

# **LR 467 INTERIM STUDY REPORT**

## **PATIENT PROTECTION AND AFFORDABLE CARE ACT**

### **Select Committee Interim Study**

**Prepared by**

**Michelle Chaffee**

**Legal Counsel, Health and Human Services Committee**

**December 2010**

LR 467 was an Interim Study to conduct research and provide recommendations for implementing the federal Patient Protection and Affordable Care Act. It was introduced by Senator Tim Gay on March 26, 2010. On April 7, 2010 the Executive Board of the Nebraska Legislature referred it to the Health and Human Services Committee.

**Resolution:**

ONE HUNDRED FIRST LEGISLATURE, SECOND SESSION  
LEGISLATIVE RESOLUTION 467

Introduced by Gay, 14; Campbell, 25; Gloor, 35; Heidemann, 1; Mello, 5; Nordquist, 7; Pahls, 31.

**PURPOSE:** The purpose of this interim study is to conduct research and provide recommendations for implementing the federal Patient Protection and Affordable Care Act. The interim study will examine health care financing and delivery under the act to determine the impact on health care coverage for all Nebraskans. This study shall be conducted by a select committee consisting of two members of the Appropriations Committee of the Legislature appointed by the chairperson of the committee, two members of the Banking, Commerce and Insurance Committee of the Legislature appointed by the chairperson of the committee, two members of the Health and Human Services Committee of the Legislature appointed by the chairperson of the committee, and three additional members who are not members of such committees, with one member appointed by each chairperson of such committees. The chairperson of the select committee shall be the chairperson of the Health and Human Services Committee unless he or she is not appointed to the select committee, in which case the chairperson of the select committee shall be one of the two members of the Health and Human Services Committee who were appointed to the select committee, selected by the chairperson of the Health and In conducting the study, the select committee shall consult with employers, small businesses, consumers, insurers, health care providers, the Department of Health and Human Services, the Department of Insurance, and other interested parties. Issues considered by the select committee may include, but shall not be limited to:

- (1) The effect of the federal Patient Protection and Affordable Care Act on Nebraska;
- (2) The role of employer-sponsored insurance and public programs in providing health care coverage for Nebraskans; and
- (3) Available funding options to ensure a financially sustainable and affordable health care system.

NOW, THEREFORE, BE IT RESOLVED BY THE MEMBERS OF THE ONE HUNDRED FIRST LEGISLATURE OF NEBRASKA, SECOND SESSION:

1. That a select committee of the Legislature shall be designated as provided in this resolution to conduct an interim study to carry out the purposes of this resolution.

2. That the committee shall upon the conclusion of its study make a report of its findings, together with its recommendations, to the Legislative Council or Legislature on or before December 31, 2010.

**Members of the Select Committee** responsible for completing the LR 467 Interim Study were:

Representing Health and Human Services Committee  
Senator Tim Gay, Chair Select Committee  
Senator Kathy Campbell  
Senator Heath Mello (at-large)

Representing Appropriations Committee  
Senator Lavonne Heidemann  
Senator Jeremy Nordquist  
Senator Tanya Cook (at-large)

Representing Banking, Commerce and Insurance Committee  
Senator Pahls  
Senator Mike Gloor  
Senator Galen Hadley (at-large)

### **Public Hearings**

The public hearings for LR 467 Interim Study were held Thursday, September 16<sup>th</sup>; Friday, September 17<sup>th</sup> and Thursday, October 7<sup>th</sup> in room 1510 in the Nebraska State Capitol. Below are the testifier and summary of the topics covered. The exhibits are included with this Interim Study Report. Additional research resources provided to the Select Committee are also included with this Report.

Testifiers on Thursday, September 16, 2010 included:

Joy Johnson Wilson, *Federal Affairs Counsel and Health Policy Director at the National Conference of State Legislatures (NCSL)*. NCSL represents the legislatures of the 50 states, its commonwealths, territories and the District of Columbia. As Federal Affairs Counsel, she assists with overall government relations, administrative and public affairs activities in the Washington Office. As Director of Health Policy, she designs and implements the lobbying strategy for the conference on health care issues. She recently served as a non-voting member of the Medicaid Commission established by HHS Secretary Mike Leavitt.

Topic: Overview and state perspective  
Exhibit #1

Mark Bowen, *Director of Government Relations at UNMC*. Mr. Bowen has served at University of Nebraska Medical Center (UNMC) since 2007. He has extensive knowledge of the Affordable Care Act and has been working to facilitate education regarding the provisions of the Act and the strategic implementation of the Act at UNMC. Prior to coming to UNMC Mark was Chief of Staff for the City of Lincoln for seven years. He holds a journalism degree and teaching certificate from the University of Nebraska-Lincoln and began his career as communications specialist for the Lincoln Public Schools. In 1981, he moved to Washington, D.C., to serve as press secretary and communications director to U.S. Senator Jim Exon and handle education issues. In 1991, he returned to Nebraska as the state director for the senator, managing legislative issues and supervising four district offices. Subsequently, he served for four years as the state director of the U.S. Department of Agriculture's Farm Service Agency.

Topic: Overview and implementation  
Exhibit #2

Cory Shaw MD, *CEO of the UNMC Physicians*, the physician practice plan for the University of Nebraska Medical Center. In this role, he is responsible for the strategic and day-to-day operations of the clinical practice including all clinical, financial and administrative functions. In 2005, Shaw was appointed to serve as a member of the Nebraska Medicaid Reform Advisory Committee. He serves on the steering committee for the American Association of Medical College's group on faculty practice. He previously served on the Nebraska Coalition on Access to Health Insurance. He earned his undergraduate degree from the University of Nebraska-Lincoln and his master's degree from the University of Missouri-Columbia.

Topic: Medicaid, Access of care  
Exhibit #3

Thomas Tape, M.D., *Professor and Chief of UNMC General Internal Medicine*. Dr. Tape received his BA from Dartmouth College in 1977 and an MD from Washington University in St. Louis in 1981 and did his residency and fellowship training in internal medicine at the University of Rochester (NY). Dr. Tape joined the UNMC internal medicine faculty in 1986. His work at UNMC has blended teaching, research, patient care and administration. His research has focused on better understanding how physicians make diagnostic and therapeutic medical decisions with the aim of improving the quality of those decisions. He has also devoted extensive time to helping design and implement electronic medical records systems that enhance physician productivity and improve patient care. He oversees the clinical, teaching, and research duties of approximately 40 faculty members. Dr. Tape is currently serving a four-year term as governor of the Nebraska Chapter of the American College of Physicians (ACP). With approximately 129,000 members, ACP has a keen interest in health care reform at both the state and federal levels.

Topics- Primary Care Workforce  
Exhibit #4

Pamela D. Bataillon, MBA, MSN, RN, *Associate Professor and Assistant Dean for Administration at the UNMC College of Nursing*. She is responsible for the implementation of organizational business strategies. Immediately prior to joining UNMC, she served as legislative staff as a Robert Wood Johnson Foundation Health Policy Fellow for U.S. Senator Blanche L. Lincoln and as staff assistant to the Senate's Special Committee on Aging. Her Senate work included research, analysis and advising on a wide range of health issues, particularly those related to long term care and integration of health care in the community. She was Chief Operating Officer of Visiting Nurse Association (VNA) of the Midlands, CEO of the Visiting Nurse Association of Pottawattamie County and Health Department Director for Pottawattamie County, re-engineering the operational and finance functions to strengthen clinical care, financial management, and to prepare the organizations to survive and thrive under the incoming prospective payment for home health services. She led the two Iowa organizations to valued positions as the State's strategic planning partners in maternal-child health and community-based care for the elderly and chronically ill.

Topic: Health Care Workforce  
Exhibit #5

Judy Baker, *Regional Director of the U.S. Department of Health and Human Services, Region VII, Kansas City*, has served in the health services arena for 30 years in both the private and public sectors. Before being appointed by Secretary Kathleen Sebelius to the regional post, she completed two terms as State Representative for the state of Missouri. While in the legislature, she worked on several key health care-related initiatives and contributed to policymaking on the health care committees. These accomplishments helped earn her the recognition of "Emerging Health Care Leader" from the National Conference of State Legislatures. Ms. Baker's educational background includes a bachelor's degree in educational studies, a master's degree in divinity, and a master's in health care administration and informatics from the University of Missouri.

