



MEMORANDUM

January 11, 2016

Subject: Actions Taken by Federal Officials and Entities Through December 20, 2015, to Meet Certain Statutory Deadlines in the Affordable Care Act

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This memorandum was prepared to enable distribution to more than one congressional office.

This memorandum identifies certain statutorily imposed deadlines in the Patient Protection and Affordable Care Act (ACA)¹ and summarizes the actions taken to meet those deadlines. It is the latest in a series of CRS memoranda on this topic.²

The original memo in the series, dated November 23, 2010, established a methodology for determining what constitutes a statutory deadline.³ To make those determinations, CRS relied on a close reading of the statutory text, acceptable principles of statutory interpretation, and subject matter expertise regarding typical implementing agency practice in the issue areas covered by the ACA. CRS considered only those provisions that require the Secretary of Health and Human Services (HHS) or another federal official or agency to take a specific action by a specific date. Accordingly, several categories of provisions were excluded.⁴

¹ ACA was signed into law on March 23, 2010 (P.L. 111-148, 124 Stat. 119). On March 30, 2010, the President signed the Health Care and Education Reconciliation Act (HCERA; P.L. 111-152, 124 Stat. 1029), which amended numerous provisions in the ACA. HCERA also included multiple new freestanding provisions related to the ACA. Several laws enacted since then have made additional changes to specific ACA provisions; see CRS Report R43289, *Legislative Actions to Repeal, Defund, or Delay the Affordable Care Act*, by C. Stephen Redhead and Janet Kinzer. All references to the ACA in this memo refer, collectively, to the law as amended, the related HCERA provisions, and subsequently enacted amendments.

² Adam Salazar, Research Assistant, helped identify the deadlines in Tables 4 and 5 of this memorandum.

³ CRS Congressional Distribution Memorandum, “Deadlines for the HHS Secretary and Other Federal Entities in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148); March 23, 2010 – March 23, 2011,” by C. Stephen Redhead and Todd B. Tatelman, November 23, 2010.

⁴ The largest category, by far, of excluded provisions were those that merely had an “effective date” attached to them, as opposed to a specific deadline for official government action. For example, the ACA made numerous changes to existing Medicare payment systems, either permanently or on a temporary basis, effective at the beginning of the payment year. In almost all cases, the Centers for Medicare & Medicare Services (CMS) has opted to address these changes in its annual rulemaking updates for the various payment systems. For example, the annual final rules updating Medicare payment policies and rates for physician services and for hospital inpatient services both include multiple sets of provisions to incorporate and implement ACA mandates.

The details of the methodology are included in the **Appendix**. The November 23, 2010, memorandum included some analysis of the legal enforceability of statutory deadlines, which also appears in the **Appendix**.

The statutory deadlines, and the actions taken to meet them, are summarized below in five tables. **Table 1** provides updated information on a number of deadlines within the first year of ACA's enactment (i.e., through March 23, 2011). These deadlines were listed in the previous memo in the series (dated April 21, 2014),⁵ but at the time we were unable to demonstrate that they had been fully implemented. **Table 2** and **Table 3** similarly update information presented in the previous memo on the implementation of deadlines that fall within the second and third year of the ACA's enactment, respectively.

Table 4 and **Table 5** are both new. They summarize implementation actions taken pursuant to deadlines that we identified in the fourth and fifth years of enactment, respectively.

Each table row entry includes the following information: (1) the deadline; (2) the ACA section number; (3) a brief description of the provision's requirements; and (4) a summary of the actions taken *as of December 20, 2015*. The information on actions taken as of that date is largely, but not exclusively, based on an examination of publicly available sources. In obtaining this information, CRS relied on official federal sources, such as agency websites and the Federal Register.⁶ If CRS was unable to find any public information about implementation of an ACA provision using these sources, then this is indicated in the table by the phrase "No public information located." That indication does not necessarily mean that an agency or other federal entity has taken no action towards meeting a deadline. It may be that there has been internal activity, but that CRS was unable to locate or confirm any information about the activity.

Acronyms

The following laws and federal agencies are referred to in the tables by their acronym:

- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Community Living Assistance Services and Supports (CLASS) Act
- Food and Drug Administration (FDA)
- Government Accountability Office (GAO)
- Health Insurance Portability and Accountability Act (HIPAA)
- Health Resources and Services Administration (HRSA)
- Indian Health Care Improvement Act (IHCIA)
- Indian Health Service (IHS)
- Medicare Payment Advisory Commission (MedPAC)
- Public Health Service Act (PHSA)

⁵ CRS Congressional Distribution Memorandum, "Deadlines for the HHS Secretary and Other Federal Entities in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148): Addendum to CRS Congressional Distribution Memorandum Dated April 5, 2011," by C. Stephen Redhead and Todd B. Tatelman, April 21, 2014.

⁶ A more comprehensive analysis of federal government actions taken to meet ACA deadlines would require the examination of internal agency documents and interviews with agency officials. Such activities are generally beyond the scope of this memorandum. However, CRS did rely on personal communication with the IHS Congressional and Legislative Affairs Office for information on implementation of several of the ACA provisions relating to Indian health, with the CMS Office of Legislation, and the with HRSA Office of Legislation.

Table I. ACA Deadlines in the First Year After Enactment (March 23, 2010 – March 23, 2011)

Updated Information on Deadlines Included in the CRS Memorandum Dated April 21, 2014

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
Title I: Private Health Insurance, Administrative Simplification			
March 23, 2011	1001	Requires the HHS Secretary, by regulation, to develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage in compiling and providing an accurate summary of benefits and coverage. Requires the Secretary, in developing such standards, to consult with the National Association of Insurance Commissioners (NAIC), a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals. [PHSA Sec. 2715]	On February 14, 2012, HHS, the Department of Labor (DOL), and the Treasury Department published jointly the following two documents: (1) "Summary of Benefits and Coverage and Uniform Glossary," Final Rule (77 <i>Federal Register</i> 8668); and (2) "Summary of Benefits and Coverage and Uniform Glossary – Templates, Instructions, and Related Materials," Guidance for Compliance and Notice of Availability of Templates, Instructions, and Related Materials (77 <i>Federal Register</i> 8706).
Title II: Medicaid, Children's Health Insurance Program (CHIP)			
Sept. 19, 2010	10201(i)	Requires the HHS Secretary to promulgate regulations relating to applications for, and renewals of, any Medicaid or CHIP section 1115 demonstration project that has an impact on eligibility, enrollment, benefits, cost-sharing, or financing.	On February 27, 2012, CMS published a final rule, "Medicaid Program; Review and Approval Process for Section 1115 Demonstrations" (77 <i>Federal Register</i> 11678).
Title III: Medicare, Health Care Quality			
Dec. 31, 2010	3012	Requires the Interagency Working Group on Health Care Quality, convened by the President and chaired by the HHS Secretary, to submit to Congress, and publish on the Internet, a report on its progress and recommendations.	The Interagency Working Group on Health Care Quality was convened, consisting of senior-level officials from 24 federal agencies. The group held its first meeting on March 4, 2011, and meets once a year. No report has been submitted to Congress. See http://www.ahrq.gov/workingforquality/nqs/nqsfactsheet.htm .
Jan. 1, 2011	3006(f)	Requires the HHS Secretary to develop and submit to Congress a plan that would implement value-based purchasing for ambulatory surgery centers (ASCs).	On April 18, 2011, HHS released "Report to Congress: Medicare Ambulatory Surgical Center Value-Based Purchasing Implementation Plan." See https://www.cms.gov/ASCPayment/downloads/C_ASC_RTC%202011.pdf .

