



**Core Purpose:**  
To assure the highest quality of health care in Iowa through our  
role as physician and patient advocate.

**KEEPING WATCH!**

**HEALTH REFORM MEASURES  
IMPACTING MEDICAL PRACTICES**

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**Iowa Medical Group Management Association**

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## DISCLAIMER

This presentation is general in nature. The federal health reform legislation is wide in scope. Much has yet to be learned particularly as the law is implemented through rules and other directives. This presentation does not constitute and is not meant to provide legal advice.

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**“DEMOCRACY IS THE WORST  
FORM OF GOVERNMENT  
EXCEPT FOR ALL THE OTHERS.”**

Winston Churchill

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## **2010 FEDERAL HEALTH REFORM**

**The Patient Protection and Affordable Care Act  
(PPACA or ACA)  
(HR 3590)**

**AND**

**The Health Care and Education Reconciliation Act of 2010  
(HR 4872)**

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## **FEDERAL HEALTH REORM AFFECTS EVERYBODY**

- The people (e.g., parent, worker, patient, taxpayer)
- Government (e.g., payer, provider, protector)
- Business
- Insurers
- Physicians, hospitals, other care providers

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## HEALTH REFORM HAS PASSED BUT WILL IT SURVIVE?

- **House**

253 Democrats  
177 Republicans  
0 Independents  
5 Vacancies

- **Senate**

57 Democrats  
41 Republicans  
2 Independents (caucus with the Democrats)  
(Senate filibuster ... requires 60 votes to overturn)

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## IOWA'S CONGRESSIONAL DELEGATION – RESPECT THE ROLE OF LEADERSHIP

- **Senator Grassley** – Ranking member (Minority Party), Senate Finance Committee; Judiciary Committee; Budget Committee
- **Senator Harkin** – Chair, Health, Education, Labor & Pensions (HELP) Committee
- **Representative Bruce Braley** – House Energy and Commerce Committee

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## HEALTH CARE REFORM - DRIVERS

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## COSTS

- U.S. spending on health care in 2009: \$2.47 trillion.
- 17.3% of the gross domestic product (GDP), 25% of GDP by 2025.
- Medicare/Medicaid: 1/5 of federal budget.

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## ACCESS

- 46.3 million uninsured (15.4% of U.S. population) in 2007.
- 25 million (estimated) underinsured (insufficient resources to manage medical bills).
- Medical debt contributes to ½ of all filed bankruptcies.

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## QUALITY

- U.S. ranks below most industrialized nations on several key health indicators.
- U.S. spends nearly twice as much on health care as most other industrialized democracies.

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**THE AMERICAN MEDICAL  
ASSOCIATION –**

“The new law makes medical care more accessible, coverage more reliable and insurance companies more accountable. And it strengthens wellness and prevention.”

Cecil Wilson, MD  
AMA President

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**IOWA MEDICAL SOCIETY –**

Geographic Equity in Medicare Payment  
(GPCIs)

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## PHYSICIAN PAYMENT – MEDICARE/MEDICAID

- **Medicare** – a federal program for the elderly and disabled.
- **Medicaid** – a federal/state program for the poor with the federal government paying a share and each participating state agreeing to match the remaining amount (i.e., Iowa's federal/state match is approximately 64%/36%).
- **Federal Poverty Level (FPL)** - set each year by the federal government.
- **FPL 2009/2010**: 1 person - \$10,830; 2- \$14,570; 3- \$18,310; 4-\$22,050; 5-\$25,790; 6-\$29,530; 7-\$33,270; 8-\$37,010.

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## PAYMENT FOR OUTPATIENT SERVICES BY PAYER – IOWA

(Iowa Hospital Association, Jan.-Oct. 2009)

- Medicare – 36.9%
- Wellmark (Iowa's largest commercial carrier) – 23.9%
- Medicaid – 10.5%
- Other Insurers – 24.4%
- Uninsured ("Private Pay") – 4.3%

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## ELDERLY (MEDICARE PATIENTS) IN IOWA

- From now until 2025, Iowa's elderly population is projected to substantially increase while Iowa's general population is expected to hold steady or decline.
- Currently 17% of all Iowans are enrolled in Medicare.
- Approximately 94% of Iowa's physicians participate in Medicare.

