 1) Guidance	**5-10-10** **5-10-10**
1251	**Preservation of right to maintain existing coverage --** Allows any individual enrolled in any form of health insurance to maintain their coverage as it existed on the date of enactment.	Regulation- Omnibus Health Insurance Market Interim Final Rule (Part 2)	**6-14-10**
1303	**Special rules** -- **Voluntary Choice of Coverage of Abortion Services** -- ***10104*** -- Affirms that States may prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition. Allows plans to elect whether or not to cover abortion. Requires a segregation of funds for subsidy-eligible individuals in plans that cover abortions for which the expenditure of Federal funds appropriated for HHS is not permitted. Subsidy-eligible individuals would make two payments, with one going to an allocation account to be used exclusively for payment of such services. Requires State insurance commissioners to ensure compliance with the requirement to segregate federal funds in accordance with generally accepted accounting requirements and guidance from OMB and GAO. Plans would be required to include in their benefit descriptions whether or not they cover abortion, as they will do for all other benefits. Replaces provider conscience protections with new conscience language that would prohibit qualified health plans	Regulation-Omnibus Health Insurance Market Interim Final Rule (Part1) Guidance	**5-10-10** **5-10-10**

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Section of the Law	Subject	Implementing Document	Release Date
	from discriminating against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions. Federal and State laws regarding abortion are not preempted.		
2001 (2of3)	**Medicaid coverage for the lowest income populations -- *Eligibility* --**Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents). Creates a new mandatory Medicaid eligibility category for all such "newly-eligible" individuals with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. States have the option to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment.	SMD Letter SMD Letter Enhanced Funding Proposed Rule (CMS-2346-P)	**04/09/2010** **7/2/2010** **11/18/10**
2302	**Concurrent care for children --** Allows children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness.	SMD Letter	**09/09/2010**
2303 (1of2)	**State eligibility option for family planning services --** Adds a new optional categorically-needy eligibility group to Medicaid comprised of (1) non-pregnant individuals with income up to the highest level applicable to pregnant women covered under Medicaid or CHIP, and (2) individuals eligible under the standards and processes of existing section 1115 waivers that provide family planning services and supplies. Benefits would be limited to family planning services and supplies, including related medical diagnostic and treatment services.	SMD Letter SMD Letter	**07/2/2010** **7/2/2010**

Section of the Law	Subject	Implementing Document	Release Date
2402 (2of2)	**Removal of barriers to providing home and community-based services --** Removes barriers to providing HCBS 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, and to extend full Medicaid benefits to individuals receiving HCBS under a State plan amendment.	SMD Letter	**08/6/2010**
2403	**Money Follows the Person Rebalancing Demonstration --** Extends the Money Follows the Person Rebalancing Demonstration through September 30, 2016 and changes the eligibility rules for individuals to participate in the demonstration project by requiring that individuals reside in an inpatient facility for not less than 90 consecutive days.	SMD Letter Issue Grant Solicitations Award Planning Grant	**6/22/2010** **7/26/2010** **9/28/2010**
2501 (1of2)	**Prescription drug rebates --** The flat rebate for single source and innovator multiple source outpatient prescription drugs would increase from 15.1 percent to 23.1 percent, except the rebate for clotting factors and outpatient drugs approved by the Food and Drug Administration exclusively for pediatric indications would increase to 17.1 percent. The basic rebate percentage for multi-source, non-innovator drugs would increase from 11 percent to 13 percent. Drug manufacturers would also be required to pay rebates for drugs dispensed to Medicaid beneficiaries who receive care from a Medicaid managed care organization (MCO). Total rebate liability would be limited to 100 percent of the average manufacturer price (AMP). Additional revenue generated by these increases will be remitted to the federal government.	SMD Letter	**04/22/2010**
2501	**Prescription drug rebates --** ***RB -- 1206 -- Drug rebates for new formulations of existing drugs --*** For purposes of applying the additional rebate, narrows the	SMD Letter	**04/22/2010**

RB = Reconciliation bill

Section of the Law	Subject	Implementing Document	Release Date
(2of2)	definition of a new formulation of a drug to a line extension of a single source or innovator multiple source drug that is an oral solid dosage form of the drug.		
2902	**Elimination of sunset for reimbursement for all Medicare Part B services furnished by certain Indian hospitals and clinics --** Removes the sunset provision, allowing IHS and I/T/U services to continue to be reimbursed by Medicare Part B.	Guidance -- JSM Federal Register Notice -- Updates to the OPPS and ASC Payment system Resulting from 2010 HCR provisions	**3/29/2010** **7/2/2010**
3002 (1of4)	**Improvements to the physician quality reporting initiative --** Extends through 2014 payments under the PQRI program, which provide incentives to physicians who report quality data to Medicare. Creates appeals and feedback processes for participating professionals in PQRI. Establishes a participation pathway for physicians completing a qualified Maintenance of Certification program with their specialty board of medicine.	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule Guidance – Change Request	06/25/2010 11/2/2010 11/2/2010
3002 (3of4)	**Improvements to the physician quality reporting initiative --** Requires the Secretary establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures.	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule Guidance – Change Request	06/25/2010 11/2/2010 11/2/2010