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
March 23, 2011	3507	Requires the HHS Secretary to submit to Congress a report providing the determination of whether the addition of quantitative summaries of the benefits and risks of prescription drugs would improve health care decision making by clinicians and patients.	FDA's Office of Prescription Drug Promotion released an initial progress report in March 2011. The agency indicated that conducting the necessary research and literature reviews and consulting with the appropriate experts would take about three years. FDA subsequently submitted progress reports in May 2012 and June 2013. The final report was released in February 2015. It concluded that it would not be appropriate to require quantitative risk and benefit information to be added to promotional labeling or print advertising for all prescription drugs. See http://www.fda.gov/downloads/AboutFDA/CentersOffices/OfficeofMedicalProductsandTobacco/CDER/ReportsBudgets/UCM443887.pdf .
Title IV: Prevention and Public Health			
March 23, 2011	4001(g)	Requires the chairperson of the National Prevention, Health Promotion and Public Health Council to publish a national prevention, health promotion and public health strategy.	On June 16, 2011, the U.S. Surgeon General and members of the National Prevention, Health Promotion and Public Health Council released "National Prevention Strategy: America's Plan for Better Health and Wellness." See http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf .
Title V: Health Workforce			
April 1, May 7, June 1, July 1, 2010	5602	Requires the HHS Secretary to appoint a negotiated rulemaking committee (pursuant to 5 U.S.C. §§ 561 et seq.) to establish a methodology and criteria for designating medically underserved populations and health professions shortage areas. By May 7, 2010, the Secretary must publish a notice announcing the intent to form such a committee to negotiate and develop a proposed rule. The committee is required to provide a status report to the Secretary by April 1, 2010. [Note: This predates the deadline for publication of a notice of intent to form the committee.] A final committee report containing a proposed rule is due by June 1, 2010. The target date for HHS to publish the proposed rule for notice and comment is July 1, 2010.	On May 11, 2010, HRSA published a notice of intent to form the negotiated rulemaking committee (75 <i>Federal Register</i> 26167-26171). The committee members were appointed on July 9, 2010, and the committee began meeting on a monthly basis. The committee submitted a preliminary report to the Secretary on March 17, 2011, and released its final report on October 31, 2011. See http://www.hrsa.gov/advisorycommittees/shortage/index.html . The committee failed to reach a consensus; therefore, the HHS Secretary was not required to use the results of its deliberations for the proposed rule. HRSA has not released a proposed rule.

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
Titles VII & X: 340B Drug Pricing, Indian Health			
Sept. 19, 2010	7102	Requires the HHS Secretary to promulgate regulations regarding the PHSA section 340B drug pricing program to (1) establish and implement an administrative process for the resolution of claims by covered entities that they have been overcharged for drugs purchased under the program, and manufacturers' post-audit claims of violations related to drug rebates or resale; and (2) establish civil monetary penalties (CMPs) for noncompliant drug manufacturers.	On September 20, 2010, HRSA published two Advance Notices of Proposed Rulemaking: (1) 340B Drug Pricing Program Administrative Dispute Resolution Process (75 <i>Federal Register</i> 57233-57235); and (2) 340B Drug Pricing Program Manufacturer Civil Monetary Penalties (75 <i>Federal Register</i> 57230-57232). On June 17, 2015, HRSA published a Notice of Proposed Rulemaking, "340B Drug Pricing Program Ceiling Price and Manufacturer Civil Monetary Penalties Regulation" (80 <i>Federal Register</i> 34583), which would implement the ACA's 340B program integrity provision. On August 28, 2015, HRSA published 340B Drug Pricing Program Omnibus Guidance (80 <i>Federal Register</i> 52300).
June 21, 2010	10221	Requires the HHS Secretary to develop a plan to increase IHS's behavioral health care staff by 500 positions (200 of which will be devoted to child, adolescent and family services) within 5 years of enactment. [IHClA Sec. 127]	In August 2011, IHS released "American Indian/Alaska Native Behavioral Health Strategic Plan 2011-2015," which included an implementation plan for developing a skilled and culturally competent behavioral health workforce. See http://www.ihs.gov/behavioral/documents/AIANNationalBHStrategicPlan.pdf . IHS informed CRS that the plan was submitted to the relevant congressional committees.
March 23, 2011	10221	Requires the HHS Secretary, acting through the IHS, to assess the need for, availability, and cost of inpatient mental health care for Indians. [IHClA Sec. 181]	IHS completed its assessment on March 17, 2011. ^a
March 23, 2011	10221	Requires the HHS Secretary and the Secretary of the Interior to enter into a Memorandum of Agreement (MOA) regarding mental illness and self-destructive behavior among Indians and strategies for addressing unmet needs. [IHClA Sec. 181]	In March 2011, HHS and the Department of the Interior amended a 2009 MOA on behavioral health care delivery to incorporate the requirements of the new IHClA provision. ^a
March 23, 2011	10221	Requires the HHS Secretary to establish protocols, policies, and procedures for IHS programs for victims of domestic or sexual violence. [IHClA Sec. 181]	In March 2011, IHS issued an agency-wide policy on how hospitals should respond to adult and adolescent victims of sexual assault. See http://www.ihs.gov/MedicalPrograms/MCH/V/DV01.cfm . [Note: On Oct. 26, 2011, GAO released report GAO-12-29, "Indian Health Service: Continued Efforts Needed to Help Strengthen Response to Sexual Assaults and Domestic Violence." See http://www.gao.gov/new.items/d1229.pdf .]

Source: Prepared by the Congressional Research Service based on (i) the text of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148), as amended; and (ii) publicly available information from official federal sources.

- a. See Letter from Yvette Roubideaux, Director, Indian Health Service, to Tribal Leaders, May 5, 2011, http://www.npaihb.org/images/resources_docs/weeklymailout/2011/may/week2/GM_11-057_IHS_on_IHClA_1stYearImplementation.pdf.

Table 2. Selected ACA Deadlines in the Second Year After Enactment (March 24, 2011 – March 23, 2012)

Updated Information on Deadlines Included in the CRS Memorandum Dated April 21, 2014

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
Title I: Private Health Insurance, Administrative Simplification			
July 1, 2011	1104(b)	Requires the HHS Secretary to adopt operating rules for the following HIPAA electronic transaction standards: (i) health care claim status inquiry and response; (ii) health plan eligibility inquiry and response. [Note: This is the first of four deadlines for adopting operating rules for the HIPAA electronic transaction standards; see Tables 3, 4, and 5.]	On July 8, 2011, HHS published an interim final rule, “Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions” (76 <i>Federal Register</i> 40458). The compliance deadline was January 1, 2013.
Jan. 1, 2012	1104(c)	Requires the HHS Secretary to adopt a HIPAA electronic transaction standard for electronic funds transfers (EFT).	On January 5, 2012, HHS published an interim final rule, “Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFT) and Remittance Advice” (77 <i>Federal Register</i> 1556).
Jan. 1, 2012	10109(b)	Requires the HHS Secretary to seek input from the National Committee on Vital and Health Statistics (NCVHS) and the Health Information Technology Policy and Standards Committees on whether certain other specified administrative and financial transactions beyond those addressed under HIPAA would benefit from the adoption of standards and operating rules.	On March 2, 2012, NCVHS issued a letter to the HHS Secretary concluding that there are meaningful opportunities for increased efficiencies and simplification through standardization in all the areas specified in ACA Sec. 10109. NCVHS plans to develop a strategy for further action. See http://www.ncvhs.hhs.gov/120302lt3.pdf . No further public information located.
March 23, 2012	1001	Requires the HHS Secretary to develop requirements for health plans to report on their efforts to improve health outcomes, prevent hospital readmission, ensure patient safety and reduce medical errors, and implement wellness and health promotion activities. Requires the HHS Secretary to promulgate regulations that provide criteria for determining reimbursement structure to improve quality.	No public information located.
Title II: Medicaid, Children’s Health Insurance Program (CHIP)			
July 1, 2011	2702(a)	Requires the HHS Secretary to issue regulations prohibiting federal Medicaid payment for specified health care-acquired conditions.	On June 6, 2011, CMS published a final rule, “Medicaid Program; Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions” (76 <i>Federal Register</i> 32816). The rule took effect on July 1, 2011.
March 23, 2012	2952(c)	Requires the HHS Secretary to submit to Congress a report on the benefits of screening for postpartum depression.	On March 9, 2012, AHRQ published a systematic review titled “Efficacy and Safety of Screening for Postpartum Depression.” See http://effectivehealthcare.ahrq.gov/ehc/products/379/997/PPD_Protocol_20120309.pdf . No report has been submitted to Congress.