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## PHYSICIAN MEDICARE PAYMENT – “SGR”

- Early on, this issue was separated out of health reform legislation.
- Medicare sets spending targets tied to growth in the Gross Domestic Product (GDP) in comparison to growth in physician services.
- “Sustainable Growth Rate” (**SGR**) formula is designed to control growth in Medicare spending by making payment adjustment -- up or down -- each year.
- Since 2002, Medicare spending on physician services has exceeded spending targets -- SGR adjustment has called for payment decreases.
- Congress has implemented annual “fixes.”

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AGREED: MEDICARE'S PHYSICIAN PAYMENT SYSTEM IS BROKEN  
HOW TO FIX IT? NO AGREEMENT

- In 2010, application of the SGR meant a 21.3% cut in Medicare physician payment.
- Four Congressional fixes in 2010.
- Latest: a 2.2% increase for June 1-November 30, 2010 (cost: \$6B).
- AMA/Federation tells Congress: **"Repeal the SGR!"**
- Congress says: **"Where's the money?"** (Estimate: \$276 billion over 10 years).
- AMA House of Delegates resolution (June 2010): consider new payment models.

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PHYSICIAN MEDICARE PAYMENT -  
GPCIs

- The Medicare RBRVS physician fee schedule is national.
- Geographic Practice Cost Indexes (GPCIs) were adopted to reflect differences in costs among Medicare's payment localities for 1) physician work (**Work GPCI**), 2) physician practice expenses (**Practice Expense GPCI**), and 3) physician malpractice premiums (**Malpractice GPCI**), resulting in a Geographic Adjustment Factor (**GAF**) for each Medicare payment locality.
- Medicare payment to physicians for the *same* service varies considerably from one payment locality to another because of the GPCIs/GAF. The "band of disparity" between the Medicare payment locality with the highest GAF (excluding Alaska) and the payment locality with the lowest GAF (excluding Puerto Rico) is nearly 22% with the PPACA adjustments to the PE and work GPCIs, and nearly 27% without the PPACA adjustments.
- The PE GPCI in particular is based on proxy data, *not* actual physician practice expenses.
- **Medical Economics**: cost of practice in Midwest states is *higher* than in all other regions -- but under the GPCIs, Midwest states are among the *lowest* paid.
- **AMA PPIS data**: no measurable distinction in practice expenses from region-to-region or in urban/rural areas.

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## PPACA RELIEF RE: GPCIs

- GPCI relief with a PE GPCI bump-up for states with a PE GPCI below 1.0 for CY 2010 and CY 2011 and a 1.0 floor on the work GPCI for 2010: approximately a 5% increase in Medicare payment for Iowa physicians in CY 2010, less in CY 2011.
- Studies to be conducted by the Institute of Medicine and CMS re: the GPCIs, reports due in 2011, adjustments in payment due in 2012. *Note: CMS 3-year GPCI review.*

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## CY2011 PROPOSED MEDICARE PHYSICIAN PAYMENT RULE RE: GPCIs

- PPACA-directed adjustments to the PE GPCI are accounted for in the proposed rule.
- PPACA's 1.0 floor on the work GPCI does **not** extend into CY 2011.
- CMS 3-year GPCI review as required by Congress.
- CMS made further adjustments to the GPCIs that *should* have been favorable to a Medicare region like Iowa yet Iowa is negatively affected and remains one of the lowest paid Medicare payment localities.
- The "band of GPCI disparity" remains wide.

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## PPACA INCENTIVE PAYMENT FOR PRIMARY CARE (PCIP)

- In the case of primary care services furnished on or after January 1, 2011 and before January 1, 2016 by a primary care practitioner, there shall also be paid on a monthly or quarterly basis an amount equal to 10% of the payment amount for such services under Medicare Part B.
- Medicare HPSA physician bonus program. Medicare's bonus program already operational for medical services provided in health professional shortage areas (HPSAs) is **not** affected by the new PCIP.

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## PROPOSED CY 2011 MEDICARE PHYSICIAN PAYMENT RULE

- Eligible for the 10% PCIP if a primary specialty designation of family medicine (08), internal medicine (11), geriatric medicine (38), or pediatric medicine (37) or if a nurse practitioner (50), clinical nurse specialist (89), or physician assistant (97) billing directly (not incident to).
- So long as primary care services accounted for at least 60% of the practitioner's allowed charges under Part B of all claims submitted in a prior period – for CY 2011, CMS will use CY 2009 claims data processed through June 30, 2010.
- "Primary care services" are identified and designated by HCPCS codes 99201-99215, 99304-99340, and 99341-99350 (set forth in rule).
- PCIP is equal to 10% of "Medicare allowed charges" paid to the eligible practitioner for primary care services; PCIP paid quarterly; professional or institutional (CAH) payment; must include practitioner's NPI on line item for primary care services.
- Newly-enrolled primary care physicians not eligible for PCIP for two years due to claims lag/60% rule ... CMS invites public comment.
- CMS will post a listing of practitioners eligible for the CY 2011 PCIP; can challenge only if a mistake.