Topics: Federal perspective of Health Care Reform, CMS  
Exhibit #6

Jose Balardo, JD, MSW, MS, *Acting Regional Health Administrator, Region VII, Kansas City*, Captain (CAPT) Jose Balardo is a career officer of the United States Public Health Service (USPHS). His professional education is as follows: Bachelor's (1988) and Master's Degree in Social Work from Virginia Commonwealth University (1990); Master's of Science Degree in Administration (Specialization: Health Care Administration) from the University of Maryland (1999); and a Juris Doctorate, (Specialization: Health Care Law) from the University of Baltimore School of Law. As the Acting RHA, CAPT Balardo is the principal federal public health leader for Region VII. He has the overall responsibility for managing five programs: Office of Minority Health, Office on Women's Health, Office of Population Affairs, Regional Resource Network for HIV/AIDS Capacity Building, and the Medical Reserve Corps. Prior to serving in

his current capacity, CAPT Balardo served as the Deputy RHA for nearly three years. Before joining OPHS, he was the Director of the Healthy Tomorrows Partnership for Children Program in the DHHS Health Resources and Services Administration's (HRSA). The Healthy Tomorrows Program purpose is to stimulate innovative community-based programs that employ prevention strategies to promote access to health care for mothers and children nationwide. Before joining Healthy Tomorrows, CAPT Ballard served as a Program Director in the Division of Perinatal Systems and Women's Health. He was the Program Director for 12 urban and rural Healthy Start (a national initiative created to reduce infant mortality rates in targeted areas) sites. Prior to joining the USPHS, he served as a Medical Service Corp Officer in the U.S. Army. While in the Army, CAPT Balardo served as the Administrator for several family-centered, community-based programs at different military installations within the United States. He also served as the Chief Mental Health Officer while deployed to Somalia, Africa during Operation Restore Hope.

Topic: Public Health Services, Public Health  
Exhibit #7

Vivianne Chaumont, *Director of the Division of Medicaid and Long-Term Care in the Nebraska Department of Health and Human Services (DHHS)* For almost 30 years she has had a lead role in developing and implementing policy that impacts the daily lives of children, the elderly and others in need. Prior to coming to Nebraska she was the CEO of ValueOptions of AZ, Inc., a company with contracts to manage the care and delivery of services to Medicaid clients and individuals with mental illness in Arizona. Previous to that, from 1985 to 2005, she worked in Colorado, first as Assistant Attorney General in the Colorado Office of the Attorney General where she was chief counsel for the state's Medicaid program and the Children's Basic Health Plan, along with other public assistance and public health programs; then as the director of the Medical Assistance Office within the Colorado Department of Health Care Policy and Financing, where she was responsible for establishing and managing policies of Colorado's Medicaid program. From 1980 to 1984 she was counsel for the California Department of Health Services, advising the department on programs relating to environmental health. Ms. Chaumont received her bachelor's degree in 1975 and law degree in 1978 from the University of California – Davis.

Topics: Medicaid  
Exhibit # 8

Testifier for Friday, September 17, 2010 was:

Ann Frohman *Director of the Nebraska Department of Insurance (NDOI)*. Ms Frohman was appointed by Governor Dave Heineman in November, 2007. She has vast experience in insurance regulation. Starting her career as a clerk for the Nebraska Supreme Court, Ms. Frohman developed an early and lasting interest in corporate and regulatory law. She developed particular

expertise on the impact of state and federal constitutional law on regulatory law. That interest in regulatory and corporate law developed during her time as a staff attorney for the NDOI from 1990-1996. During her time as a staff attorney, Ms. Frohman coordinated the development of many of Nebraska's insurance laws. As Director, Ms. Frohman oversees one of the largest domestic insurance industries in the United States.

Topics- Insurance, Exchanges  
Exhibit # 9

Testifiers for Thursday, October 7, 2010 included:

JoAnn Lamphere, DrPH, *Director, State Government Relations & Advocacy, Health & Long-term Care, AARP* Dr. Lamphere leads a team of legislative experts and serves as a main strategy advisor to AARP's fifty-three state offices. Dr. Lamphere provides political and analytic guidance to support enactment of national and state legislative priorities in areas of health care reform; long-term services and supports; effective, quality health care; and prescription drug affordability. Since passage of national health care reform, her priority is to assure the successful implementation of the Affordable Care Act across the states. Dr. Lamphere rejoined AARP in 2006 after serving six years as a senior consultant with The Lewin Group, where her areas of expertise included public sector financing, state health reform, long-term care policy, and tax credits for health coverage. From 1997 to 2000, she was Senior Policy Advisor for AARP's Public Policy Institute. Her professional experience also includes Senior Associate, Alpha Center, Washington, DC; Research Associate and Lecturer, Department of Health Policy and Management, University of North Carolina at Chapel Hill; Administrative Manager, New England Medical Center, Boston; and Health Policy Analyst and Program Director, New York State Department of Health. She earned her doctorate in Health Policy and Management from Columbia University and is an Adjunct Associate Professor at the University of Maryland. In addition to being a noted author and frequent lecturer, she is a founding member of the Campaign for Effective Patient Care.

Topics: Impact of PPACA on Medicare beneficiaries and changes that may affect state programs; Exchanges from elder consumer perspective; Integration of Medicaid and health insurance exchanges; PPACA and long-term care- Balancing Incentive Payment and Community First Choice Option  
Exhibit #1

Mark Intermill, *American Association of Retire Persons*

Bruce Rieker, *Nebraska Hospital Association*

Topic: Health care access, quality, systems changes, financing  
Exhibit #2

- NHA PowerPoint- LR 467 Interim Study Hearing
- PPACA and HCEARA Summary of Provisions

- State Policymakers Priorities for Successful Implementation of Health Reform (National Academy for State Health Policy, May 2010)
- State Structures for Implement Health Reform (National Academy for State Health Policy, October 13, 2010)
- State Decision-Making Implementing National Health Reform (NGA Health Summit Discussion Draft)
- Health Care Reform Where are we and What's Next (UNMC November 22, 2010)
- Letter Vivianne Chaumont, Milliman Report Update (November 17, 2010)
- 2011 State Legislature Check List for Health Reform Implementation (NCSL, December 2010)

### **Executive Session**

An executive session of the Select Committee was held on November 15, 2010. Present were Senators Gay, Campbell, Gloor, Hadley, Mello and Nordquist. Discussion regarding proposed next steps ensued. It was determined that the Select Committee would recommend a Legislative Resolution for continued discussion, review, implementation and oversight of the Patient Protection and Affordable Care Act.

### **Legislative Recommendation: Legislative Resolution**

Subsequent to the executive session, discussion, and review of proposed resolutions by the Select Committee of the LR 467 Interim Study the draft recommendation for a Legislative Resolution for a Health Care Reform Implementation and Oversight Committee of the Legislature is as follows.

## **ONE HUNDRED SECOND LEGISLATURE, FIRST SESSION**

### **LEGISLATIVE RESOLUTION**

Introduced by

WHEREAS, the One Hundred First Legislature, Second Session, created a select committee pursuant to Legislative Resolution 467 to conduct research and provide recommendations for implementing the federal Patient Protection and Affordable Care Act; and

WHEREAS, the interim study conducted pursuant to Legislative Resolution 467 examined health care financing and delivery under the federal act to determine the impact on health care coverage for all Nebraskans; and

WHEREAS, the select committee conducted several public hearings in Nebraska to facilitate wide collaboration, gather guidance and information from a variety of sources, and begin to develop recommendations to present to the Legislature regarding health care reform and the implementation of the federal act in Nebraska; and

WHEREAS, the select committee has determined that continued input is necessary to monitor the ongoing development of the implementation of the federal act.