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
Title III: Medicare, Health Care Quality			
June 1, 2011	4204(e)	Requires the Comptroller General to submit to Congress a report on Medicare beneficiaries' access to recommended vaccines covered under Part D.	On December 15, 2011, GAO released report GAO-12-61, "Medicare: Many Factors, Including Administrative Challenges, Affect Access to Part D Vaccinations." See http://www.gao.gov/assets/590/587009.pdf .
July 1, 2011	3113	Requires the HHS Secretary to begin a 2-year, \$100 million demonstration under Part B that will make separate payments to labs for complex diagnostic tests provided to Medicare beneficiaries.	On July 5, 2011, CMS published a notice of an opportunity to participate in the demonstration, "Medicare Program; Section 3113: The Treatment of Certain Complex Diagnostic Laboratory Tests Demonstration" (76 <i>Federal Register</i> 39110). See https://innovation.cms.gov/Medicare-Demonstrations/Treatment-of-Certain-Complex-Diagnostic-Laboratory-Tests.html .
July 1, 2011	3313(a)	Requires the HHS Office of Inspector General (OIG) to submit to Congress an annual report (beginning in 2011) on the extent to which drugs commonly used by dual eligibles are included on Part D drug formularies.	HHS/OIG released its initial report, "Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles" on April 26, 2011, See http://oig.hhs.gov/oei/reports/oei-05-10-00390.pdf . Annual reports have been released each year since.
Oct. 1, 2011	3006(a) & (b)	Requires the HHS Secretary to submit to Congress plans for implementing a value-based purchasing (VBP) program for Medicare payments to skilled nursing facilities (SNF) and to home health agencies.	On March 22, 2012, HHS released its plan to implement a home health agency VBP program. See http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/downloads/Stage-2-NPRM.pdf . On June 20, 2012, HHS released its plan to implement a SNF VBP program. See http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPFS/Downloads/SNF-VBP-RTC.pdf .
Oct. 1, 2011	3313(b)	Requires the HHS/OIG to submit to Congress a report that compares the prices of drugs covered under Part D with the prices of outpatient drugs covered under state Medicaid plans.	In August 2011, HHS/OIG released a report, "Higher Rebates for Brand-Name Drugs Result in Lower Costs for Medicaid Compared to Medicare Part D." See http://oig.hhs.gov/oei/reports/oei-03-10-00320.pdf .
Dec. 1, 2011	3014(b)	Requires the HHS Secretary to make publicly available a list of specified quality and efficiency measures under consideration for use in Medicare payment systems and other health care programs.	On December 2, 2011, NQF posted a list of measures on its website. See http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx .
Jan. 1, 2012	3008(b)	Requires the HHS Secretary to submit to Congress a report with recommendations on expanding Medicare payment adjustments for healthcare acquired conditions beyond inpatient hospital services (required under ACA Sec. 3008(a)) to other providers participating in Medicare.	In December 2012, CMS published a report, "CMS Report to Congress: Assessing the Feasibility of Extending the Hospital Acquired Conditions (HAC) IPPS Payment Policy to Non-IPPS Settings." See http://innovation.cms.gov/Files/x/HospAcquiredConditionsRTC.pdf .

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
Jan. 1, 2012	3022	Requires the HHS Secretary to establish an integrated care delivery model—the Medicare Shared Savings Program—using Accountable Care Organizations (ACOs). While ACOs can be designed with varying features, most models put primary care physicians at the core, along with other providers, and emphasize simultaneously reducing costs and improving quality. Under the Medicare Shared Savings Program, CMS will contract for ACOs to assume responsibility for improving quality of care provided, coordinating care across providers, and reducing the cost of care Medicare beneficiaries receive. If cost and quality targets are met, ACOs will receive a share of any savings realized by CMS.	CMS's final rule to implement the Medicare Shared Savings Program was published on Nov. 2, 2011 (<i>76 Federal Register 67802</i>). Three additional documents were issued in connection with the shared savings program: (1) a joint CMS and HHS/OIG interim final rule with comment period establishing waivers of the application of the physician self-referral (Stark) law and the federal anti-kickback statute to ACOs (<i>76 Federal Register 67992</i> ; Nov. 2, 2011); (2) a joint Federal Trade Commission (FTC) and Department of Justice (DOJ) policy statement regarding the application of federal antitrust laws to ACOs (<i>76 Federal Register 67026</i> ; Oct. 28, 2011); and (3) an IRS notice summarizing how existing IRS guidance may apply to tax-exempt organizations such as charitable hospitals that participate in ACOs (IRS Notice 2011-20; Apr. 18, 2011). See https://www.cms.gov/sharedsavingsprogram/ .
Jan. 1, 2012	3024	Requires the HHS Secretary to implement a 3-year Independence at Home demonstration to test whether home-based care can reduce hospitalization, improve patient care, and lower costs to Medicare.	The demonstration, which includes 15 participating practices and consortia, began on June 1, 2012. See https://innovation.cms.gov/initiatives/independence-at-home/ .
Feb. 1, 2012	3014(b)	Requires NQF to transmit to HHS its first annual review of quality measures being considered for use in federal rulemaking.	In February 2012, the Measure Applications Partnership (MAP), convened by NQF, published the required pre-rulemaking report. This initial report (and subsequent annual reports) may be found at https://www.qualityforum.org/Setting_Priorities/Partnership/MAP_Final_Reports.aspx .
March 1, 2012	3014(b)	Requires the HHS Secretary to make publicly available an assessment of the quality and efficiency impact of the use of endorsed quality measures.	In March 2012, CMS published this information in a report, "National Impact Assessment of Medicare Quality Measures." See https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/NationalImpactAssessmentofQualityMeasuresFINAL.PDF .
March 23, 2012	3013(a)	Requires the HHS Secretary to develop at least 10 outcome measures for acute and chronic diseases.	CMS informed CRS in October 2013 that the 10 outcome measures for acute and chronic disease had been developed.
March 23, 2012	3505(a)	Requires the Secretary to submit to Congress a report on the status of grants to, and financial stability of, trauma centers.	No funding has been appropriated for these grants and, therefore, no report has been submitted.
March 23, 2012	3508	Authorizes the HHS Secretary to fund demonstration projects to integrate quality improvement and patient safety training into clinical education of health professionals, and evaluate such projects. Requires the Secretary, by Mar. 23, 2012, to submit to Congress a report on the projects and their evaluation.	No funding has been appropriated for these grants and, therefore, no report has been submitted.

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
Title IV: Prevention and Public Health, Health Disparities			
Sept. 23, 2011	4302(b)	Requires the HHS Secretary to submit to Congress a report evaluating health care disparities data collection under Medicaid and CHIP.	On September 29, 2011, HHS released "Report to Congress: Approaches for Identifying, Collecting, and Evaluating Data on Health Care Disparities in Medicaid and CHIP." See http://www.healthcare.gov/law/resources/reports/disparities09292011a.pdf .
Sept. 23, 2011	4103	Requires the HHS Secretary to make publicly available a health risk assessment model to support Medicare coverage of personalized prevention plan services.	CDC's "Interim Guidance for Health Risk Assessments and their Modes of Provision for Medicare Beneficiaries" is available at http://www.cms.gov/coveragegeninfo/downloads/healthriskassessmentsCDCfinal.pdf .
March 23, 2012	4102(a)	Requires the HHS Secretary to implement a 5-year national public education campaign on oral health care prevention and education.	No funds have been appropriated for the public education campaign, which has not been implemented.
March 23, 2012	4203	Requires the Architectural and Transportation Barriers Compliance Board (the Access Board), in consultation with FDA, to promulgate standards to ensure that medical diagnostic equipment is accessible to, and usable by, individuals with disabilities.	The Access Board published proposed standards on February 9, 2012 (<i>77 Federal Register</i> 6916) then organized an advisory committee to review the comments on the proposal and prepare recommendations for the Board to use in finalizing the standards. The advisory committee submitted its recommendations to the Board on December 6, 2013. For more information, see http://www.access-board.gov/guidelines-and-standards/health-care/about-this-rulemaking .
March 23, 2012	4303	Requires CDC to conduct a national survey of employer-based health policies and programs.	No publicly available CDC survey report was located. However, the RAND Corporation published such a survey on contract from DOL and HHS in 2013. See "Research Report: Workplace Wellness Programs Study, Final Report," http://www.rand.org/pubs/research_reports/RR254.html , which was prepared as required by ACA Sec. 1201 (amending PHSA Sec. 2705(m)), and was due March 23, 2013. RAND published a follow-up report for DOL in 2014. See "Workplace Wellness Programs: Services Offered, Participation, and Incentives," http://www.dol.gov/ebsa/pdf/WellnessStudyFinal.pdf .
March 23, 2012	10407(d)	Requires the HHS Secretary to submit to Congress a report on the appropriate level of diabetes medical education.	No public information located.
Title V: Health Workforce			
April 1, 2011	5101	Requires the National Health Care Workforce Commission to submit to Congress a report containing a review of, and recommendations on, high-priority health care workforce issues.	The 15-member commission was appointed in 2010, but has received no funding and has not produced any reports. See http://www.cq.com/doc/hbnews-3962182?wr=bzR2QWhQbmtjMG1HalczZVVpWWTNiZw ; and http://www.nytimes.com/2013/02/25/health/health-care-panel-lacking-budget-is-left-waiting.html?_r=1& .