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### PPACA BONUS PAYMENT FOR GENERAL SURGEONS IN HEALTH PROFESSIONAL SHORTAGE AREAS

- In the case of major surgical procedures furnished by a general surgeon on or after January 1, 2011 and before January 1, 2016, in a health professional shortage area (HPSA)), there shall be paid on a monthly or quarterly basis an amount equal to 10% of the payment amount for eligible services.
- “General surgeon” – CMS specialty code (02) designated as primary specialty code.
- “Major surgical procedure” is a surgical procedure for which a 10-day or 90-day global period is used for payment.
- Existing Medicare HPSA physician bonus payment program **not** affected by this PPACA provision.

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### PROPOSED CY 2011 MEDICARE PHYSICIAN PAYMENT RULE

- “HPSA surgical incentive payment program.”
- General surgeon is determined by (02) primary specialty enrollment designation.
- Surgeon’s NPI must be included on the line-item for the major surgical procedure.
- Professional claim or institutional (CAH) claim.
- HPSA as designated by HHS (zip codes) as of December 31 of prior year (i.e., 2010); modifier for HPSA zip codes not automatically paid.
- Eligible “major surgical procedures” listed in Addendum D (4285 procedures).
- Incentive payments to be made quarterly.

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## PPACA BONUS PAYMENT FOR PSYCHOTHERAPY SERVICES

- PPACA *extends* Medicare' 5% increase in payment for specified mental health services through December 31, 2010.
- Payment for 24 psychiatry CPT codes (90804-90819, 90821-90824, 90826-90829) remains increased by 5% until the end of CY 2010.

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## PPACA MEDICARE CLAIMS FILING DEADLINE

- Prior to PPACA, CMS was authorized to establish a minimum time limit for filing Part B claims of 15 months and a potential maximum of 27 months after the service was furnished, depending on what month of the year the service was furnished.
- PPACA requires that all claims for services furnished **on or after January 1, 2010** must be filed within one (1) calendar year after the date of service. Further, claims for services furnished **during the last three months (October-December) of 2009** must be filed no later than December 31, 2010.

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**PROPOSED CY 2011 MEDICARE PHYSICIAN PAYMENT  
RULE –  
CLAIMS SUBMISSION REQUIREMENTS**

- Claims for services provided on or after January 1, 2010 must be submitted no later than the close of the period ending one (1) calendar year after the date of service.
- Claims for services furnished before January 1, 2010 must be filed on or before December 31 of the following year for services that were furnished during the first nine (9) months of a calendar year, and on or before December 31 of the second following year for services furnished during the last three (3) months of the calendar year, except for services provided in the last three (3) months of 2009, all claims must be filed no later than December 31, 2010.
- CMS exceptions – 1) retroactive eligibility; 2) limited dual eligible Medicare/Medicaid situations; 3) errors or misrepresentations of CMS contractors; 4) newly enrolled providers.
- CMS does not define “date of service.” Ordinarily, date the service is actually furnished. CMS is soliciting comments re: defining “date of service.”

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**PPACA – CMS REVIEW OF PHYSICIAN PAYMENT  
CODES/RVUS**

- MedPAC (2006 report): “Misvalued services can distort the price signals for physician services as well as other health care services that physicians order, such as hospital services.”
- CMS and the AMA RUC work cooperatively to address misvalued codes.
- PPACA directs CMS to specifically examine potentially misvalued codes in seven categories: 1) fastest growth codes; 2) codes experiencing substantial changes in practice expenses; 3) recent codes for new technologies or services; 4) multiple codes billed with furnishing a single service; 5) low relative value codes particularly those often billed multiple times for a single treatment; 6) old “Harvard” codes; and 7) other codes as identified by CMS.
- PPACA also authorizes CMS to make coding revisions, including consolidation of individual services into bundled codes for payment under the physician fee schedule.
- Proposed CY 2011 Medicare physician payment rule addresses work in each of the seven code categories and its processes for validating RVUs and their work elements as directed by PPACA.