NOW, THEREFORE, BE IT RESOLVED BY THE MEMBERS OF THE ONE HUNDRED SECOND LEGISLATURE OF NEBRASKA, FIRST SESSION:

1. That the Legislature hereby calls for the Executive Board of the Legislative Council to meet forthwith and reappoint the select committee of the Legislature to be known as the Health Care Reform Implementation and Oversight Committee of the Legislature. The committee shall consist of nine members of the Legislature appointed by the executive board. The executive board shall give first consideration to members of the select committee appointed pursuant to Legislative Resolution 467. The membership of the Health Care Reform Implementation and Oversight Committee of the Legislature shall consist of two members of the Appropriations Committee, two members of the Banking, Commerce and Insurance Committee, the chairperson and one other member of the Health and Human Services Committee, and three additional members of the Legislature. The chairperson of the Health and Human Services Committee shall serve as the chairperson of the Health Care Reform Implementation and Oversight Committee.

2. That the Health Care Reform Implementation and Oversight Committee shall continue the work of the select committee appointed pursuant to Legislative Resolution 467. The committee shall consult and encourage collaboration, coordination, and system wide communication with a broad array of public and private entities involved in Nebraska health care issues, including employers, small businesses, consumers, insurers, health care providers, institutions of higher education, community health centers, national and regional policy research organizations, state agencies, federal agencies, and other interested parties. The committee shall assist with the communication and collaboration of health care reform implementation between standing committees of the Legislature as the committees develop health care reform policies and proposed legislation within their subject matter jurisdiction.

3. That the Health Care Reform Implementation and Oversight Committee may consider issues, including, but not limited to:

a. Nebraska's strategic implementation of the federal Patient Protection and Affordable Care Act with special attention to Medicaid expansion, eligibility determination and enrollment processes, benefit design, the insurance exchange, health insurance reform, and workforce development;

b. Review of policy improvements and efficiencies to Nebraska health care delivery systems and payment reforms to ensure Nebraskans have quality and access, including capacity and affordability, through Nebraska's health care systems;

- State Structures for Implement Health Reform (National Academy for State Health Policy, October 13, 2010)
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b. Review of policy improvements and efficiencies to Nebraska health care delivery systems and payment reforms to ensure Nebraskans have quality and access, including capacity and affordability, through Nebraska's health care systems;

c. Utilization of technology for safe storage and transmission of health information, medical administration efficiencies, health care delivery, and aggregate data across systems to monitor population health, identify priorities for improvement, and track progress toward improvement goals;

d. Leveraging federal grants, pilot programs, and other nonstate funding sources to assist with health care reform; and

e. Aligning purchasing power of the state within Medicaid, the Children's Health Insurance Program, public employees and retirees, and the insurance exchange to form public-private partnerships to coordinate and integrate efforts with providers, employer-sponsored insurance companies, and other stakeholders to provide health care redesign in Nebraska to improve efficiencies and delivery, ensure financial sustainability, and maximize public health and wellness.

4. That the Health Care Reform Implementation and Oversight Committee is hereby authorized to continue its work until the beginning of the One Hundred Second Legislature, Second Session, and shall, upon the conclusion of its work, make a report of its findings, together with its recommendations, to the Legislature on or before December 31, 2011.

**PUBLIC HEARING**  
**SEPTEMBER 16, 2010**

**LR 467 INTERIM STUDY REPORT**

**PATIENT PROTECTION AND  
AFFORDABLE CARE ACT**

**LR 467 Interim Study**  
**September 16<sup>th</sup> and 17<sup>th</sup> 2010 Hearing Presenters**

**Thursday, September 16, 2010**

**9:00 am-Noon**

**Joy Johnson Wilson** is Federal Affairs Counsel and Health Policy Director at the National Conference of State Legislature (NCSL). NCSL represents the legislatures of the 50 states, its commonwealths, territories and the District of Columbia. As Federal Affairs Counsel, she assists with overall government relations, administrative and public affairs activities in the Washington Office. As Director of Health Policy, she designs and implements the lobbying strategy for the conference on health care issues. She recently served as a non-voting member of the Medicaid Commission established by HHS Secretary Mike Leavitt.

**Mark Bowen** is Director of Government Relations at UNMC. Mr. Bowen has served at UNMC since 2007. He has extensive knowledge of the Affordable Care Act and has been working to facilitate education regarding the provisions of the Act and the strategic implementation of the Act at UNMC. Prior to coming to UNMC Mark was Chief of Staff for the City of Lincoln for seven years where he directed and advanced the state and federal legislative program for the City of Lincoln, including organizing and advocating legislative priorities and analyzing the effect of legislation on operations, policy and revenue. He obtained his journalism degree from the University of Nebraska-Lincoln and began his career as communications specialist for the Lincoln Public Schools. In 1981, he moved to Washington, D.C., to serve as U.S. Senator Jim Exon's press secretary/communication director. In 1991, he became state director for the senator, a job in which he coordinated legislative strategy and supervised four district offices. Subsequently he served for four years as state director of the U.S. Department of Agriculture's Farm Service Agency.

**Thursday, September 16, 2010**

**1:00 p.m. - 4:00 p.m.**

**Judy Baker** Regional Director of the U.S. Department of Health and Human Services (HHS), has served in the health services arena for 30 years in both the private and public sectors. Before being appointed by Secretary Kathleen Sebelius to the regional post, she completed two terms as State Representative for the state of Missouri. While in the legislature, she worked on several key health care-related initiatives and contributed to policymaking on the health care committees. These accomplishments helped earn her the recognition of "Emerging Health Care Leader" from the National Conference of State Legislatures.

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# Federal Health Reform - The Basics



INTERIM HEARING  
IMPLEMENTATION OF  
THE PATIENT PROTECTION AND AFFORDABLE CARE ACT  
NEBRASKA UNICAMERAL LEGISLATURE  
SEPTEMBER 16, 2010

JOY JOHNSON WILSON  
HEALTH POLICY DIRECTOR  
NATIONAL CONFERENCE OF STATE LEGISLATURES

## The Laws



- The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA) was signed into law on March 23, 2010.
- The Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was signed into law on March 31, 2010 and amended some of the provisions of P.L. 111-148.
- The **package** is now often referred to as... "The Affordable Care Act"

## Health Reform Overview



- Maintains an employer-based health care system
  - Imposes a penalty on employers that fail to provide coverage or whose employees go to the health insurance exchange for coverage and receive federal subsidies
- Expands and modifies the Medicaid to become the foundation for the reformed health care system
  - All individuals with incomes at or below 133% of the federal poverty level (FPL) are eligible
- Requires individuals to obtain qualified coverage
  - Imposes a tax on individuals who fail to comply
- Imposes new reforms on health insurers and makes major revisions in the way health insurance is regulated

## Health Reform Overview



- Establishes health care exchanges to help individuals and small businesses (initially) to purchase qualified coverage
  - Establishes subsidies for premiums and cost-sharing for individuals with incomes between 133% and 400% of the federal poverty level (FPL)

## Medicaid Expansion

- Establishes a national minimum eligibility level at 133% of FPL (\$14,400)
- Eligibility is based on solely on income using Modified Adjusted Gross Income (MAGI) as the standard
  - Eliminates state defined income disregards and **establishes a standard income disregard of 5 percent**
  - (SSI, child welfare, SSDI, medically needy, Medicare Savings Programs beneficiaries are exempt)
- Adds new **mandatory** categories of Medicaid-eligibles: (1) Single, childless adults who are not disabled; (2) Parents; (3) Former Foster Care Children (aged-out of foster care) up to age 26

## Medicaid - Enhanced FMAP

- Enhanced FMAP for **Newly Eligibles** 2014 – 2020

Year	Federal Match
<b>2014</b>	<b>100%</b>
<b>2015</b>	<b>100%</b>
<b>2016</b>	<b>100%</b>
2017	95%
2018	94%
2019	93%
<b>2020 and thereafter</b>	<b>90%</b>

There are special provisions for "expansion states"

## Medicaid- Maintenance of Effort



- Temporary Maintenance of Effort
  - Prohibits changes in **eligibility standards, methodologies and procedures** that are more restrictive than those in place on date of enactment (March 23, 2010)
  - Expires for non-mandatory adults in 2014 when the health care exchanges become effective and on September 30, 2019 for children under age 19.
- **Children's Health Insurance Program (CHIP) retention** is a grant condition for continued participation in the Medicaid program