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
Oct. 1, 2011	5101	Requires the National Health Care Workforce Commission to submit to Congress a report containing a review of, and recommendations on, national health care workforce priorities, goals, and policies.	The 15-member commission was appointed in 2010, but has received no funding and has not produced any reports. See http://www.cq.com/doc/hbnews-3962182?wr=bzR2QWhQbmtjMGIHalczZVVpWWTNiZw ; and http://www.nytimes.com/2013/02/25/health/health-care-panel-lacking-budget-is-left-waiting.html?_r=1& .
Sept. 23, 2011	5507(a)	Requires the HHS Secretary to award 3-year demonstration grants to states for developing core training competencies and certification programs for personal or home care aides. ACA appropriated a total of \$15 million for the grant program over the period FY2010-FY2012.	HRSA awarded Personal and Home Care Aide State Training (PHCAST) grants in FY2010-FY2012. See http://bhpr.hrsa.gov/nursing/grants/phcast.html .
July 1, 2011	5503(a) & (b)	Requires the HHS Secretary to reduce the residency caps of hospitals with unused residency positions for the purpose of making graduate medical education (GME) payments under Medicare. Further requires the Secretary to redistribute these unused positions, based on a specified formula. Direct GME and indirect medical education (IME) payments for the redistributed residency positions are to be made on the same basis as the payments for existing residency positions. Effective beginning July 1, 2011.	On November 24, 2010, CMS published final rules for various Medicare hospital payment systems for 2011, which included the GME payment changes pursuant to ACA Sec. 5503 (75 <i>Federal Register</i> 72147).
July 1, 2011	5602	Requires the HHS Secretary to publish a final rule (incorporating public comment on an earlier interim final rule) on a comprehensive methodology and criteria for designating medically underserved populations and health professions shortage areas.	A final rule has yet to be published. See the entry for ACA Sec. 5602 in Table I for the status of other HHS actions taken towards meeting this regulatory deadline.
March 23, 2012	5304	Requires the HHS Secretary to establish an alternative dental care provider demonstration project.	The FY2011, FY2012, FY2013, FY2014, and FY2015 Labor-HHS-Education appropriations acts all prohibited funding the demonstration. The FY2016 Labor-HHS-Education appropriations act continues the funding prohibition.
March 23, 2012	5507(a)	Requires the HHS Secretary to submit to Congress a report on initial implementation of the home health aide demonstration project.	HHS submitted a report to the relevant congressional committees in January 2012. See http://bhpr.hrsa.gov/nursing/grants/phcastimplementationreport.pdf .
Title VI: Elder Justice, Transparency and Program Integrity			
Sept. 23, 2011	6703(a)	Requires the Advisory Board on Elder Abuse, Neglect, and Exploitation to prepare and submit to the Elder Justice Coordinating Council and to Congress a report containing information on the status of federal, state, and local public and private elder justice activities and recommendations on elder justice programs, research, and enforcement, among other things.	On July 14, 2010, HHS published a notice establishing the Advisory Board (75 <i>Federal Register</i> 40838), but the Board has received no funding and has not submitted a report.

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
Sept. 23, 2011	6703(c)	Requires the HHS Secretary to submit to the Elder Justice Coordinating Council and to Congress a report containing the findings and recommendations of a study on establishing a national nurse aide registry.	No funding has been appropriated for these grants and, therefore, no report has been submitted.
March 23, 2012	6703(a)	Requires the Elder Justice Coordinating Council to submit to Congress a report on the Council's activities with recommendations for legislation, model laws, or other action as appropriate.	On October 11, 2012, the HHS Secretary convened the inaugural meeting of the Elder Justice Coordinating Council (EJCC). The Council is a permanent group, anticipated to meet twice a year, and is supported by the Elder Justice Interagency Working Group (EJWG). Since the inaugural meeting, the Council has convened two times, on May 13, 2013 and September 24, 2013. During these meetings EJWG members presented proposals for federal action and a summary of steps for federal involvement in the prevention, detection, and prosecution of elder abuse. In addition, the EJWG has coordinated a report of federal activities in elder justice since 2010. For a copy of the report, a list of EJCC members, and more information on EJCC meetings and proposals, see http://www.aoa.gov/AoA_programs/Elder_Rights/EJCC/Index.aspx .
March 23, 2012	6101(a)	Requires the HHS Secretary to promulgate final regulations on required disclosure of ownership and other information by nursing facilities.	On May 6, 2011, CMS published the FY2012 Skilled Nursing Facility (SNF) reimbursement update proposed rule (<i>76 Federal Register 26364</i>), which included a discussion of the agency's proposals for implementing ACA Sec. 6101(a) and requested comments. On August 8, 2011, CMS published the FY2012 SNF final rule (<i>76 Federal Register 48486</i>), in which it indicated that the proposed changes to implement ACA Sec. 6101 would be issued at a later, but unspecified, date. No additional public information on the implementation of 6101(a) has been located.
March 23, 2012	6102	Requires the HHS Secretary in collaboration with the OIG to promulgate regulations for an effective compliance and ethics program at nursing facilities.	Regulations implementing ACA Sec. 6102 have yet to be issued; however, prior to ACA's enactment nursing facilities were required to have an effective compliance program in place. The HHS/OIG has published guidance on implementation of compliance and ethics programs that are effective until new regulations are issued. See <i>73 Federal Register 56832</i> , September 30, 2008, "OIG Supplemental Compliance Program Guidance for Nursing Facilities," http://www.gpo.gov/fdsys/pkg/FR-2008-09-30/pdf/E8-22796.pdf .
March 23, 2012	6102	Requires the HHS Secretary to establish and implement a Quality Assurance and Performance Improvement (QAPI) program for nursing homes.	CMS has not yet published a proposed rule to implement a QAPI program for nursing homes and other long-term care facilities. The agency maintains a nursing home QAPI website at http://cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/NHQAPI.html .

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
March 23, 2012	6107	Requires GAO to submit a report to Congress on the Five-Star Quality Rating System for nursing facilities.	On March 23, 2012, GAO published report GAO-12-390, "Nursing Homes: CMS Needs Milestones and Timelines to Ensure Goals for the Five-Star Quality Rating System Are Met." See http://www.gao.gov/assets/590/589563.pdf . GAO's report examined (1) how CMS developed and implemented the Five-Star System and what key methodological decisions were made during development, (2) the circumstances under which CMS considered modifying the Five-Star System, and (3) the extent to which CMS established plans to help ensure it achieves the Five-Star System goals.
Titles VII, VIII & X: 340B Drug Pricing, CLASS Act, Indian Health			
Sept. 23, 2011	7103(a)	Requires the Comptroller General to submit to Congress a report on whether the 340B program should be expanded, whether mandatory 340B sales of certain products could hinder patients' access to those therapies through any provider, and whether 340B income is being used by covered entities to further program objectives.	On September 23, 2011, GAO released report GAO-11-836, "Drug Pricing: Manufacture Discounts in the 340B Program Offer Benefits, but Federal Oversight Needs Improvement." See http://www.gao.gov/new.items/d11836.pdf .
Jan. 1, 2012	8002(a)	Requires the HHS Secretary to establish an eligibility assessment system for individuals who apply to receive benefits under the CLASS Act.	On January 3, 2013, President Obama signed the American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240). Among its provisions, ATRA repealed the CLASS Act and made several conforming statutory changes to the Medicaid statute. ATRA also repealed ACA's annual appropriation (FY2011-FY2015) to the National Clearinghouse for Long Term Care Information and rescinded the unobligated balance.
Jan. 15, 2012	7002(f)	Requires the HHS Secretary to transmit to Congress its plans for establishing an abbreviated licensure pathway for biological products that are demonstrated to be biosimilar to or interchangeable with an FDA-licensed biological product.	On February 15, 2012, FDA published three draft guidance documents on key scientific and regulatory factors involved in submitting applications for approval of biosimilar products (77 <i>Federal Register</i> 8883, 8884, 8885). See http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/TherapeuticBiologicApplications/Biosimilars/ucm241720.htm . On March 6, 2015, FDA announced the approval of the first biosimilar product Zarxio. See http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm436648.htm .
Sept. 23, 2011	10221	Requires the HHS Secretary to submit a report to Congress on protocols, policies, procedures, and other programs for victims of domestic or sexual violence. [IHCA Sec. 181]	IHS informed CRS on December 10, 2015, that the report is completed and is in the IHS clearance process.
Sept. 23, 2011	10221	Requires the HHS Secretary to submit a report describing the specified elements of the prescription drug monitoring program. [IHCA Sec. 196]	IHS informed CRS on December 10, 2015, that the report is completed and is in the IHS clearance process.