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## MEDICAID

- Medicaid payments for primary care services provided by primary care doctors (family medicine, general internal medicine, pediatric medicine) increased to 100% of the Medicare payment rates for years 2013-2014. States will receive 100% federal match for increased payment amounts.
- Expands Medicaid to all individuals under age 65 with incomes up to 133% of FPL.
- A 23% increase in the federal match for the state children's health insurance program for years 2015-2019.

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FRAUD AND ABUSE – DISCLOSURE FOR IN-OFFICE  
ANCILLARY SERVICES  
EXCEPTION TO THE PROHIBITION ON PHYSICIAN SELF-REFERRAL  
RE: CERTAIN IMAGING SERVICES

- PPACA places a new disclosure responsibility upon physicians who refer their patients for MRI, CT or PET scanning services available in their offices under the Stark law ownership/compensation exception for in-office ancillary services.
- Referring physicians are required to give patients written notice that such services also are available from other suppliers in the area in which the patient resides.
- Suppliers must be identified in the notice.
- Notice was to be given starting January 1, 2010 (law had not yet passed then).

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**PROPOSED CY 2011 PHYSICIAN PAYMENT RULE--  
PROVIDES DIRECTION RE: PPACA DISCLOSURE REQUIREMENT**

- Services that trigger disclosure: MRI, CT, PET. CMS asks for comments on whether other designated health services should be included.
- Disclosure requirements: 1) written notice that can be understood; 2) given to the patient at the time of referral; 3) must state that the patient may obtain the services from a person other than the physician or physician's group; 4) must include a list of other suppliers (i.e., physician, facility, or other entity), but **not** other providers of services (i.e., hospitals) – CMS soliciting comments; 5) listing of suppliers located within a 25-mile radius of the referring physician's office location at the time of referral (*not* the patient's residence) – CMS soliciting comments; 6) listing must include no fewer than 10 alternative suppliers unless less than 10 are located within the 25 mile radius; 7) if no other suppliers within the 25 mile radius, then need not list suppliers but must give the notice; 8) information on each supplier shall include name, address, telephone, distance from physician's office; 9) no exception provided for emergencies or time-sensitive testing – CMS soliciting comment; 10) document disclosure signed by the patient and keep in the patient's medical record – CMS soliciting comments.
- Effective date: January 1, 2011, **not** retroactive to January 1, 2010.

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**PPACA -- NEW MODELS OF CARE  
CENTER FOR MEDICARE AND MEDICAID INNOVATION**

- Overall goal: care models to improve quality/slow growth in Medicare spending.
- Payment and practice reforms in primary care.
- Patient-centered medical home models for high-need individuals.
- Medical homes that address women's unique health care needs.
- Coordination of care for geriatric patients with multiple chronic conditions and unable to perform daily living activities and/or with cognitive impairments.
- Care coordination for chronically ill patients at high-risk of hospitalization.
- Community-based care teams to support small-practice medical homes.
- Payment to physicians for using patient decision-support tools to improve understanding of medical treatment options.

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### PPACA - MEDICARE SHARED SAVINGS PROGRAM

- Accountable care organizations (ACOs).
- Physicians, networks of individual practices, partnerships with hospitals, for instance.
- ACO must have at least 5000 Medicare beneficiaries and must agree to be accountable for quality, cost, and overall care for those beneficiaries.
- Must be legally organized to receive and distribute payments for any shared savings above an established threshold benchmark.
- Must have defined processes to promote evidence-based medicine and report on quality and cost measures.
- Payments to ACO physicians will be made under the usual Medicare structure.
- Three-year demonstrations.

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### PPACA - INDEPENDENCE AT HOME DEMONSTRATION PROGRAM

- To bring primary care services to homes of high-cost Medicare beneficiaries with multiple chronic conditions.
- Health teams eligible for shared savings if they achieve high quality outcomes, patient satisfaction and cost savings.

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PPACA - COMMUNITY HEALTH TEAMS  
FOR PATIENT-CENTERED MEDICAL HOMES

- Grants/contracts to establish community-based interdisciplinary, interprofessional health teams to support primary care practices (including OB/GYN) within local hospital service areas.
- Provide capitated payments to primary care providers.
- Note: coordination among a range of health care professionals.