Section of the Law	Subject	Implementing Document	Release Date
3003	**Improvements to the physician feedback program –** 1. Expands Medicare's physician resource use feedback program to provide for development of individualized reports by 2012. Reports will compare 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. 2. Develop a public domain episode grouper NLT 1/1/2012	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	06/25/2010 11/2/2010
3027	**Extension of gainsharing demonstration --** The Deficit Reduction Act of 2005 authorized a demonstration to evaluate arrangements between hospitals and physicians designed to improve the quality and efficiency of care provided to beneficiaries. This provision would extend the demonstration through September 30, 2011 and ***extend the date for the final report to Congress on the demonstration to September 30, 2012.*** It would also authorize an additional $1.6 million in FY2010 for carrying out the demonstration.	Contract modification	**05-01-10**
3102 (1of3)	**Extension of the work geographic index floor and revisions to the practice expense geographic adjustment under the Medicare physician fee schedule --** Extends a floor on geographic adjustments to the work portion of the fee schedule through the end of 2010, with the effect of increasing practitioner fees in rural areas. ***RB -- 1108 -- PE GPCI ADJUSTMENT FOR 2010 --*** Requires that for services furnished during 2010, the employee wage and rent portions of the practice expense geographic index reflect 1/2 of the difference between the relative costs	Guidance – Change Request Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**5/10/010** **06/25/2010** 11/2/2010

RB = Reconciliation bill

Section of the Law	Subject	Implementing Document	Release Date
	of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.		
3102 (2of3)	**Extension of the work geographic index floor and revisions to the practice expense geographic adjustment under the Medicare physician fee schedule --** Provides immediate relief to areas negatively impacted by the geographic adjustment for practice expenses, and requires the Secretary of HHS to improve the methodology for calculating practice expense adjustments beginning in 2012.	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**06/25/2010** 11/2/2010
3102 (3of3)	**Extension of the work geographic index floor and revisions to the practice expense geographic adjustment under the Medicare physician fee schedule --** ***10324 -- Protections for frontier states*** **–** Provides that for purposes of payment for services furnished in a frontier State on or after January 1, 2011, after calculating the practice expense index the Secretary is required to increase any such index to 1.00 if such index would otherwise be less that 1.00.	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**06/25/2010** 11/2/2010
3103	**Extension of exceptions process for Medicare therapy caps --** Extends the process allowing exceptions to limitations on medically necessary therapy until December 31, 2010.	Guidance – Change Request /JSM Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**03/29/2010** **06/25/2010** **11/2/2010**

Section of the Law	Subject	Implementing Document	Release Date
3104	**Extension of payment for technical component of certain physician pathology services --** Extends a provision that directly reimburses qualified rural hospitals for certain clinical laboratory services through the end of 2010.	Guidance -- JSM Guidance -- Change request Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**03/29/2010** **4/9/2010** **06/25/2010** **11/2/2010**
3105	**Extension of ambulance add-ons --** Extends bonus payments made by Medicare for ground and air ambulance services in rural and other areas 1-1-11.	Guidance -- JSM Guidance -- Change request Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**03/29/2010** **4/9/2010** **06/25/2010** **11/2/2010**
3106	**Extension of certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities --** Extends Sections 114 (c) and (d) of the Medicare, Medicaid and SCHIP Extension Act of 2007 by two years.	Federal Register Notice -- Changes to the IPPS Resulting from 2010 HCR Provisions Regulation – IPPS Final Rule	**05/21/10** **07/30/2010**

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Section of the Law	Subject	Implementing Document	Release Date
	10312-- amd'd		
3107	**Extension of physician fee schedule mental health add-on --** Increases the payment rate for psychiatric services by 5 percent for two years, through the end of 2010.	Guidance -- Change request Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**5/10/2010** **6/25/2010** **11/2/2010**
3108	**Permitting physician assistants to order post-hospital extended care services --** Authorizes clinical nurses or physician assistants to order skilled nursing care services in the Medicare program beginning in 2011.	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**6/25/2010** **11/2/2010**
3109	**Exemption of certain pharmacies from accreditation requirements --** Allows pharmacies which meet certain criteria, including having less than 5 percent of revenues from Medicare DMEPOS billings for the past 3 years, to be exempt from accreditation requirements until the Secretary of HHS develops pharmacy-specific standards.	Fact Sheet Guidance -- Change Request	**7/7/2010** **6/25/2010**