## Medicaid MOE - Financial Hardship Exemption



- **State Financial Hardship Exemption**
  - If the **governor of a state certifies** that the state has a budget deficit in the current year or will have a budget deficit in the succeeding year, the state will not have to maintain the eligibility standards from March 23, 2010 to non-mandatory adults with incomes above 133% of the federal poverty level (FPL).
  - **This provision becomes effective December 31, 2010 and sunsets on December 31, 2013.**

## New Medicaid Mandates

- Phase-in Medicare rates for primary care providers (100% federal match for increment above current rate) **for 2013 and 2014 only**
- Coverage of preventive services, no cost-sharing
- Reimbursement of Medicaid services provided by school-based health clinics
- Quality measures for adult beneficiaries
- Non-Payment for certain Health Care Acquired Conditions (mirrors Medicare provision)
- State use of National Correct Coding Initiative (NCCI) – 10/1/2010
- Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women (10/1/2010)
- Background checks for direct patient access employees of long term care facilities and providers

## Reduction in DSH Payments

- Directs the HHS Secretary to reduce DSH payments to states by \$14.1 billion between FY 2014-FY 2020
- Requires the Secretary to carry out the reductions using the "DSH Health Reform Methodology" that will impose the largest reductions on states that:
  - Have the lowest percentage of uninsured individuals (determined on the basis of: (1) data from the Bureau of the Census; (2) audited hospital reports; and (3) other information likely to yield accurate data) during the most recent year for which the data is available; or
  - Do not target their DSH payments on: (a) hospitals with high volumes of Medicaid inpatients; and (b) hospitals that have high levels of uncompensated care (excluding bad debt).

## Demonstrations Projects

- **Demonstrations**
  - Evaluate Integrated Care (bundled payments) around a Hospitalization; Medicaid Global Payments; Pediatric Accountable Care Organization (ACO); and Medicaid Emergency Psychiatric Care
- **Prevention and Wellness**
  - Incentives for Coverage of Preventive Services
    - ✦ Add 1 percentage point to regular FMAP
  - Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women (see mandates)
  - Incentive Grants for the Prevention of Chronic Diseases (1/1/2011)
    - ✦ Promoting healthy lifestyles
  - Medical Home – State Option

## Medicaid & Long-Term Care

- **Community First Option (10/1/2011)**
- Home & Community-Based Services
- Home & Community-Based Incentives (2011)
- Money Follows the Person Rebalancing Demonstration
- Treatment of Spousal Impoverishment in Home & Community-Based Programs (1/1/2014)
- Funding for Aging and Disability Resource Centers
- Waiver Authority for Dual-Eligible Demonstrations
- **Establishes a Federal Coordinated Health Care Office within CMS (for dual-eligibles) – 3/1/2010**

## What Happens to CHIP?

### • **Authorization**

- Extends the current Children's Health Insurance Program (CHIP) authorization period for two years, through **September 30, 2014**.

### • **Maintenance of Effort**

- Requires states, upon enactment, to maintain current income eligibility levels for CHIP through **September 30, 2019**.
- Prohibits states from implementing implement eligibility standards, methodologies, or procedures that were more restrictive than those in place on the date of enactment (March 23, 2010), **with the exception of waiting lists for enrolling children in CHIP**.
- Conditions future Medicaid payments on compliance with the CHIP maintenance of effort provision.

## What Happens to CHIP?

### • **Eligibility for Tax Credits in the Health Insurance Exchange**

- Provides that CHIP-eligible children, who cannot enroll in CHIP due to federal allotment caps, will be deemed ineligible for CHIP and will then be eligible for tax credits in the exchange.

### • **Enhanced Federal Matching Payments**

- Provides that from FY 2016 to FY 2019, states will receive a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent.

## CHIP & the Health Insurance Exchange

### • **CHIP and the Health Insurance Exchange**

- Provides that after FY 2015 states may enroll targeted low-income children in qualified health plans that have been certified by the Secretary.
- Requires the Secretary to no later than April 1, 2015 to review in each state the benefits offered for children and the cost-sharing imposed by qualified health plans offered through a Health Insurance Exchange.
- Requires the Secretary to certify (certification of comparability of pediatric coverage) plans that offer benefits for children and impose cost-sharing that the Secretary determines are at least comparable to the benefits and cost-sharing protections provided under the state CHIP.

## CHIP - State Employee's Children

### • **Exceptions to Exclusion of Children of State and Local Government Employees**

- **Maintenance of Effort with Respect to Per Person Agency Contribution for Family Coverage** – Requires the amount of annual agency expenditures made on behalf of each employee enrolled in health coverage paid for by the agency that includes dependent coverage for the most recent state fiscal year is not less than the amount of such expenditures made by the agency for the 1997 state fiscal year, increased by the percentage increase in the medical care expenditure category of the Consumer Price Index for All-Urban Consumers (all items: U.S. City Average) for two preceding fiscal years.
  - × **Hardship Exception** – A child qualifies for a hardship exemption if the state determines, on a case-by-case basis, that the annual aggregate amount of premiums and cost-sharing imposed for coverage of the family of the child would exceed 5 percent of such family's income for the year involved.

## Employer Responsibility

- **Penalties for Failure to Provide Coverage**
  - Requires an employer with more than 50 full-time equivalent employees that does not offer coverage and has at least one full-time equivalent employee receiving the premium assistance tax credit to make a payment of **\$2000 per full-time equivalent** employee.
    - Excludes/disregards the first 30 full-time employees.
  - Requires an employer with more than 50 full-time equivalent employees that offers coverage and has at least one full-time equivalent employee receiving the premium assistance tax credit to make a payment of **\$3000 per full-time equivalent employee**.
    - Excludes/disregards the first 30 full-time employees.
    - Penalty capped at \$2000 x number of full-time employees after applying the 30 full-time employee disregard.
- **Large Employers with Waiting Periods**
  - Amends the employer shared responsibility policy such that a large employer requiring a waiting period before an employee may enroll in coverage of longer than 60 days will pay a fine of **\$600 per full-time equivalent employee**.

## Small Business Tax Credit

- Small employers (under 50 FTEs) are exempt from the employer responsibility provisions and penalties.
- Small employers with fewer than 25 full-time equivalent employees and average annual wages of less than \$50,000 that purchase health insurance for employees are eligible for the tax credit. The maximum credit will be available to employers with 10 or fewer full-time equivalent employees and average annual wages of less than \$25,000.
- To be eligible for a tax credit, the employer must contribute at least 50 percent of the total premium cost.
- Businesses that receive state health care tax credits may also qualify for the federal tax credit.
- Dental and vision care qualify for the credit as well.

## Small Business Tax Credit cont.

- **2010 - 2013**

- For 2010 through 2013, eligible employers will receive a small business credit for up to 35 percent of their contribution toward the employee's health insurance premium.
- Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 25 percent of their contribution.

- **2014 and thereafter**

- For 2014 and beyond, small employers who purchase coverage through the new Health Insurance Exchanges can receive a tax credit for two years of up to 50 percent of their contribution.
- Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 35 percent of their contribution.

## Individual Responsibility

- Requires individuals to maintain minimum essential coverage beginning in 2014.
- **Penalties for Failure to Maintain Coverage**
  - Failure to maintain coverage will result in a penalty that is the greater of a flat fee \$95 in 2014; \$325 in 2015; and \$695 in 2016 **OR** the following percent of the excess household income above the threshold amount required to file a tax return---1% of income in 2014; 2% of income in 2015; 2.5% of income in 2016 and subsequent years.
  - For those under the age of 18, the applicable penalty will be one-half of the amounts listed above.
  - Families will pay half the amount for children up to a cap of \$2,250 for the entire family.
  - After 2016, dollar amounts will increase by the annual cost of living adjustment.

## Individual Responsibility

- **Exceptions** to the individual responsibility requirement to maintain minimum essential coverage are made for:
  - religious objectors;
  - individuals not lawfully present; and
  - incarcerated individuals.
- **Exemptions** from the penalty will be made for those who:
  - cannot afford coverage (where the lowest cost premium available exceeds 8% of income), thereby qualifying for a “hardship waiver”;
  - taxpayers with income under 100 percent of the federal poverty level;
  - members of Indian tribes; and
  - individuals who were not covered for a period of less than three months during the year.