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
Sept. 23, 2011	10221	Requires the Attorney General (AG) to submit a report to Congress describing certain factors regarding the AG's responsibility related to prescription drug abuse in Indian communities. [IHClA Sec. 196]	In October 2011, the Department of Justice released "Indian Health Care Improvement Act, Report Required by 25 U.S.C. 1680q(b)(2)." See http://www.justice.gov/tribal/docs/ihia-pdmp-rpt-to-congress.pdf .
Sept. 23, 2011	10221	Requires the HHS Secretary to submit a report to Congress describing disease and injury prevention activities by IHS and other federal agencies. [IHClA Sec. 198]	IHS informed CRS on December 10, 2015, that the report is completed and is in the IHS clearance process.
Sept. 23, 2011	10221	Requires GAO to submit a report to Congress containing the results and recommendations resulting from a study evaluating the effectiveness of the coordination of health care services provided to Indians either through Medicare, Medicaid, or CHIP, with those provided by IHS, with funding from state or local governments or Indian tribes. [IHClA Sec. 199]	On September 5, 2013, GAO released report GAO-13-553, "Indian Health Service: Most American Indians and Alaska Natives Potentially Eligible for Expanded Health Coverage, but Action Needed to Increase Enrollment." See http://www.gao.gov/products/GAO-13-553 .
Sept. 23, 2011	10221	Requires the Comptroller General to study (in consultation with IHS, Indian tribes, and tribal organizations) and make recommendations to improve the use of health care services provided under the contract health service (CHS) program. This will include analyses of amounts reimbursed to providers, suppliers, and entities under CHS, compared to reimbursements through other public and private programs; barriers to access to health care under CHS; adequacy of federal funding of CHS; and other matters that GAO determines appropriate. [IHClA Sec. 199]	On September 23, 2011, GAO released report GAO-11-767, "Indian Health Service: Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need." See http://www.gao.gov/new.items/d11767.pdf . On June 15, 2012, GAO released a second CHS report in response to this mandate: GAO-12-446, "Indian Health Service: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program." See http://www.gao.gov/assets/600/591631.pdf . On April 13, 2013, GAO released Report GAO-13-272, "Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services." See http://www.gao.gov/assets/660/653728.pdf .
Feb. 6, 2012	10221	Requires the President to include, within IHS's annual budget request and justification, amounts that reflect changes in the cost of health care services adjusted by the consumer price index and amounts adjusted to reflect changes in the IHS service population. [IHClA Sec. 195]	IHS's FY2016 budget included these adjustments. See http://www.ihs.gov/budgetformulation/includes/themes/newihstheme/documents/FY2016CongressionalJustification.pdf .
Feb. 6, 2012	10221	Requires the Secretary to submit a report to the President describing the health care facility priority system and the top 10 priorities for various construction projects under this priority system. This report is to be included in the annual report that the President is required to transmit to Congress at the time the annual budget is submitted (see above). [IHClA Sec. 141]	IHS updates its health care facility priority report annually.

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
March 23, 2012	10221	Requires the Secretary to submit a biennial report to Congress on the grants awarded for the prevention, control, and elimination of communicable and infectious diseases. [IHClA Sec. 133]	No funding has been appropriated for these grants and, therefore, no report has been submitted.
March 23, 2012	10221	Requires the Secretary, through IHS, to submit a report to Congress describing the activities carried out by the Office of Indian Men's Health and findings related to Indian Men's Health. [IHClA Sec. 136]	IHS informed CRS on December 10, 2015, that the report is completed and is in the IHS clearance process.
March 23, 2012	10221	Requires the Director of the IHS office of HIV/AIDS Prevention and Treatment to submit a report to Congress describing the office's activities and findings related to HIV/AIDS prevention and treatment activities specific to Indians. [IHClA Sec. 201]	IHS informed CRS on December 10, 2015, that the report is completed and is in the IHS clearance process.

Source: Prepared by the Congressional Research Service based on (i) the text of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148), as amended; and (ii) publicly available information from official federal sources.

Table 3. Selected ACA Deadlines in the Third Year After Enactment (March 24, 2012 – March 23, 2013)

Updated Information on Deadlines Included in the CRS Memorandum Dated April 21, 2014

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
Title I: Private Health Insurance, Administrative Simplification			
July 1, 2012	1104(b)	Requires the HHS Secretary to adopt operating rules for electronic funds transfers and for health care payment and remittance advice transactions. [Note: This is the second of four deadlines for adopting operating rules for the HIPAA electronic transaction standards; see Tables 2, 4, and 5.]	On August 10, 2012, HHS published a final rule, “Administrative Simplification: Adoption of Operating Rules for Health Care Electronic Funds Transfers (EFT) and Remittance Advice Transactions” (77 <i>Federal Register</i> 48008). The compliance deadline was January 1, 2014.
Oct. 1, 2012	1104(c)	Requires the HHS Secretary, based on input from NCVHS, to adopt a standard for a unique health plan identifier (HPID) that takes effect by October 1, 2012.	On September 5, 2012, HHS published a final rule, “Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier” (77 <i>Federal Register</i> 54664). The rule took effect on November 5, 2012. Large health plans must obtain an HPID by November 5, 2014, and small health plans must do so by November 5, 2015.
Jan. 1, 2013	1104(c)	Effective date for the operating rules for the following HIPAA electronic transactions: eligibility for a health plan, and health care claim status.	The operating rules for health plan eligibility and health care claim status were published on July 8, 2011 (see Table 2). The compliance deadline for the operating rules was January 1, 2013.
Jan. 1, 2013	1411(i)	Requires the HHS Secretary to report to Congress the results of a study on the procedures necessary to protect certain employer and employee rights under ACA.	No public information located.
March 23, 2013	1201	Requires the HHS Secretary to submit a report to Congress regarding the impact and effectiveness of wellness programs and incentives.	HHS and the Department of Labor contracted with RAND, which published <i>Workplace Wellness Programs Study, Final Report</i> , May 30, 2013, http://www.rand.org/pubs/research_reports/RR254.html .
Title II: Medicaid, Children’s Health Insurance Program (CHIP)			
Jan. 1, 2013	2701	Requires the HHS Secretary, in consultation with the states, to develop a standardized format for reporting adult health quality measures.	CMS has provided states with technical specifications and a resource manual with which to collect the Medicaid Adult Core Set measures. See http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html .