Section of the Law	Subject	Implementing Document	Release Date
3111 (1of2)	**Payment for bone density tests --** Restores payment for dual-energy x-ray absorptiometry (DXA) services furnished during 2010 and 2011 to 70 percent of the Medicare rate paid in 2006.	Guidance -- Change Request Guidance -- Change Request Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**5/10/2010** **5/28/10** **06/25/2010** **11/2/2010**
3112	**Revision to the Medicare Improvement Fund--** Eliminates the remaining funds in the Medicare Improvement Fund.	Self-Implementing	N/A
3114	**Improved access for certified nurse-midwife services --** Increases the payment rate for certified nurse midwives for covered services from 65 percent of the rate that would be paid were a physician performing a service to the full rate.	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**06/25/2010** **11/2/2010**
3121	**Extension of outpatient hold harmless provision --** Extends the existing outpatient hold harmless provision through the end of FY2010 and would allow Sole Community Hospitals with more than 100 beds to also be eligible to receive this adjustment through the end of FY2010.	Guidance – JSM Regulation – OPPS Proposed Rule Regulation – OPPS Final Rule	**03/31/2010** **07/2/2010** 11/2/2010

Section of the Law	Subject	Implementing Document	Release Date
3122	**Extension of Reasonable Cost Payment for Clinical Lab Tests Furnished to Hospitals Patients in Certain Rural Areas --** Re-institutes reasonable cost payment for clinical lab tests performed by hospitals with fewer than 50 beds in qualified rural areas as part of their outpatient services for cost reporting periods beginning on or after July 1, 2010, through June 30, 2011. This could affect services performed as late as June 30, 2012.	Guidance – JSM Guidance – Change Request Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**03/29/2010** **4/2/2010** **06/25/2010** 11/2/2010
3123	**Extension of the Rural Community Hospital Demonstration Program --** Extends the program for five years and expands eligible sites to additional States and additional rural hospitals. ***Sec. 10313 -- Revisions to the extension for the Rural Community Hospital demonstration program*** -- Makes adjustments to payment levels provided within the demonstration program.	Regulation –Changes to the IPPS Resulting from 2011 HCR Proposed Rule Regulation – IPPS Final Rule	**05/21/2010** **07/30/2010**
3124	**Extension of the Medicare-dependent hospital (MDH) program --** Extends the Medicare-dependent hospital program by one year through October 1, 2012. It would also require HHS to study whether certain urban hospitals should qualify for the MDH program.	Regulation –Changes to the IPPS Resulting from 2011 HCR Proposed Rule Regulation – IPPS Final Rule	**05/21/2010** **07/30/2010**

Section of the Law	Subject	Implementing Document	Release Date
3124	**Extension of the Medicare-dependent hospital (MDH) program --** Extends the Medicare-dependent hospital program by one year through October 1, 2012. It would also require HHS to study whether certain urban hospitals should qualify for the MDH program.	Regulation –Changes to the IPPS Resulting from 2011 HCR Proposed Rule Regulation – IPPS Final Rule	**05/21/2010** **07/30/2010**
3125	**Temporary improvements to the Medicare inpatient hospital payment adjustment for low-volume hospitals --** Expands the program providing a temporary adjustment to inpatient hospital payments for certain low-volume hospitals through FY2012 and would modify eligibility requirements regarding distance from another facility and number of eligible discharges. ***Sec. 10314 -- Adjustment to low-volume hospital provision*** -- Increases threshold for eligible hospitals from 1,500 Medicare Part A discharges per year to 1,600 per year.	Regulation –Changes to the IPPS Resulting from 2011 HCR Proposed Rule Regulation – IPPS Final Rule	**05/21/2010** **07/30/2010**
3128	**Technical correction related to critical access hospital services --** Clarifies that CAHs can continue to be eligible to receive 101 percent of reasonable costs for providing outpatient care regardless of eligible billing method the facility uses and for providing qualifying ambulance services. *(as if included in MMA of 2003)*	Regulation –Changes to the IPPS Resulting from 2011 HCR Proposed Rule Regulation – IPPS Final Rule	**05/21/2010** **07/30/2010**