## Health Insurance Reforms - **Now**

- Temporary high-risk pools
- Minimum medical loss ratios
- Prohibition on rescissions (exception for fraud)
- Extension of dependent coverage for young adults (expires at the 26<sup>th</sup> birthday for most)
- Limits preexisting condition exclusions for children
- Limits lifetime and/or annual caps
- Reinsurance for early retirees (applies to state and local government plans)

## Early Retiree Reinsurance Program (ERRP)



- Establishes a \$5 billion temporary program to reimburse employers (including state and local governments) for the cost of providing health care coverage to early retirees (ages 55-64) and their spouses, surviving spouses, and dependents.
- Effective for plan years beginning on or after October 1, 2011. Program ends January 1, 2014. For each beneficiary, the employer plan will receive up to 80% of costs, minus negotiated price concessions, for health benefits between \$15,000 and \$90,000. This reinsurance corridor will be adjusted in subsequent fiscal years by the medical component of the consumer price index.

## Early Retiree Reinsurance Program (ERRP)



- **Approved Entities in Nebraska** (as of September 10, 2010)
  - Ameritas Holding Company; City of Omaha; Clark County Firefighters Local 1908 Security Fund; Connectivity Solutions Manufacturing, Inc.; Connectivity Solutions Manufacturing, Inc.; Douglas County, Nebraska; Educators Health Alliance Inc.; Father Flanagan's Boys' Home; Great Plains Communications, Inc.; IBEW Local Union No. 22/NECA Health & Welfare Fund; Metropolitan Utilities District of Omaha; Mutual of Omaha Insurance Company; NEBCO, Inc.; Nebraska Public Power District; Omaha Construction Industry Health and Welfare Plan; Omaha Public Power District; **State of Nebraska**; and Steamfitters and Plumbers Local Union No. 464

## Coverage for Adult Children



- Requires plans, **for plan years beginning on or after September 23, 2010** to extend coverage to adult children, up to age 26, on their parent's health insurance plan, if the parents want them to do so.
- State laws that provide additional protection are saved unless they prevent the application of the new federal law.
- Additional coverage is available for young adults who have parents that have access to cafeteria plans to offset health costs with pretax dollars.

## Medical Loss Ratio



- Large group plans that fail to have a medical loss ratio (MLR) of 85 percent and individual and small group plans that fail to have a MLR or 80% by January 1, 2011, will be required to provide rebates to plan participants.
- HHS is authorized to adjust these rates to avoid market destabilization.
- HHS is working closely with the National Association of Insurance Commissioners (NAIC) and other stakeholders to develop a plan.

## Treatment of Grandfathered Plans



- Plans in effect prior to enactment (March 23, 2010) that make no major changes to the plan are given grandfathered status and some of the new reforms will not apply to them as long as they keep their plan without major changes.
- The following provisions, effective for plan years beginning on or after September 23, 2010 apply to grandfathered plans---
  - Prohibits lifetime limits
  - Prohibits rescissions
  - Requires dependent coverage up to age 26
  - Prohibits preexisting condition exclusions for dependents
  - Allows restricted annual limits (as determined by the HHS Secretary)

## Health Insurance Reforms - Later



- **Prohibition on preexisting condition exclusions**
- **Guaranteed issue/Guaranteed renewal**
- Premium rating rules
- Non-discrimination in benefits
- Mental health and substance abuse services parity
- Prohibits discrimination based on health status
- Prohibits annual and lifetime caps

## American Health Benefit Exchanges



### • **State Responsibilities**

- Requires states, by 2014, to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and includes an Exchange for small businesses
- **States must declare intention to administer the exchange or to permit the federal fall-back by the end of 2012**
  - **The first round of planning grants will become available this month**
  - **A second round of planning grants is expected early next year**

## American Health Benefit Exchanges



### • **HHS Secretary Responsibilities**

- Establish certification criteria for qualified health plans, requiring such plans to meet marketing requirements, ensure a sufficient choice of providers, include essential community providers in their networks, be accredited on quality, implement a quality improvement strategy, use a uniform enrollment form, present plan information in a standard format, and provide data on quality measures
- Develop a rating system for qualified health plans, including information on enrollee satisfaction, and a model template for an Exchange's Internet portal
- Determine an initial and annual open enrollment period, as well as special enrollment periods for certain circumstances

## Health Insurance Exchange

- Provides premium and cost-sharing assistance to individuals, who obtain coverage through the exchange, with incomes up to 400% of FPL.
- Establishes Multi-State Plans modeled after Federal Employees Health Benefits Program (FEHBP) and administered by the federal Office of Personnel Management (OPM).
  - This was adopted in lieu of the “Public Option”.
- Cooperatives
  - Non-profit entities, operated by a board of directors, contracts established by the HHS Secretary.

## Health Insurance Exchanges - Key State Issues

- **To Do or Not to Do**
  - States must decide before the end of 2010 whether they want to run the exchange or let HHS do it
- **Do You Want to Have a Different Kind of Party?**
  - Do you want to dance with a neighbor (state compacts)?
  - Basic Health Plan (for people with income between 133-200% of FPL)
  - Waiver will be available in 2017 (Your own Mississippi Plan)
- **What to Do**
  - How many exchanges?
  - How will it/they be governed?
- **How Will You Do What You Want To Do ?(level of regulation)**
  - One Stop Shopping Organizer
  - Selective Organizer (minimum standards)
  - Big Time Negotiator (minimum standards, plus)

## Health Insurance Exchanges - Key State Issues

- **How Will You Pay for It?**
  - The exchange must be self-sustaining after the first year
- **How Will You Make It Work**
  - Interoperability between Medicaid and the Exchange for eligibility determinations
  - Public Education
  - Training Staff
  - Infrastructure and Workforce Concerns
- **Beginning the Legislative Process**
  - NAIC Model Act will debut soon



## WHAT DOES THE NEW HEALTH LAW MEAN FOR STATES?

Joy Johnson Wilson, Health Policy Director  
National Conference of State Legislatures  
September 16, 2010

### States & the Federal Government

- A renegotiation of roles between the states and the federal government regarding health care insurance regulation, financing and administration over the next 10 years.
  - Assessing competency
  - Trust exercises
  - Trial and error
  - Making adjustments as needed

## Keeping Love Alive

- Couples counseling (states and the federal government)
  - Insurance regulation
  - Medicaid (administration, financing, benefits, providers....the future of....)
  - Health insurance exchanges
  - States as employers

## Keeping Love Alive ....Part II

- Couples counseling (state executive and legislative branches of government)
  - Establishing and agreeing on priorities
  - Developing effective strategies to implement key reforms
  - Identifying and agreeing on financing

## Elements of Success

- Meeting Overall Goals
  - ▣ Coverage
  - ▣ Health Outcomes/Quality
  - ▣ Cost Effective and Efficient Care
  - ▣ Workforce/Infrastructure
- Meeting Program Goals
  - ▣ Health Insurance Exchange(s)
  - ▣ Medicaid Expansion
  - ▣ Insurance Regulation
  - ▣ State Innovation

## Health Insurance Exchanges

- ▣ Establishing the health insurance exchanges
  - Consumer friendly
  - Business friendly
  - Interoperable with Medicaid
  - Effective and efficient operation in general
  - New service delivery models

## Mainstreaming Medicaid

- ❑ Improve infrastructure (workforce and facilities)
- ❑ Improve quality of care/customer satisfaction
- ❑ Successful marketing to non-traditional eligibles
- ❑ New service delivery models

## **REAL** Insurance Reform/Regulation

- ❑ **R**esponsive
- ❑ **E**ffective
- ❑ **A**ccountable
- ❑ **L**ocal

## Keeping State Innovation Alive

- Effectively use new tools (loans, grants, pilots and demonstration projects) to further **state and national goals**
- Effectively use the **flexibility** afforded to states
- Use **existing resources** (private, academic, volunteer, non-profit.....) and keep ALL stakeholders fully engaged to develop and initiate programs that relate to your state.