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
Titles III & X: Medicare, Health Care Quality			
Oct. 1, 2012	3004	Requires the HHS Secretary to publish quality measures for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs.	<p>On August 18, 2011, CMS published three finalized quality measures for use in the Long-Term Care Hospital Quality Reporting Program (<i>76 Federal Register</i> 51745-51750).</p> <p>On August 5, 2011, CMS published two finalized quality measures for use in the Inpatient Rehabilitation Hospital Quality Reporting Program in the FY2012 Inpatient Rehabilitation Facility (IRF) PPS final rule (<i>76 Federal Register</i> 47874).</p> <p>On August 4, 2011, CMS published two finalized quality measures for use in the Hospice Quality Reporting Program in FY2014 (<i>76 Federal Register</i> 47302, 47320).</p>
Oct. 1, 2012	3005	Requires the HHS Secretary to publish quality measures for cancer hospitals.	On August 31, 2012, CMS published five finalized quality measures for use in the PPS-Exempt Cancer Hospital Quality Reporting Program beginning with FY2014 (<i>77 Federal Register</i> 53561).
Oct. 1, 2012	10322	Requires the HHS Secretary to publish quality measures for psychiatric hospitals.	On August 31, 2012, CMS published six finalized quality measures for use in the Inpatient Psychiatric Facility Quality Reporting Program beginning with FY2014 (<i>77 Federal Register</i> 53652).
Jan. 1, 2013	10331	Requires the HHS Secretary to implement a plan for making comparable information on physician performance available through the Physician Compare website.	The CMS Physician Compare website was launched on December 30, 2010. See http://www.medicare.gov/physiciancompare/search.html . The first step of the required plan was outlined in the 2012 Physician Fee Schedule (PFS) Final Rule (<i>76 Federal Register</i> 73025), initiating a phased approach to public reporting. The second step of the plan was outlined in the 2013 PFS Final Rule (<i>77 Federal Register</i> 68891).
March 23, 2013	3013(a)	Requires the HHS Secretary to develop at least 10 outcome measures for primary and preventive care.	CMS informed CRS in October 2013 that the 10 outcome measures for primary and preventive care are under development.
Title VI: Transparency and Program Integrity			
May 1, 2012	6001(b)	Requires the HHS Secretary to begin conducting audits of physician-owned hospitals to determine compliance with Stark Law requirements.	No public information located. [Note: ACA Sec. 6001 amended certain exceptions to the Stark law to impose additional limitations on physician ownership or investment in hospitals, including restrictions on facility expansion. CMS extended the deadline for physician-owned hospitals to report ownership and investment information, pursuant to Sec. 6001, pending further notification. For more information, see https://www.cms.gov/medicare/fraud-and-abuse/physicianselfreferral/physician_owned_hospitals.html . See also March 12, 2-15 MLN Connects Provider eNews at https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-03-12-eNews.html?DLPage=5&DLEntries=10&DLSort=0&DLSortDir=descending#_Toc413835827 .]

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
March 28, 2012	6402(j)	Requires the HHS Secretary to submit a report to Congress on the effectiveness of the Medicare Integrity Program (MIP) funds.	The Secretary was required to report on the effectiveness of the Medicaid Integrity Program under the Deficit Reduction Act of 2005 (P.L. 109-171). ACA Sec. 6402(j) added the requirement that the Secretary report on the effectiveness of the Medicare Integrity Program. The Secretary now issues a combined report on the effectiveness of the Medicare and Medicaid Integrity Programs. To date, combined reports have been submitted for FY2011 and for FY2012. See https://www.cms.gov/regulations-and-guidance/legislation/deficitreductionact/repcongress.html .
Title X: Indian Health			
Feb. 5, 2013 ^a	10221	Requires the President to include, within IHS's annual budget request and justification, amounts that reflect changes in the cost of health care services adjusted by the consumer price index and amounts adjusted to reflect changes in the IHS service population. [IHCIA Sec. 195]	IHS's FY2016 budget included these adjustments. See http://www.ihs.gov/budgetformulation/includes/themes/newihstheme/documents/FY2016CongressionalJustification.pdf .
Feb. 5, 2013 ^a	10221	Requires the Secretary to submit a report to the President describing the health care facility priority system and the top 10 priorities for various construction projects under this priority system. This report is to be included in the annual report that the President is required to transmit to Congress at the time the annual budget is submitted (see above). [IHCIA Sec. 141]	IHS updates its health care facility priority report annually.
March 23, 2013	10221	Requires the HHS Secretary to submit a report to Congress on the current health status and resource deficiencies of each tribe or service unit. [IHCIA Sec. 121]	IHS informed CRS on December 10, 2015, that the report is completed and is in the IHS clearance process.
March 23, 2013	10221	Requires the HHS Secretary to submit a report to Congress considering the feasibility of considering the Navajo Nation ^b as a state for Medicaid purposes. [IHCIA Sec. 155]	IHS informed CRS on December 10, 2015, that the report is completed and is in the IHS clearance process.

Source: Prepared by the Congressional Research Service based on (i) the text of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148), as amended; and (ii) publicly available information from official federal sources.

- a. This is the date that the President's FY2014 budget was due. The FY2014 budget was actually released on April 10, 2013.
- b. Navajo Nation resides on the Navajo reservation that is located in parts of Arizona, Utah, and New Mexico.

Table 4. Selected ACA Deadlines in the Fourth Year After Enactment (March 24, 2013 – March 23, 2014)

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
Title I: Private Health Insurance, Administrative Simplification			
July 1, 2013	1333	Requires the HHS Secretary, in consultation with the National Association of Insurance Commissioners, to issue regulations for the creation of health care choice compacts. The compacts would allow multiple states to enter into an agreement under which one or more individual plans would be offered in all such states but only be subject to the laws and regulations of the state in which the plan was written or issued.	No public information located.
Jan. 1, 2014	1104(b)	Requires the HHS Secretary to establish a committee to review, and provide recommendations for updating and improving, the HIPAA electronic transaction standards and operating rules.	NCVHS has been designated as the committee responsible for reviewing the status of adoption and implementation of the HIPAA standards and operating rules, and for advising on changes needed. The review committee's charter was approved in September 2014. See http://www.ncvhs.hhs.gov/wp-content/uploads/2014/11/Review-Committee-Charter-NCVHS-Approved-Sept-2014-Final.pdf .
Jan. 1, 2014	1104(c)	Requires the HHS Secretary to adopt a HIPAA electronic transaction standard and associated operating rules for health claims attachments. [Note: This is the third of four deadlines for adopting operating rules for the HIPAA electronic transaction standards; see Tables 2, 3, and 5.]	A final rule has not yet been issued. In a September 23, 2014, letter to the HHS Secretary, NCVHS said that it was premature to recommend the new standards on health claims attachments currently under development. See http://www.ncvhs.hhs.gov/wp-content/uploads/2014/10/140923lt4.pdf .
Title II: Medicaid, Children's Health Insurance Program (CHIP)			
Dec. 31, 2013	2401	Requires the HHS Secretary to submit to Congress an interim report evaluating the Community First Choice Option.	The interim report was provided to Congress in June 2014. See http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/community-first-choice-interim-report-to-congress.pdf .
Title III: Medicare, Health Care Quality			
April 30, 2013	3403	Requires the Chief Actuary of CMS to determine whether the projected Medicare per capita growth rate for the implementation year exceeds the projected Medicare per capita target growth rate for the implementation year. [Note: This determination for the Independent Payment Advisory Board (IPAB) must continue to be made on an annual basis.]	The initial determination was published by CMS on April 30, 2013. For more information on this and subsequent annual IPAB determinations, see https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/IPAB-Determination.html .

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
March 1, 2014	3131(d)	Requires the HHS Secretary to submit to Congress a report on home health agency costs associated with providing ongoing access to care to low-income Medicare beneficiaries or those in medically underserved areas, among other things.	In December 2014, HHS submitted the report, "Medicare Home Health Study: An Investigation on Access to Care and Payment for Vulnerable Patient Populations." See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/HH-Report-to-Congress.pdf .
Title IV: Prevention and Public Health, Health Disparities			
Sept. 30, 2013	4202(b)	Requires the HHS Secretary to submit to Congress a report on programs that promote healthy lifestyles and chronic disease self-management for Medicare beneficiaries based on an evidence review and evaluation of programs.	HHS has published an inventory of HHS programs (2011) and a report on successful non-HHS activities (2012) to improve the quality of care and health outcomes for persons with multiple chronic conditions (MCC), including but not limited to Medicare beneficiaries. See "HHS Initiative on Multiple Chronic Conditions," http://www.hhs.gov/ash/initiatives/mcc/ .
Jan. 1, 2014	4108	Requires the HHS Secretary to submit to Congress an initial evaluation of the impact of ACA state grants for initiatives to help prevent chronic disease in Medicaid beneficiaries.	The initial report was submitted to Congress in November 2013. See "Medicaid Incentives for the Prevention of Chronic Diseases Model," https://innovation.cms.gov/initiatives/MIPCD/index.html .
March 23, 2014	4302(b)	Requires the HHS Secretary to submit to Congress a report with recommendations for improving the identification of health care disparities for beneficiaries of Medicaid and CHIP.	See "Report to Congress: Improving the Identification of Health Care Disparities in Medicaid and CHIP," November, 2014, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/4302b-rtc-2014.pdf .