Section of the Law	Subject	Implementing Document	Release Date
3131 (2of7)	**Payment adjustments for home health care --** Establishes a 10 percent cap on the amount of reimbursement a home health provider can receive from outlier payments and would reinstate an add-on payment for rural home health providers from April 1, 2010 through 2015.	Guidance – Change Request Regulation – HHA Proposed Rule Regulation – HHA Final Rule	**03/31/2010** **7/16/2010** **11/2/2010**
3131 (7of7)	**Payment adjustments for home health care --** Reinstate an add-on payment for rural home health providers from April 1, 2010 through 2015	Guidance -- JSM Guidance -- Change Request	**04/08/2010** **04/23/2010**
3132 (3of3)	**Hospice reform** - Requires a hospice physician or nurse practitioner to have a face-to-face encounter with the individual to determine continued eligibility for hospice care prior to the 180th day recertification and each subsequent recertification and attests that such visit took place as established by the Secretary.	Regulation – Home Health PPS Proposed Rule Regulation – HHA Final Rule	**7/16/2010** **11/2/2010**
3134	**Misvalued codes under the physician fee schedule --** Directs the Secretary to regularly review fee schedule rates for physician services paid for by Medicare, including services that have experienced high growth rates. Strengthens the Secretary's authority to adjust fee schedule rates that are found to be misvalued or inaccurate. Eliminates the Practicing Physicians Advisory Council (PPAC).	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**06/25/2010** **11/2/2010**

Section of the Law	Subject	Implementing Document	Release Date
3135 (1of3)	**Modification of equipment utilization factor for advanced imaging services -- *RB - - 1107 -- Payment for Imaging Services --*** Sets the assumed utilization rate at 75 percent for the practice expense portion of advanced diagnostic imaging services.	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**06/25/2010** **11/2/2010**
3135 (2of3)	**Modification of equipment utilization factor for advanced imaging services --** Adjusts the technical component discount on single session imaging studies on contiguous body parts from 25 percent to 50 percent.	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**06/25/2010** **11/2/2010**
3136	**Revision of payment for power-driven wheelchairs --** Eliminates the option for Medicare to purchase power-driven wheelchairs with a lump-sum payment at the time the chair is supplied. Medicare would continue to make the same payments for power-driven chairs over a 13-month period. Purchase option for complex rehabilitative power wheelchairs would be maintained.	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**06/25/2010** **11/2/2010**
3137 (1of3)	**Hospital wage index improvement --** Extends reclassifications under section 508 of the Medicare Modernization Act (P.L 108-173) through the end of FY2011. Also directs the Secretary to restore the average hourly wage comparison thresholds used to determine hospital reclassifications to the percentages used as of September 30, 2008.	Guidance -- JSM Guidance – Change Request Regulation –Changes to the IPPS Resulting from 2011 HCR Proposed Rule Regulation – IPPS Final Rule	**4/22/2010** **7/10/2010** **05/21/2010** **07/30/2010**

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Section of the Law	Subject	Implementing Document	Release Date
3137 (2of3)	**Hospital wage index improvement** -- ***Sec. 10317-- Revisions to extension of Section 508 hospital provisions*** -- Clarifies the Secretary may only use wage data of certain eligible hospitals in carrying out this provision if doing so does not result in lower wage index adjustments for affected facilities.	Guidance – JSM Regulation – IPPS Proposed Rule Regulation – IPPS Final Rule	**4/22/2010** **04/19/2010** **07/30/2010**
3138	**Treatment of certain cancer hospitals** -- Directs the Secretary to study whether existing cancer hospitals that are exempt from the inpatient prospective payment system 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. ***10324 -- Protections for frontier states*** -- With respect to covered OPD services furnished on or after January 1, 2011, the area wage adjustment factor applicable under the payment system established under this subsection to any hospital outpatient department which is located in a frontier State may not be less than 1.00.	Regulation – OPPS Proposed Rule Regulation – OPPS Final Rule	**07/2/2010** **11/2/2010**
3139	**Payment for biosimilar biological products** -- Sets the add-on payment rate for biosimilar products reimbursement under Medicare Part B at 6 percent of the average sales price of the brand biological product.	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**06/25/2010** **11/2/2010**
3141	**Application of budget neutrality on a national basis in the calculation of the**	Federal Register Notice -- Changes to the IPPS Resulting	**05/21/2010**

Section of the Law	Subject	Implementing Document	Release Date
	Medicare hospital wage index floor -- Starting on October 1, 2010, the provision would require application of budget neutrality associated with the effect of the imputed rural and rural floor to be applied on a national, rather than State-specific basis through a uniform, national adjustment to the area wage index.	from 2010 HCR Provisions Regulation – IPPS Final Rule	**07/30/2010**
3201 (1of2)	**Medicare Advantage payment --** ***RB -- 1102 -- Medicare Advantage payments --*** Freezes Medicare Advantage payments in 2011. Benchmarks will vary from 95% of Medicare spending in high-cost areas to 115% of Medicare spending in low-cost areas. The changes will be phased-in over 3, 5 or 7 years, depending on the level of payment reductions.	2011 Call Letter Regulation – Revisions to the Parts C & D Contract Years 2012 Proposed Rule	**04-05-10** **11-10-10**
3301 (1of3)	**Medicare coverage gap discount program --** Requires drug manufacturers to provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning January 1, 2011.	Guidance -- HPMS Federal Register Notice Regulation – Revisions to the Parts C & D Contract Years 2012 Proposed Rule	**4/30/2010** **05/21/2010** **11-10-10**
3301 (2of3)	**Medicare coverage gap discount program --** Requires the Secretary establish a model agreement for use under the program in consultation with manufacturers and allow for comment on such model agreement.	Federal Register Notice	**05-21-10**