## State Policymaker Memo Pad

- **BE INFORMED**....know the implementation timelines and key decisions that must be made
- **IDENTIFY RESOURCES** to further state goals
- **DON'T LOSE YOUR STATE IDENTITY**
- **PROVIDE FEEDBACK** to the federal government
- **BE FLEXIBLE....IT'S GOING TO BE A BUMPY RIDE**.....

LR467 Select Committee  
Interim Hearing- Patient Protection & Affordable Care Act  
September 16, 2010

Comments on Implementation Timeline, Insurance Exchanges, and Grant Opportunities  
Mark Bowen, Director of Government Relations, University of Nebraska Medical Center

Thank you for the opportunity to comment.

A group composed of representatives of the University of Nebraska Medical Center (UNMC), our hospital partner the Nebraska Medical Center, the UNMC Physicians Group, and area business officials began meeting 17 months ago to examine the health reform legislation to assess how it may affect Nebraska. We have been viewed as a knowledgeable and objective resource by the media, public and business for information about health reform. Since the bill's passage, we have continued to study the implications and identified opportunities the health care reform law offers.

Today, we will address the three aspects of the law. First, I will speak to the timeframe for implementation, the opportunities for collaboration, the state insurance exchanges and grant opportunities; Second, Mr. Cory Shaw CEO of the UNMC Physicians Group will comment on the potential changes and opportunities in the health care delivery system and Medicaid, and; Third, Dr. Tom Tape, Professor and Chief of UNMC General Internal Medicine, and Pam Bataillon, Assistant Dean of the UNMC College of Nursing will speak to issues affecting the health workforce, how the training and education of the future health workforce may change.

We recognize that the Patient Protection & Affordable Care Act is primarily an insurance reform law that features many provisions to begin improving the delivery of healthcare and the overall health of citizens through use of more preventative, wellness and primary care services.

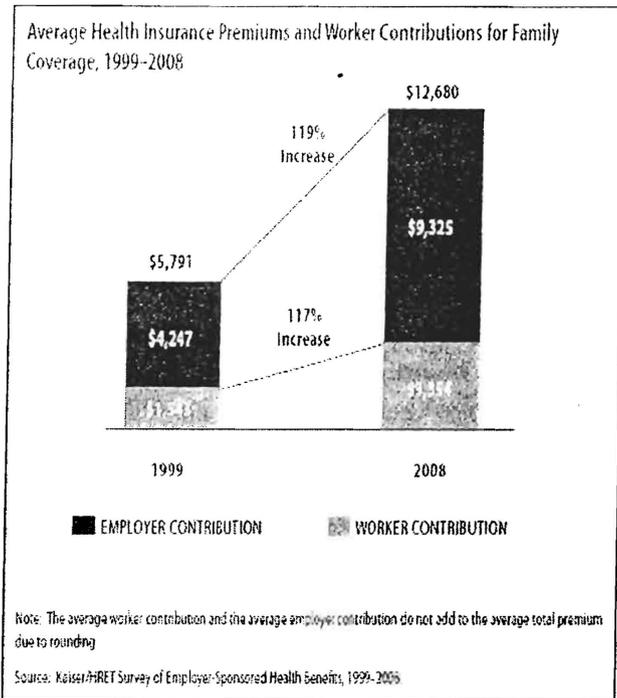
A common theme in the health reform bill is collaboration in ways that have not previously been available or encouraged. We will each touch on some of those opportunities.

### **IMPLEMENTATION TIMELINE**

Implementation of the Health Care Reform law began earlier this year and continues through 2017. The majority of the law is implemented in 2014. While this may seem like a lot of time, insurance companies, health care providers, health delivery systems and state governments need that time to prepare, make decisions, and make changes in their systems, processes and policies to implement the law.

Some changes are already underway. States have already declared whether they will operate their own temporary high risk insurance program or defer to the Federal government. Effective this year insurers are prohibited from denying coverage to children with pre-existing conditions. Dependents up to age 26 can remain on their parents' insurance policy. Insurers can no longer set lifetime coverage limits or rescind insurance from citizens who become ill. The Medicare prescription "Doughnut Hole" starts closing with a \$250 rebate available this year (about 48,000 Nebraskans may qualify). Tax credits are

available for small businesses to help them buy health insurance. On the revenue side the 10% tax on indoor tanning services started last July.



A central goal of the health reform law is to increase the number of citizens who have health insurance and work toward providing insurance at affordable prices. Through the debate it was clear that one of the issues Congress would address was the reality that health insurance costs were increasing faster than wages and there were too many uninsured citizens.

The law sets up a timeline for states to establish clearinghouses called "Insurance Exchanges" to make health insurance information more accessible for citizens to compare policies and a mechanism to ensure that insurance rates are affordable.

About one-half of the states have organized implementation task forces, commissions or committees as they consider their options.

### Timeline and implementation considerations for states:

- Begin planning as soon as possible. Health reform continues to have many moving parts and there will likely be a need to recalibrate an implementation plan as federal regulations are issued.
- If an implementation group is assembled, make it inclusive of state officials, insurers, health care providers and all relevant stakeholders.

### HEALTH INSURANCE EXCHANGES

By 2014 each state is directed to set-up a private insurance based "Insurance Exchange" for uninsured individuals and one for small businesses (those with 100 or fewer employees). States have the option to combine them into one Exchange. Federal grants are available to states to fund efforts to consider creating an Exchange.

States have the flexibility to establish an Exchange that best serves its citizens and small businesses. There is no mandated method. States could operate an Exchange through an existing state agency or delegate the authority to a nonprofit organization. States can operate their own Exchange or collaborate with other states to create a multi-state Insurance Exchange.

From a health delivery perspective, Nebraska and the populations of our neighboring states have similar health characteristics. Since we have similar characteristics, it may be beneficial for the state to examine the option of a multistate state insurance exchange to see if it offers any financial benefits. If a state

decides not to establish an Exchange, the Federal government has reserved the right to step in and operate one within the state.

The Exchange is intended to create access to information for uninsured citizens to compare health insurance policies. It also creates a larger pool of clients for private insurance companies to help make the private insurance policies available at affordable rates. The Exchanges will likely be of interest to small businesses across Nebraska. Exchanges will offer four levels of insurance coverage, plus two nationwide multi-state plans identified by the U.S. Office of Personnel Management that oversees the federal employees' health benefit program will be added to increase the options.

Exchange items states should be aware of include:

- The availability of federal funds to pay for considering whether to create an Insurance Exchange can be renewed annually through 2014, assuming progress is being achieved.
- States deciding to establish an Insurance Exchange will have the option to adopt the federal standards or enact a state law or regulation that implements the operating standards.
- Insurers have existing infrastructure and expertise that could be an asset in deciding whether to create an Exchange. There may be value in collaborating with Insurers to hold down implementation costs.
- The federal law deferred to each state to decide the issue of whether insurance coverage offered through the Exchange would cover abortion. Federal law prohibits public subsidies from being used toward a premium that covers abortion. State legislatures can prohibit abortion coverage from being offered through an Insurance Exchange.

<b>Insurance policy levels from the Exchanges</b>	
<small>The higher the percent of coverage the higher the premium:</small>	
• <u>Bronze Policy</u>	- Covers 60% of the plan's costs, out-of-pocket limits of \$5,950 for individuals, \$11,900 for families (equal to those of Health Savings Accounts).
• <u>Silver Policy</u>	- Covers 70% of the plan's costs, out-of-pocket limits matching the HSA limits:
• <u>Gold Policy</u>	- Covers 80% of the plan's costs, with the HSA out-of-pocket limits:
• <u>Platinum Policy</u>	- Covers 90% of the plan's costs, with the HSA out-of-pocket limits:
• <u>Under 30 OPTION</u>	- Option to buy catastrophic coverage with a high deductible and that includes prevention benefits and three primary care visits.

**GRANT OPPORTUNITIES & COLLABORATION**

There are dozens of grant opportunities and additional opportunities to participate in pilot programs and demonstration projects. UNMC has already responded to eight grant opportunities. The grant opportunities span the topics from workplace wellness programs, health homes for Medicaid enrollees with chronic conditions, rural physician training grants, nurse managed health clinics, incentives for community based services as long-term alternatives to nursing homes, workforce planning grants and there are many others. Not all entities are eligible for every opportunity, but many opportunities encourage collaboration.