Source: Prepared by the Congressional Research Service based on (i) the text of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148), as amended; and (ii) publicly available information from official federal sources.

Table 5. Selected ACA Deadlines in the Fifth Year After Enactment (March 24, 2014 – March 23, 2015)

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
Title I: Private Health Insurance, Administrative Simplification			
April 1, May 1, Aug. 1, 2014	1104(b)	Requires the HHS Secretary, by April 1, 2014, to assess a penalty fee against a health plan that has failed to certify its compliance with applicable HIPAA electronic transactions standards and associated operating rules. Requires the HHS Secretary, by May 1, 2014, to provide the Treasury Secretary with a list of health plans that have been assessed a penalty fee for noncompliance. Requires the Treasury Secretary, by August 1, 2014, to provide notice to each health plan that has been assessed a penalty fee.	ACA section 1104(b) requires health plans to file a statement with HHS certifying that they are in compliance with the applicable HIPAA standards and operating rules. The first certification of compliance is due by December 31, 2013, and applies to the following standards and operating rules: (i) health care claim status inquiry and response; (ii) health plan eligibility inquiry and response; and (iii) EFT and remittance advice. The second certification of compliance is due by December 31, 2015, and applies to the standards and operating rules for health care claims; plan enrollment and disenrollment; premium payments; prior authorization and referral; and health claims attachments. On January 2, 2014, HHS published a proposed rule on the requirements for the first certification of compliance (79 <i>Federal Register</i> 298), which would delay the filing deadline by two years (i.e., until December 31, 2015). A final rule has not been issued. Under the ACA, the second certification of compliance is also due by December 31, 2015; however, HHS has yet to adopt the applicable operating rules (see entry below).
April 1, 2014	1104(b)	Requires the NCVHS review committee (see Table 4) to conduct hearings to evaluate and review the adopted standards and operating rules for HIPAA electronic transactions.	The review committee held a hearing on July 16-17, 2015. A report is expected by the end of 2015. See http://www.ncvhs.hhs.gov/transcripts-minutes/summary-of-the-june-16-17-2015-ncvhs-subcommittee-on-standards-review-committee/ .
July 1, 2014	1104(b)	Requires the HHS Secretary to adopt operating rules for the following four HIPAA electronic transactions: health care claims, plan enrollment/disenrollment, premium payments, and prior authorization and referral. [Note: This is the fourth and final deadline for adopting operating rules for the HIPAA electronic transaction standards; see Tables 2, 3, and 4.]	A final rule has not been issued. The Council for Affordable Quality Healthcare's (CAQH's) Committee on Operating Rules for Information Exchange has approved operating rules for these four HIPAA electronic transactions. These rules will be included in an interim final rule, which HHS anticipates will be published in 2016.
July 1, 2014	1201	Requires the HHS Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, to establish a 10-state demonstration project in which participating states are required to apply the ACA wellness program provisions to health insurers in the individual market. [Note: This ACA provision amends PHSA Sec. 2705(l).]	No public information located.

Deadline	ACA Section	Requirements	Actions Taken as of December 20, 2015
Dec. 31, 2014	1322	Requires GAO to conduct an ongoing study on competition and market concentration in the health insurance market in the United States and report to the appropriate committees of the Congress.	On December 1, 2014, GAO released report GAO-15-101R, "Private Health Insurance: Concentration of Enrollees among Individual, Small Group, and Large Group Insurers from 2010 through 2013." See http://www.gao.gov/assets/670/667245.pdf .
March 23, 2015	1401	Requires GAO to study and submit to Congress a report on the affordability of health insurance coverage, including the impact of the ACA premium tax credits, and the ability of individuals to maintain essential health benefits coverage.	On March 23, 2015, GAO released report GAO-15-312, "Private Health Insurance: Early Evidence Finds Premium Tax Credit Likely Contributed to Expanded Coverage, but Some Lack Access to Affordable Plans." See http://www.gao.gov/assets/670/669165.pdf .
Title III & X: Medicare, Health Care Quality			
Jan. 1, 2015	10331(f)	Requires the HHS Secretary to submit a report to Congress on the Physician Compare website, including efforts to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice.	In August 2014, HHS submitted the report, "Physician Compare Report to Congress." See https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/Downloads/Physician-Compare-Report-to-Congress.pdf .
Jan. 1, 2015	3131(a)	Requires MedPAC to study and submit to Congress a report on implementation of home health payment rebasing adjustments.	In December 2014, MedPAC submitted the report, "Impact of Home Health Payment Rebased on Beneficiary Access to and Quality of Care." See http://www.medpac.gov/documents/reports/dec14_homehealth_rebasing_report.pdf?sfvrsn=0 .

Source: Prepared by the Congressional Research Service based on (i) the text of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148), as amended; and (ii) publicly available information from official federal sources.

Appendix. Methodology for Determining Statutory Deadlines and their Legal Enforceability

Categorical Exclusions

Given the complexity of the ACA and the variety of legislative drafting techniques used, CRS was required to make a number of decisions as to whether a specific provision qualified for inclusion in the tables. To make those determinations, CRS relied on a close reading of the statutory text, acceptable principles of statutory interpretation (commonly referred to as “canons”), and subject matter expertise regarding typical implementing agency practice in the issue areas covered by the ACA. As a result of our review of the ACA, several categories of provisions, described below, were excluded from the tables.

Effective Dates

The largest category of exclusions included provisions that merely had an “effective date” attached to them, as opposed to a specific deadline for official federal government action. For example, ACA Sec. 1001, which adds new sections to the Public Health Service Act (PHSA), requires the HHS Secretary to define several terms related to private health insurance coverage. Pursuant to ACA Sec. 1004, these definitions took effect on September 23, 2010. However, because the ACA did not provide a specific date for the Secretary’s actions, merely an effective date, these provisions were not included in the tables.

In contrast, it should be noted that there are a few provisions in the ACA where an effective date operates as a deadline. For instance, in ACA Sec. 10501(i), the Administrator of the Centers for Medicare & Medicaid Services (CMS) is directed to develop and implement a new prospective payment system for federally qualified health centers. The ACA establishes January 1, 2011, as the effective date of the provision. Given that the only lawful way in which the effective date can be met is if CMS takes the necessary actions to authorize payments to qualified centers the effective date functions as a deadline. Thus, this type of provision was included in the tables. However, several other ACA provisions that require CMS to modify *existing* Medicare payment systems, either permanently or on a temporary basis, were not included in the tables. These types of provisions are being implemented as part of CMS’s annual rulemaking updates for the applicable Medicare payment systems.⁷

Medicaid and Medicare Benefit Expansions

The ACA includes a number of provisions that require coverage of new Medicare benefits, effective for services provided on or after a specified date. None of these provisions are included in the tables. While the effective date appears to operate as a deadline, there is no explicit requirement for a specific action to be taken. As with the Medicare payment changes, CMS seems to have opted to implement the required benefit expansions in its annual rulemaking updates for applicable Medicare payment systems.⁸ The ACA also includes two provisions that mandate new Medicaid benefits (i.e., Secs. 2301 and 4107), both of which have an effective date. Again, while the effective date appears to operate as a deadline, there is no

⁷ For example, ACA Sec. 3002, which extends the Physician Quality Reporting Initiative incentive payments and introduces a new bonus for professionals who meet a continuous assessment requirement, is addressed in the final rule updating the Physician Fee Schedule for 2011. The final rule was published in the November 29, 2010 *Federal Register*. See <http://edocket.access.gpo.gov/2010/pdf/2010-27969.pdf>.