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Section of the Law	Subject	Implementing Document	Release Date
3401 (1of3)	**Revision of certain market basket updates and incorporation of productivity improvements into market basket updates that do not include such improvements --** Incorporates a productivity adjustment into the market basket update for inpatient hospitals, home health providers, skilled nursing facilities, hospice providers, inpatient psychiatric facilities, long-term care hospitals and inpatient rehabilitation facilities beginning in various years and implements additional market basket reductions for certain providers. It would also incorporate a productivity adjustment into payment updates for Part B providers who do not already have such an adjustment. ***Sec. 10319 -- Revisions to market basket adjustments*** -- Modifies market adjustments for inpatient hospitals, inpatient rehabilitation facilities, inpatient psychiatric hospitals and outpatient hospitals in 2012 and 2013 and for long-term care hospitals in 2011, 2012 and 2013. Also, modifies market basket adjustments for home health providers in 2013 and hospice providers in 2013 through 2019. ***RB -- 1105 -- Market basket updates***-- Revises the hospital market basket reduction that is in addition to the productivity adjustment as follows: -0.3 in FY14 and -0.75 in FY17, FY18 and FY19. Removes Senate provision that eliminates the additional market basket for hospitals based on coverage levels. Providers affected are inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals and outpatient hospitals.	Guidance -- JSM (IRF,SNF,IPPS, LTCH, OPPS, HH,) Guidance -- JSM (IPPS, LTCH) Regulation – IPPS Proposed Rules Regulation – PFS and OPPS Proposed Rule Federal Register Notice – Changes to the OPPS/ASC Resulting from 2010 HCR Provisions Regulation – HH Proposed Rule Regulation – IPPS Final Rules Psych PPS Notice Regulation – PFS and OPPS Final Rule Regulation – HH Final Rule	**4/1/2010** **4/14/2010** **04/19/2010** **6/25/2010** **7/2/2010** **7/16/2010** **07/30/2010** **5/1/2010** **11/2/2010** **11/2/10**
4103 (1of4)	**Medicare coverage of annual wellness visit providing a personalized prevention plan --** Provides coverage under Medicare, with no co-payment or deductible, for	Regulation -- Physician Fee Schedule Proposed Rule	**06/25/2010**

RB = Reconciliation bill

Section of the Law	Subject	Implementing Document	Release Date
	an annual wellness visit and personalized prevention plan services. Such services would include a comprehensive health risk assessment. The personalized prevention plan would take into account the findings of the health risk assessment and include elements such as: a five- to ten-year screening schedule; a list of identified risk factors and conditions and a strategy to address them; health advice and referral to education and preventive counseling community-based interventions to address modifiable risk factors such as physical activity, smoking, and nutrition.	Regulation – Physician Fee Schedule Final Rule	**11/2/2010**
4103 (2of4)	**Medicare coverage of annual wellness visit providing a personalized prevention plan** -- Requires the Secretary establish publicly available guidelines for health risk assessments. Requires the Secretary establish standards for interactive telephonic or webbased programs used to furnish health risk assessments.	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**06/25/2010** **11/2/2010**
4104	**Removal of barriers to preventive services in Medicare --** This section would waive beneficiary coinsurance requirements for most preventive services, requiring Medicare to cover 100 percent of the costs. Services for which no coinsurance or deductible would be required are the personalized prevention plan services and any covered preventive service if it is recommended with a grade of A or B by the U.S. Preventive Services Task Force. ***Sec. 10406 -- Amendment relating to waiving coinsurance for preventive services*** – Clarifies that Medicare beneficiaries do not have to pay coinsurance (including	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule Guidance – Change Request Regulation – Revisions to the Parts C & D Contract Year	**06/25/2010** **11/2/2010** **11/2/2010** **11/10/10**