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PPACA - OTHER COMMUNITY-BASED  
INITIATIVES

- Increase funding by \$11B for community health centers (five years, beginning in 2011).
- Increase funding by \$1.5B for National Health Service Corps (five years, beginning in 2011).
- New programs to support school-based health centers and nurse-managed health clinics.

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## PPACA - PREVENTIVE SERVICES AND WELLNESS

- Eliminate cost-sharing for Medicare covered preventive services as recommended by the US Preventive Services Task Force effective January 1, 2011.
- Provide Medicaid 1% federal share bump-up for coverage and elimination of cost-sharing for preventive services (recommended by US Preventive Services Task Force) and immunizations (recommended by Advisory Committee on Immunization Practices).
- Provide incentives to Medicare/Medicaid beneficiaries to complete behavior modification programs, targeting high blood pressure, high cholesterol, and diabetes.
- \$25M for Childhood Obesity Demonstration Project through 2013.
- Establish a Prevention and Public Health Fund for prevention, wellness, and public health activities, including prevention research and health screenings.
- Grant program to support delivery of evidence-based and community-based prevention and wellness services, especially in rural and frontier areas (beginning in 2010).
- Grants to small employers to establish wellness programs (beginning in 2011).
- Advisory Group on Prevention, Health Promotion, and Integrative and Public Health re: lifestyle-based chronic disease prevention and management, integrative care practices, and health promotion (July 1, 2010).

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## PROPOSED CY2011 MEDICARE PHYSICIAN PAYMENT RULE - PREVENTIVE SERVICES

- "Removal of barriers to preventive services in Medicare."
- Definition of "preventive services": Initial preventive physical exam (IPPE); annual wellness visit; pneumococcal, influenza, and hepatitis B vaccine and administration; screening mammography; screening pap smear and screening pelvic exam; prostate cancer screening tests; colorectal cancer screening tests; outpatient diabetes self-management training (DSMT); bone mass measurement; screening for glaucoma; medical nutrition therapy (MNT) services; cardiovascular screening blood tests; diabetes screening tests; ultrasound screening for abdominal aortic aneurysm (AAA); others as identified; **not** electrocardiograms.
- Table 38 of proposed rule: lists preventive services for which deductibles and coinsurances will be waived and Medicare will pay at the 100% - not all are included, must have A or B grade from USPST.

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## PPAC - EMERGENCY/TRAUMA SERVICES

- Establish a new trauma care program to strengthen emergency department and trauma center capacity.
- Fund research on emergency medicine, including pediatric emergency medicine.
- Develop demonstration programs for innovative models of emergency care systems.

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## PPACA - NATIONAL HEALTH CARE WORKFORCE COMMISSION

- Training, recruitment and retention.
- Regional centers to perform workforce analyses, emphasizing primary care.
- Scholarship and loan repayment programs to help recruit physicians to underserved areas, rural areas, and work with uninsured and/or minority populations.
- Grants to support training programs in family medicine, general internal medicine, general pediatrics, and mental/behavioral health.

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### ESTIMATED CHANGES IN COVERAGE UNDER PPACA BY 2019

- Medicaid and CHIP: from 35M to 51M.
- Employer-sponsored coverage: from 162M to 159M.
- Non-group and other coverage: from 30M to 25M.
- Insurance exchange health coverage: from 0 to 24M.
- Uninsured: from 54M to 23M.

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### PPACA - COVERAGE MANDATE/PENALTY/SUBSIDIES/ TAX CREDITS

- In 2014, individuals (citizen, legal residents) without “qualifying” health coverage will pay a tax penalty at the greater of \$95 or 1.0% taxable income, increasing in 2015 to the greater of \$325 or 2.0% of taxable income; and in 2016, at the greater of \$695 or 2.5% of taxable income.
- Sliding-scale tax credits for the purchase of insurance for individuals/families with incomes between 133-400% FPL.
- Cost-sharing subsidies for individuals/families with incomes up to 400% of the FPL.

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STATE-BASED AMERICAN HEALTH BENEFIT EXCHANGES  
(EXCHANGES) and  
SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP)

- Exchanges to be administered by a government agency or a non-profit organization.
- Provide “qualified” health coverage options to individuals and small businesses.
- Funding available to assist the states in establishing Exchanges.
- Grant-based Consumer Operated and Oriented Plan (CO-OP) program – non-profit, member-run health plans in each state.
- State-established Basic Health Plans for uninsured individuals with incomes between 133%-200% of FPL.
- At least two national or multi-state commercial health plans to be established through the federal Office of Personnel and included as part of the Exchanges of each state.