⁸ For example, ACA Sec. 4103 requires Medicare Part B to cover personalized prevention plan services, including a comprehensive health risk assessment, effective January 1, 2011. CMS addressed this new benefit in the final rule updating the Physician Fee Schedule for 2011. The final rule was published in the November 29, 2010 *Federal Register*. See <http://edocket.access.gpo.gov/2010/pdf/2010-27969.pdf>.

explicit requirement for a specific action to be taken. Moreover, meeting the deadline depends on actions to be taken by the states. For these reasons, the two provisions were not included in the tables.

Discretionary Appropriations

Another category of provisions that has been excluded from the tables are those that contain deadlines that are contingent on future appropriated funds. In other words, even if the ACA authorized the funding, without an actual appropriation, it is unlikely that the deadline will be binding. Because Congress is not legally required to appropriate funds, even for authorized programs, there is nothing that guarantees the entity charged with meeting the deadline will have the necessary funding to do so. ACA Sec. 3503 serves as an example of such a provision. It requires the HHS Secretary to establish a grant program to support medication management services provided by pharmacists. Although the ACA provided an authorization of appropriations for this grant program, there is no actual funding available and, therefore, the provision is contingent on future appropriations by Congress that are discretionary. Thus, inclusion of the provision as a deadline is arguably misleading as Congress must first act to provide the funding, which they are under no legal or political obligation to do.⁹

Transfer Payments

Several provisions in the ACA require the transfer of funds from one federal account to another within a specified fiscal year. For example, ACA Sec. 3014 requires the HHS Secretary to transfer \$20 million from the Medicare Trust Funds to CMS's Program Management Account for each of FY2010 through FY2014 for the development and adoption of Medicare quality and efficiency measures, among other things. As these transfers can legally be executed at any point during the relevant fiscal year, there does not appear to be a definitive deadline for agency action. Thus, these and other similar transfer provisions were excluded from the tables.¹⁰

Non-Federal Government Actors

A number of provisions in the ACA that contained deadlines imposed these deadlines on non-federal actors, such as state governments, third-party groups, or private insurance providers. For example, ACA Sec. 1001 prohibits health plans from rescinding coverage except in instances of fraud or misrepresentation. That provision, along with several other ACA provisions that apply to health plans and health insurance issuers, became effective for plan years beginning on or after September 23, 2010. As the provision does not require any action on the part of a federal government agency or official to become effective, it and similar provisions were excluded from the tables. Likewise, ACA provisions that imposed deadlines on state officials, including several Medicaid provisions, were excluded both because of the voluntary nature of the Medicaid program itself, but also because the various states do not have uniform methods and mechanisms for complying with such deadlines. Thus, providing information on compliance would require a survey of each separate jurisdiction.

Other Exclusions

In addition to the categorical exclusions discussed above, there were several other provisions of the ACA that contained deadlines that are not included in the tables. For instance, ACA Sec. 4306, which appropriated funds for an obesity demonstration program authorized by the Children's Health Insurance

⁹ For a summary of all the programs in ACA that are subject to discretionary appropriations, see CRS Report R41390, *Discretionary Funding in the Patient Protection and Affordable Care Act (ACA)*, coordinated by C. Stephen Redhead.

¹⁰ For a summary of all the Medicare fund transfers in ACA, see CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (ACA)*, by C. Stephen Redhead.

Program Reauthorization Act of 2009 (CHIPRA),¹¹ was not included because the February 4, 2011 deadline for awarding a grant is contained in CHIPRA, not the ACA. Another excluded provision, Sec. 4101(a), requires the HHS Secretary to create a grant program for the establishment of school-based health centers. The provision appropriates funding for the program for each of FY2010 through FY2013, with the funds to remain available until expended, but it does not establish a definitive deadline for starting the program. Thus, because the deadline is ambiguous and the agency could use the funds at any time between FY2010 and FY2013 the provision was excluded. Similarly excluded was Sec. 6403, which among other things requires the HHS Secretary to terminate the Healthcare Integrity and Protection Data Bank and transfer the data to the National Practitioner Data Bank. This action must be completed by March 23, 2011, or a date determined by the Secretary through regulation, whichever is later. Because the Secretary retains discretion in setting the effective date, the provision was excluded as having an ambiguous deadline.

Finally, it should be noted that ACA Sec. 5605 was omitted from the tables as well. This provision imposed a deadline directly on congressional leadership, specifically the Speaker and Minority Leader in the House of Representatives and the Majority and Minority Leaders in the Senate, to appoint members of a commission by April 22, 2010. The commission, once constituted, then has statutorily imposed annual reporting deadlines. Finally, the National Academy of Sciences is required to take specific actions based on deadlines met by the commission. The congressional leadership did not meet the deadline for appointing the commission members. As each subsequent deadline is contingent on the appointment of the members of the commission, it appears that they cannot be satisfied as the commission's members have not yet been appointed. The expiration of the 111th Congress raises the question of whether the leadership of the 112th Congress, which convened on January 5, 2011, is lawfully required to make the commission appointments. It would appear that the answer is no. The principle at issue is that one Congress cannot bind a future Congress.¹² The incoming leadership may, of course, choose to make the appointments, but it would be doing so voluntarily, not out of any legal obligation.

Legal Effect of Deadlines

As a matter of administrative law, the enforceability of statutory deadlines is handled primarily via private civil litigation against the agency for failure to comply with the deadline. Typically, reviewing courts have deferred to the judgment of the agencies with respect to claims that they have unreasonably delayed action or violated statutory deadlines. In one prominent example, the Circuit Court of Appeals for the District of Columbia (D.C. Circuit) declined to compel a rulemaking by the Mine Safety and Health Administration (MSHA) even though the agency had violated a statutory deadline for completing regulation.¹³ The court did, however, agree to retain jurisdiction and required MSHA to report regularly on the status of its rulemaking process.¹⁴ In another decision, *In re Bluewater Network*,¹⁵ the D.C. Circuit established standards for adjudicating unreasonable delay cases, in which the relevance of congressionally imposed deadlines was specifically discussed. The court noted that the general rule ought to be a “rule of reason,” which is arguably consistent with the traditional deference afforded to agency judgment over rulemaking priorities. The court noted, however, that “where Congress has provided a timetable or other indication of the speed with which it expects the agency to proceed in the enabling statute, that statutory scheme may supply content for this rule of reason.”¹⁶ The permissive language used indicates that

¹¹ The Children's Health Insurance Program Reauthorization Act of 2009, P.L. 111-3, 123 Stat. 8 (2009).

¹² See, e.g., *Cooper v. Gen. Dynamics*, 533 F.2d 163, 169 (5th Cir.1976) (holding that one Congress cannot insulate a statute from amendments by future Congresses).

¹³ See *In re United Mine Workers of Am. Int'l Union*, 190 F.3d 545, 553-56 (D.C. Cir. 1999).

¹⁴ *Id.*

¹⁵ 234 F.3d 1305 (D.C. Cir. 2000).

¹⁶ *Id.* at 1315-16.

congressional deadlines will not always supplant the “rule of reason,” but depending on the specific situation before the court, statutory deadlines may overcome the court’s traditional deference to agency priority setting.

Congress may not always wish to rely on judicial enforcement of its statutorily imposed deadlines. In some cases, though not in any of the ACA provisions reviewed and included in the tables below, it has sought to impose legislative “hammers” or legal consequences on an agency’s failure to adhere to a deadline. Some examples of previous “hammers” have included the automatic imposition of a congressionally regulated result,¹⁷ a requirement that an agency’s proposed rule take effect if a final rule was not promulgated by the deadline,¹⁸ and the loss of agency funding if the final regulations were not promulgated by the statutory deadline.¹⁹ As previously noted, none of the provisions in the ACA establishing deadlines on agency implementation appear to contain any type of legislative “hammer.” Thus, it would appear that enforcement of any of these deadlines is to be left either to political enforcement, such as through congressional oversight and/or other forms of legislative pressure, or to the types of civil litigation discussed above.

¹⁷ See 42 U.S.C. § 6924(d)(1-2) (2006).

¹⁸ See Nutrition Labeling and Education Act of 1990, P.L. 101-535, 104 Stat. 2353 (1990).

¹⁹ See Department of Transportation and Related Agencies Appropriations Act, 1988, P.L. 100-202, 101 Stat. 1329 (1987).