Section of the Law	Subject	Implementing Document	Release Date
	co-pays and deductibles) for preventive services delivered in all settings.	2012 Proposed Rule	
4105 (2of3)	**Evidence-based coverage of preventive services in Medicare -- *10501 - (3)(A)* --** Directs the Secretary to require FQHCs to submit to the Secretary such information require in order to develop and implement the FQHC prospective payment system.	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**06/25/2010** **11/2/2010**
5104 (2of2)	**Sec. 10501 -- Amendments to Title V -- *Interagency task force to assess and improve access to health care in the State of Alaska* –** requires the Task force submit a report to Congress.	RTC	**9/17/10**
5501	**Expanding access to primary care services and general surgery service --** Beginning in 2011, provides primary care practitioners, as well as general surgeons practicing in health professional shortage areas, with a 10 percent Medicare payment bonus for five years. Half of the cost of the bonuses would be offset through an across-the-board reduction in all other services.	Guidance – Change Request Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**6-4-10** **06/25/2010** **11-2-10**
5503	**Distribution of additional residency positions --** Beginning July 1, 2011, directs the Secretary to redistribute residency positions that have been unfilled for the prior three cost reports and directs those slots for training of primary care physicians. In distributing the residency slots under this section, special preference will be given to programs located in States with a low physician resident to general population ratio and to programs located in States with the highest ratio of population living in	Regulation -- OPPS Proposed Rule Regulation – OPPS Final Rule	**7-2-10** **11-2-10**

Section of the Law	Subject	Implementing Document	Release Date
	a health professional shortage area (HPSA) relative to the general population.		
5504	**Counting resident time in outpatient settings and allowing flexibility for jointly operated residency training programs --** Modifies rules governing when hospitals can receive indirect medical education (IME) and direct graduate medical education (DGME) funding for residents who train in a non-provider setting so that any time spent by the resident in a non-provider setting shall be counted toward DGME and IME if the hospital incurs the costs of the stipends and fringe benefits.	Regulation -- OPPS Proposed Rule Regulation – OPPS Final Rule	**7-2-10** **11-2-10**
5505	**Rules for counting resident time for didactic and scholarly activities and other activities** -- Modifies current law to allow hospitals to count resident time spent in didactic conferences toward IME costs in the provider (i.e., hospital) setting and toward DGME in the non-provider (i.e., non-hospital) setting. ***Sec. 10501 -- Amendments to Title V – (j) Technical corrections to the rules for counting resident time for didactic and scholarly activities and other activities*** -- Clarifies that the Secretary is not required to reopen certain settled cost reports in applying changes to Medicare graduate medical education payment rules related to didactic training.	Regulation -- OPPS Proposed Rule Regulation – OPPS Final Rule	**7-2-10** **11-2-10**
5506	**Preservation of resident cap positions from closed hospitals --** Directs the Secretary to redistribute medical residency slots from a hospital that closes on or after the date that is two years before enactment of this legislation based on certain criteria.	Regulation -- OPPS Proposed Rule Regulation – OPPS Final Rule	**7-2-10** **11-2-10**

Section of the Law	Subject	Implementing Document	Release Date
6001 (1of3)	**Limitation on Medicare exception to the prohibition on certain physician referrals for hospitals --** Prohibits physician-owned hospitals that do not have a Medicare provider agreement in effect on **December 31, 2010** from furnishing services pursuant to referrals made by physician owners or investors (known as "self-referral"). Hospitals that have physician owners or investors and a provider agreement in effect on **December 31, 2010** may continue to access exceptions to the self-referral prohibition if certain requirements are met addressing conflicts of interest, bona fide investments, and patient safety issues, as well as new disclosure and reporting requirements. ***Sec 10601 -- Revisions to limitation on Medicare exception to the prohibition on certain physician referrals for hospitals --*** changed dates that were then changed by RB. ***RB -- 1106 -- Physician ownership referral --*** Changes to December 31, 2010 the date after which physician ownership of hospitals to which they self refer is prohibited and provides a limited exception to the growth restrictions for grandfathered physician owned hospitals that treat the highest percentage of Medicaid patients in their county (and are not the sole hospital in a county).	Regulation -- OPPS Proposed Rule Regulation – OPPS Final Rule	**7-2-10** **11-2-10**
6003	**Disclosure requirements for in-office ancillary services exception to the prohibition on physician self-referral for certain imaging services** -- Adds an additional requirement to the Medicare in-office ancillary exception that requires the referring physician to inform the patient in writing that the individual may obtain the specified service from a person other than the referring physician, a	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee	**06/25/2010** **11-2-10**

Section of the Law	Subject	Implementing Document	Release Date
	physician who is a member of the same group practice as the referring physician, or an individual who is directly supervised by the physician or by another physician in the group practice.	Schedule Final Rule	
6111	**Civil money penalties --** Provides the Secretary with authority to reduce civil monetary penalties (CMPs) from the level that they would otherwise be by 50 percent for certain facilities that self-report and promptly correct deficiencies within ten calendar days of imposition. For CMPs that are cited at the level of actual harm and immediate jeopardy, the Secretary would be provided with the authority to place CMPs in an escrow account following completion of the informal dispute resolution process, or the date that is 90 days after the date of the imposition of the CMP, whichever is earlier. If the facility's appeal is successful, the CMP, with interest, would be returned to the facility. If the appeal is unsuccessful, some portion of the proceeds may be used to fund activities that benefit facility residents.	Regulation -- CMP Reduction for Self-Reporting Proposed Rule State Medicaid informational Bulletin	**7/12/2010** **6/12/2010**
6201 (1of2)	**Nationwide program for National and State background checks on direct patient access employees of long-term care facilities and providers --** Requires the Secretary to establish a nationwide program for national and State background checks on direct patient access employees of certain long-term supports and services facilities or providers. This program is based on the background check pilot program in the Medicare Modernization Act.	Grant Solicitation	**06/15/2010**