Collaboration is common among Nebraskans. Various organizations have expressed interest in collaborating with UNMC on grant opportunities. Collaborations and working together will be viewed as a positive by the federal agencies. In addition, there are indications that the Center for Medicare and Medicaid Services (CMS) will be open to considering requests for waivers from regulations if the applicants can demonstrate it could result in a cost savings or efficiency in providing services.

The point is that there are a substantial number of grant opportunities, some clinical in nature, some oriented toward health delivery and others involving training. Many opportunities are geared toward fostering collaborations to identify ways to begin to bend the cost of services.

Grant issues to be aware of include:

- The Center for Medicare and Medicaid Services has indicated it is open to considering waivers to regulations as part of some grant applications. Would the State also be willing to consider granting waivers?
- Be open to collaborations. This is an opportunity to be innovative. An entity who is not the eligible applicant for a grant could partner with an eligible applicant to benefit patients or create a cost savings.

While the Health Reform law focuses on insurance reform, it includes a healthy dose of provisions dealing with prevention, wellness, health care delivery and workforce issues. For example, the bill starting in 2014 allows employers to offer employees discounts of up to 30% for participating in a wellness program. Wellness provisions have been shown to help hold down the cost of health care.

Prevention and wellness programs have demonstrated that they can save real dollars for businesses. The Nebraska Medical Center estimates that its wellness program has held down its health care costs. In the last five years, since the implementation of the employee wellness program, its per-employee health costs has risen only 4.2% at a time when the national average increase is close to 27% per employee. In 2014 there will be the opportunity to participate in a 10-state pilot program to apply similar rewards for participating in a wellness program in the individual insurance market.

As states deal with the implementing this comprehensive healthcare reform law, they have the flexibility to design it in a way to serve the unique needs of the citizens. Implementation efforts should be broad based and inclusive. Implementation plans should also be flexible because there are still many regulations that will be issued and the potential exists for additional legislative changes.

LR467 Select Committee  
Interim Hearing- Patient Protection & Affordable Care Act  
September 16, 2010

**Comments on Medicaid and Accountable Care Organizations**

Cory D. Shaw, Chief Executive Officer  
University of Nebraska Medical Center Physicians

**Medicaid:**

PPACA expands Medicaid to individuals under age 65 with incomes up to 133% of the Federal Poverty Level (FPL). A family of four earning less than \$29,326 will be eligible for Nebraska Medicaid. There are approximately 310,100 Nebraska residents with incomes up to 133% of the FPL. Of these individuals, approximately 90,000 individuals (29%) have private health insurance, 108,000 are covered by Medicaid, and 106,200 are uninsured.

<b>Health Insurance Coverage of the Nonelderly (0-64) with Incomes up to 133% Federal Poverty Level (FPL) states (2007-8) U.S. (2008)</b>						
	<b>NE #</b>	<b>NE %</b>	<b>NE %</b>	<b>US #</b>	<b>US %</b>	<b>US %</b>
<b>Employer</b>	59,900	19.3%	0.6%	11,128,500	17.0%	100.0%
<b>Individual</b>	30,100	9.7%	0.8%	3,650,300	5.6%	100.0%
<b>Medicaid</b>	108,000	34.8%	0.4%	26,188,800	39.9%	100.0%
<b>Other Public</b>	NSD	NSD	NSD	2,500,300	3.8%	100.0%
<b>Uninsured</b>	106,200	34.2%	0.5%	22,179,200	33.8%	100.0%
<b>Total</b>	310,100	100.0%	0.5%	65,647,200	100.0%	100.0%
<small>Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements).</small>						

States will enroll new eligible Medicaid beneficiaries by January 2014. States will continue current Medicaid and CHIP eligibility for children until 2019 and for adults until the Insurance Exchange is operating in 2014. States are exempt from maintaining the requirements for non-disabled adults with incomes exceeding 133% of the federal poverty rate from January 2011 through December 31, 2013 if it certifies it has or will have a budget deficit in the next year.

PPACA reduces aggregate Medicaid Disproportionate Share Hospital (DSH) allotments by \$500 million in 2014, \$600 million in 2015, \$600 million in 2016, \$1.8 billion in 2017, \$5 billion in 2018, \$5.6 billion in 2019, and \$4 billion in 2020. The HHS Secretary is required to develop a method to distribute the DSH reductions in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured. Currently Nebraska hospitals receive \$28.5 million annually in federal DSH payments.

Effective 2012 through 2016, the law creates new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations. Examples include changes to allow for global payments to safety net hospital systems for episodes of care and allowing pediatric medical providers organized as accountable care organizations to share in cost-savings with Medicaid programs

To finance the coverage for the newly eligible Medicaid enrollees, states will receive 100% federal funding for 2014, 2015 and 2016; 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing in 2020 and after. States will receive 100% federal financing to increase Medicaid payments for fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) so the payments will be equal to 100% of the Medicare payment rates for 2013 and 2014.

**Accountable Care Organizations:**

The health reform law created the Center for Medicare & Medicaid Innovation (CMI) to test new payment and delivery models to reduce program expenditures while preserving the quality of care. CMI is scheduled to begin in January 2011. Accountable Care Organizations (ACO) and Health Innovation Zone (HIZ) are two examples of programs HHS can test as a way to improve the quality of care of a specified population and reduce or eliminate potentially avoidable expenditures.

ACOs can be created by physician group practices, networks of physicians, partnerships between hospitals and physicians, and health systems that employ physicians and other health professionals to care for a defined population of Medicare beneficiaries. ACOs would receive a share of per capita reductions in health expenditures for assigned Medicare beneficiaries against a specified benchmark. The benchmark for each ACO will be based on the most recent 3-years of per-beneficiary expenditures for Parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. The ACO will not be subject to payment penalties if savings are not achieved.

Applicants for ACOs must meet the following criteria:

- Maintain a legal structure to facilitate receipt and distribution of shared savings
- Include adequate primary care professionals to provide services to at least 5,000 beneficiaries
- Participate in the program for at least 3-years
- Have a management structure that includes clinical and administrative systems capable of supporting evidenced-based medicine, care coordination, quality reporting and

longitudinal evaluation of quality and cost measures including Physician Quality Reporting Initiative (PQRI)

**Health Innovation Zones:**

A HIZ is a geographic region containing an Academic Medical Center (AMC), teaching hospital and other clinical and non-clinical entities that provide the full spectrum of healthcare services to a defined population and incorporate new clinical training the next generation of health care providers. A HIZ is designed to coordinate care with a multiple payers and enable resources to be allocated to achieve the greatest value.

For public and private insurers, the HIZ will provide care at an aggregate payment level less than the projected payment growth rates. With specific exemptions and waivers from certain laws, rules and regulations, savings will be achieved by creating more efficient methods of healthcare delivery and increasing provider collaboration.

**Comments on Primary Care Workforce in Nebraska**

Thomas G Tape, MD, FACP, Professor of Internal Medicine, General Medicine,  
University of Nebraska Medical Center

**Overview**

Despite the demonstrated benefits of a strong primary care infrastructure, there is a growing shortage of primary care physicians as well as other providers of primary care services in Nebraska. Fewer students are choosing primary care careers and those in primary care practice are leaving the field at an increased rate compared to practitioners in other specialties. Recently enacted health care reform legislation will further stress the primary care system by adding newly insured patients without a concomitant increase in primary care providers. To address the primary care workforce shortage, consideration should be given both to incentives to pursue a primary care career as well as to new models of care that make the field more attractive to practitioners.

**Primary care defined**

Although the term "primary care" has been in use for nearly 50 years, its precise definition has been elusive. Defined functionally, primary care is a usual source of care that provides first contact, comprehensive, long term, and coordinated care. Physicians, nurse practitioners, and physician assistants who practice in the fields of family medicine, general pediatrics, and general internal medicine are usually considered to be primary care providers. While some obstetrician-gynecologists provide primary care services for women in their childbearing years, the recently passed national health care reform legislation does not classify ob/gyn physicians as primary care providers.