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PPACA - EMPLOYER RESPONSIBILITIES/ SMALL  
BUSINESS TAX CREDITS

- In 2014, employers with more than 50 full-time equivalent employees (FTEs) must offer “qualified” coverage to their employees or risk a monthly “free rider” penalty (\$2000 x number of employees, the first 30 of which are not counted) *if* at least one FTE receives subsidized coverage through an Exchange.
- A sliding-scale tax credit is available to small employers with no more than 25 FTEs paid annual average wages of less than \$50,000 to assist in the purchase of employee health coverage.
- In 2014, employers providing basic insurance coverage must offer “free choice” vouchers to lower-income employees who may elect coverage through an Exchange.

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## PPACA - PRE-EXISTING MEDICAL CONDITIONS – STATE TEMPORARY HIGH RISK POOL

- As of January 1, 2014, individuals cannot be denied private health insurance coverage because of a pre-existing medical condition.
- Between now and 2014, \$5 billion is made available to the states for temporary high-risk pools to provide coverage for adults with pre-existing medical conditions who have been uninsured for at least 18 months.
- **Iowa:** Iowa Insurance Division has developed a high risk pool consistent with PPACA, building upon the state's existing high risk pool. Concern: inadequate resources to meet the scope of the need.
- Effective for "plan years" beginning on or after September 23, 2010, children age 18 and younger cannot be denied coverage for, or on the basis of, a pre-existing medical condition.

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## PPACA - DEPENDENT COVERAGE

- Effective for plan years beginning on or after September 21, 2010, individual and group health plans must allow uninsured children up to the age of 26 to remain on or return to their parents' plan.
- Eligible children need not reside with their parent and may be married (but the child's spouse and children would not be eligible).
- *Note:* The highest percentage of uninsured by age categories is 19-29 years of age.
- *Iowa Medicine "Legalease" (May-June 2010)* at [www.iowamedical.org](http://www.iowamedical.org) or direct link at [http://www.iowamedical.org/documents/legal/legalease/2010\\_3\\_May\\_June.pdf](http://www.iowamedical.org/documents/legal/legalease/2010_3_May_June.pdf).

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## PPACA - TAX CHANGES

- For tax year 2013, the threshold for itemized deductions for unreimbursed medical expenses increases from 7.5% to 10% of adjusted gross income, with a waiver for older taxpayers in tax years 2013-16.
- In 2013, the Medicare Part A tax rate on wages will increase from 1.45% to 2.35% on earnings over \$200,000/individuals or \$250,000/married filing jointly.
- In 2014, fees will be imposed upon health insurers.

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## PPACA - HEALTH PLANS – MEDICAL/LOSS RATIOS

- In 2010, health plans must report the proportion of premium dollars spent on clinical services and quality care.
- In 2011, large group plans that spend 15% or more of their premium dollars on costs other than medical/quality and small group or individual plans that spend 29% or more on costs other than medical/quality must give consumer rebates.
- **How to define?** Health plans have raised many objections/cautionary flags.

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## 2010 IOWA GENERAL ASSEMBLY DIRECTS DIVISION OF INSURANCE

- Senate 2201 requires commercial health plans to notify policyholders of an application for a premium rate increase that exceeds the average annual health spending growth rate identified by CMS.
- Each year the insurance commissioner shall convene a work group, including providers, to consider ways to reduce the cost of providing health insurance coverage and health care services.
- Annually, the Division of Insurance shall report to the governor 1) aggregate loss ratio data for each health plan; 2) rate increase data; 3) health care expenditures in the state and the effect of such expenditures on health insurance premium rates; 4) current capital, surplus, and reserve amounts of each health plan; and 5) a listing of medical trends affecting health insurance costs in the state.
- Division's Health Reform Website:  
<http://www.iid.state.ia.us/hcr/default.asp>.

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## PPACA - ADMINISTRATIVE SIMPLIFICATION

- Full implementation of the HIPAA electronic transaction standards.
- Crosswalk assistance in moving from ICD-9 to ICD-10 (by October 1, 2013).

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## MEDICAL LIABILITY REFORM

- \$50 million in demonstration grants to states from 2011-16.
- To develop, implement and evaluate alternatives to the existing civil litigation system.
- To receive a grant, a state must develop an alternative that allows for dispute resolution and that promotes reduction of health care errors.

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