Section of the Law	Subject	Implementing Document	Release Date
6401	**Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP** -- Provider Screening -- Requires that the Secretary, in consultation with the OIG, establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP. Requires the Secretary to determine the level of screening according to the risk of fraud, waste, and abuse with respect to each category of provider or supplier. At a minimum, all providers. The Secretary would have the authority to impose additional screening measures based on risk, including fingerprinting, criminal background checks, multi-State data base inquiries, and random or unannounced site visits.	Regulation – Program Integrity for Provider-Supplier Proposed Rule CPI -CMCS Informational Bulletin	**09/17/2010** **6/21/2010**
6402 (1of3)	**Enhanced Medicare and Medicaid program integrity provisions -- National Provider Identifier** -- Requires the Secretary to issue a regulation mandating that all Medicare, Medicaid, and CHIP providers include their NPI on enrollment applications.	Regulation – Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements, etc. Interim Final Rule (to address NPI) Regulation – Program Integrity for Provider-Supplier Proposed Rule	**4-30-10** **09/17/10**
6404	**Maximum period for submission of Medicare claims reduced to not more than 12 months --** Beginning January 2010, the maximum period for submission of Medicare claims would be reduced to not more than 12 months.	Guidance -- JSM Guidance -- Change Request Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**3-31-10** **5-7-10** **6-25-10** **11-2-10**
6405	**Physicians who order items or services required to be Medicare enrolled physicians or eligible professionals --** Requires durable medical equipment (DME)	Regulation – Changes in Provider and Supplier Enrollment, Ordering	**04/30/2010**

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Section of the Law	Subject	Implementing Document	Release Date
	or home health services to be ordered by a Medicare physician enrolled in the Medicare program. The Secretary would have the authority to extend these requirements to other Medicare items and services to reduce fraud, waste, and abuse. ***Sec 10604 -- Technical Corrections to Section 6405 --*** Clarifies that this expansion of DME requirements applies to those enrolled in Sec. 1866(j) of the SSA and not also those referred to in Sec. 1848(k)(3)(B) of the SSA.	and Referring, and Documentation Requirements, etc. Interim Final Rule (to address NPI) Guidance -- Press Release Regulation – Program Integrity for Provider-Supplier Proposed Rule	 **6/30/2010** **09/17/10**
6406 (1of2)	**Requirement for physicians to provide documentation on referrals to programs at high risk of waste and abuse --** Beginning January 1, 2010, the Secretary would have the authority to disenroll, for no more than one year, a Medicare enrolled physician or supplier that fails to maintain and provide access to written orders or requests for payment for DME, certification for home health services, or referrals for other items and services.	Regulation – Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements, etc. Interim Final Rule (to address NPI)	**04/30/2010**
6407 (1of2)	**Face-to-face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare --** Requires physicians to have a face-to-face encounter with the individual prior to issuing a certification for ***home health services***. The Secretary would be authorized to apply the face-to-face encounter requirement to other items and services based upon a finding that doing so would reduce the risk of fraud, waste, and abuse. This provision also applies to Medicaid. ***Sec. 10605 -- Certain other providers permitted to conduct face-to-face encounter***	Guidance -- Change Request Regulation – Home Health Proposed Rule Regulation – Home Health Final Rule	**11/2/2010** **07/16/2010** **11/02/2010**

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Section of the Law	Subject	Implementing Document	Release Date
	for home health services -- Clarifies that the face-to-face encounter required prior to certification for home health services may be performed by a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant.		
6409 (1of2)	**Medicare self-referral disclosure protocol --** Within six months of enactment, the Secretary, in cooperation with the HHS OIG, would be required to establish a self-referral disclosure protocol to enable health care providers and suppliers to disclose actual or potential violations of the physician self-referral law.	Guidance – Web posting	**09/23/2010**
6410 (1of2)	**Adjustments to the Medicare durable medical equipment, prosthetics, orthotics, and supplies competitive acquisition program --** Requires the Secretary to expand the number of areas to be included in round two of the competitive bidding program from 79 of the largest metropolitan statistical areas (MSAs) to 100 of the largest MSAs.	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**06/25/2010** **11/2/2010**
6410 (2of2)	**Adjustments to the Medicare durable medical equipment, prosthetics, orthotics, and supplies competitive acquisition program --** Requires the Secretary to use competitively bid prices in all areas by 2016.	Regulation -- Physician Fee Schedule Proposed Rule Regulation – Physician Fee Schedule Final Rule	**06/25/2010** **11/2/2010**
6501	**Termination of provider participation under Medicaid if terminated under Medicare or other State plan--** Requires States to terminate the participation of individuals or entities from their Medicaid programs if the participation individuals or entities were terminated from Medicare or another State's Medicaid program.	Regulation – Program Integrity for Provider-Supplier Proposed Rule	**09/17/2010**

Section of the Law	Subject	Implementing Document	Release Date
6506	**Overpayments --** Extends the period for States to recover overpayments due to fraud to one year after date of discovery of the overpayment, before an adjustment is made to the federal payment. If the State has not recovered the overpayment due to fraud within one year of discovery because there has not been a final determination of the overpayment amount, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof) before the date that is 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made. The Secretary shall promulgate regulations that require States to correct Federally identified claims overpayments, of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate corrective action.	SMD Letter	**7-13-2010**
6507 (1of2)	**Mandatory State use of national correct coding initiative --** Requires States to make their MMIS methodologies compatible with Medicare's national correct coding initiative (NCCI) that promotes correct coding and controls improper coding.	SMD Letter	**9/1/2010**

Section of the Law	Subject	Implementing Document	Release Date
6703 (1of9)	**Elder Justice --** Requires the Secretary of HHS, in consultation with the Departments of Justice and Labor, to award grants and carry out activities that provide greater protection to those individuals seeking care in facilities that provide long-term services and supports and provide greater incentives for individuals to train and seek employment at such facilities. Owners, operators, and certain employees of these facilities would be required to report suspected crimes committed at a facility. Owners or operators of such facilities would also be required to submit to the Secretary and to the State written notification of an impending closure of a facility within 60 days prior to the closure. In the notice, the owner or operator would be required to include a plan for transfer and adequate relocation of all residents.	Grant Solicitation	**07-15-10**
10201 (1of2)	**Amendments to the Social Security Act and Title II of this Act –** Increases the transparency of the Medicaid waiver development and approval processes, at the State and federal levels by Requiring the Secretary to promulgate regulations relating to the application and renewals of a demonstration project that provides for a process for public hearings.	Regulation – Proposed Rule	**09/17/2010**
10324	**Protections for frontier states --** Starting in fiscal year 2011, establishes hospital wage index and geographic practice expense floors for hospitals and physicians located in states in which at least 50 percent of the counties in the state are frontier.	Regulation -- OPPS and Physician Fee Schedule Proposed Rule Federal Register Notice -- Changes to the IPPS Resulting from 2010 HCR Provisions	**7-2-10** **5-21-10**

Section of the Law	Subject	Implementing Document	Release Date
		Regulation – OPPS and Physician Fee Schedule Final Rule	**11-2-10**
10325	**Revision to skilled nursing facility prospective payment system --**Delays implementation of certain skilled nursing facility "RUGs-IV" payment system changes by one year to October 1, 2011. Beginning October 1, 2010, the Secretary shall implement changes specific to therapy furnished on a concurrent basis that is a component of RUG-IV and changes to the look-back period to ensure that only those services furnished after admission to a SNF are used as factors in determining a case-mix classification.	Federal Register Notice -- SNF PPS	**07-19-10**
10327	**Improvements to the Physician Quality Reporting System --** Provides an additional 0.5 percent Medicare payment bonus to physicians who successfully report quality measures to CMS via a qualified Maintenance of Certification program. Eliminates the MA Regional Plan Stabilization Fund.	Regulation – Revisions to the Parts C & D Contract Years 2012 Proposed Rule	**11-10-10**
10328	**Improvement in Part D medication therapy management (MTM) programs --** Requires Part D prescription drug plans to include a comprehensive review of medications (either in person or through telehealth technology) and a written summary of the review as part of their medication therapy management programs. Plans must also enroll beneficiaries who qualify on a quarterly basis and allow for opt out.	Regulation – Revisions to the Parts C & D Contract Years 2012 Proposed Rule	**11-10-10**

Section of the Law	Subject	Implementing Document	Release Date
10332	**Availability of Medicare data for performance measurement --** Authorizes the release and use of standardized extracts of Medicare claims data to measure the performance of providers and suppliers in ways that protect patient privacy and in accordance with other requirements.	Federal Register Notice -- Medicare Program; Listening Session Regarding the Availability of Medicare Data for Performance Measurement, September 20, 2010 -- *(CMS- 0031-N)*	**08/27/2010**