**Benefits of a strong primary care workforce**

Friedberg and colleagues recently reviewed the literature on primary care and reported better preventive care, better patient satisfaction, lower cost of care, lower emergency department visits and better quality measures on several chronic diseases. (*Health Affairs* 2010;**29**:766-772) Another key study examined the relationship between the proportion of primary care physicians and health care utilization across the United States. For an average American city the size of Omaha, each one percent increase in the proportion of primary care physicians was associated with decreased yearly utilization of 503 hospital admissions, 2968 emergency department visits; and 512 surgeries. (*Am J Med.* 2008;**121**:142-148)

Susan Dentzer, the editor of the journal *Health Affairs*, wrote the following in the introduction to the May 2010 issue:

“The literature indicates that nations that have strong and efficient primary care systems have better health outcomes and lower costs, and those are two objectives that are very important to the United States. Our health outcomes are very mediocre compared to our status as an economic superpower. Costs are rising at a rate that is unsustainable. A quite probable ingredient in solving some of this is a stronger primary care system.”

### **The workforce shortage in primary care is reaching critical proportions**

The American Association of Medical Colleges (AAMC) recently reported that while 35% of physicians in the U.S. currently practice primary care, among recent residency graduates, only 20% chose to practice primary care. AAMC predicts a national shortage of primary care physicians between 35,000 and 44,000 by the year 2025.

(<http://www.aamc.org/newsroom/reporter/march10/primarycare.htm>,

<http://www.aamc.org/workforce/stateandspecialty/recentworkforcestudiesnov09.pdf>)

These national trends are also reflected in Nebraska. The rural nature of our state creates additional challenges: Although 42% of Nebraska’s population is rural, only 28% of physicians practice in rural areas. Only three counties have a provider-to-population ratio better than the national average and 51 counties are designated Health Professional Shortage Areas for primary care.

(<http://www.unmc.edu/rural/documents/NebraskaWorkforceProjectFinal091509.pdf>)

Although some identify nurse practitioners and physician assistants as potentially filling the void in the physician primary care workforce, these fields (discussed in accompanying testimony by Pam Bataillon) face similar and growing shortages. UNMC has responded by increasing enrollment across all its professional schools but it will be years before the newly enrolled students are fully trained and enter the primary care workforce.

### **Causes of the growing primary care shortage**

Multiple factors drive the decision for a health care professional to select a primary care field. In the case of physicians, the financial impact of choosing primary care is considerable. When added to the administrative hassles of primary care practice and the overwhelming demand for primary care services, many are choosing more predictable and more controllable types of practice.

It is not unusual for medical students to graduate after eight years of combined college and medical school education with more than \$200,000 in debt. However, their training is not finished and their debt will continue to increase during their three-to-nine year residency

training before they can begin making loan payments in practice. The long period of training also reduces the length of professional productivity before eventual retirement. As the income differential between primary care and other specialties continues to widen, students increasingly see a career in primary care to be a non-viable option.

Much of primary care practice involves services provided outside of a face-to-face encounter. However, these services are not paid for under the current reimbursement system. The poor reimbursement for primary care creates a sub-optimal practice model in which primary care physicians increase their in-office patient volume to cover the rising overhead costs of medical practice. The shortage of primary care providers further increases demand on the remaining practitioners. The combination of rising demand and declining reimbursement creates an especially frustrating situation for the dedicated practitioner wishing to provide the full spectrum of care. The 15-minute office visit is simply inadequate to provide longitudinal, comprehensive care. Many are retiring early; others are re-training to practice in other fields.

**Increasing coverage provided by the Affordable Care Act (ACA) will further increase the demand for primary care services**

By 2014, upwards of 32 million Americans (including 200,000 Nebraskans) will have some sort of new health care coverage. These currently un-insured Americans mainly obtain care using a legal provision that requires emergency departments to evaluate and treat any patient, regardless of the ability to pay, to the point of medical stability. Thus, for many, the emergency department has become their de-facto primary care physician. In fact, Pitts and colleagues reported this month that only 42% of annual visits for acute care treatment are made to patients' personal physicians – the emergency department accounts for the majority of the other 58%. (*Health Affairs* 2010;29:1620-29)

When the coverage provisions of the ACA roll out in 2014, these patients will be financially able to receive care from any provider. The question is: "Who will take care of these newly insured patients?" Put another way, coverage does not ensure access to care. There simply are not enough primary care providers in the state of Nebraska to satisfy the demand for comprehensive patient care.

While the ACA does provide for increased funding for primary care training and for incentives such as loan forgiveness for those willing to practice primary care, the long lead time for training means that the workforce shortage will get worse before it gets better. The Massachusetts experience with providing universal health care coverage should serve as a warning of what Nebraska can expect. The average wait to get an appointment as a new patient increased from 17 days in 2005 (before the 2006 mandatory insurance law in Massachusetts) to 44 days in 2009. Forty percent of family medicine physicians in Massachusetts are now closed to new patients and emergency rooms visits have increased by

10%.

([http://www.neimjobs.org/content/employers/MMS Physician Workforce Study 2009.pdf](http://www.neimjobs.org/content/employers/MMS_Physician_Workforce_Study_2009.pdf))

We must work together now to prepare for what we will face in 2014 when health insurance becomes mandatory across the country.

### **Potential solutions to the primary care workforce and access crisis**

The model of care and payment must fundamentally change if primary care is to remain viable in our state and in this country. The viability of primary care providers' practices is enhanced when their work is manageable, fun, and rewarding. Most are already working at beyond full capacity – seeing more patients will only add to the frustration of both providers and patients. The state of Nebraska should look for ways to encourage and incentivize innovative models of care delivery that promote primary care services. The ground work for one such innovative model has already been laid by Senator Gloor who championed LB 396 which was signed into law in 2009. It provides for a patient-centered medical home (PCMH) pilot in a medium sized city in Nebraska as well as creating a medical home advisory panel.

The PCMH is a team-based practice that oversees and coordinates the care of a panel of patients. The model emphasizes patient-centered care, preventive care, chronic disease management, and better coordination with specialists. Physicians in such practices report seeing fewer patients per day but spending more time with each patient. The practice as a whole has greater capacity, however, because of a team-based approach. With a team to help with the routine care of the less complex patients, physicians can focus their skills where they are most needed. Providers in such models report increased satisfaction with their work. There is also growing evidence that the PCMH can reduce the overall cost of health care for the population of patients being managed.

Another promising strategy involves new payment systems that reward comprehensive care of the patient as opposed to the current piecemeal fee-for-service approach. Accountable Care Organizations (ACOs) represent such a strategy. In this model, a group of providers, often partnering with a hospital, assumes financial responsibility for the overall care of a population of patients. Payments are generally made in a bundled fashion to cover an “episode” of care. To the extent that the ACO can improve quality and reduce costs, it can share in the savings. Note that ACOs and PCMHs are not mutually exclusive. In fact, the PCMH practice model would fit well into a multispecialty ACO. The former has more to do with the organization of the primary care delivery team and the latter has more to do with the larger set of multispecialty health care resources. Both the PCMH and ACOs are still very much in their infancy—it would be premature to abruptly change the current systems of care to these new models. The ACA includes funding for pilot programs to test both new models of care.

UNMC can play a role both in training new providers prepared to practice in such settings as well as in studying the costs and outcomes of care provided in such new care models. The UNMC Physicians Turner Park Internal Medicine Clinic is one such example. The clinic, which serves as the primary outpatient training site for internal medicine residents, is evolving from a traditional resident clinic to a PCMH practice. The care team has been expanded to include a nurse coordinator/educator, a social worker, a pharmacist, and a mental health provider. Pharmacy residents and mental health interns have also been added as trainees to work side-by-side with the internal medicine residents to foster the concept of team-based care.

Other approaches to promoting primary care involve incentives for students to enter primary care training programs. UNMC has embraced both primary care and rural practice incentives and has developed several successful programs including the Rural Health Opportunities Program (RHOP), the Rural Health Education Network (RHEN), the primary care residency program and the accelerated family medicine residency program.

### **Conclusion**

The primary care workforce shortage is severe and projected to become worse as more citizens obtain health care insurance coverage. Because the causes of the workforce shortage are multifactorial and complex, finding solutions will also be complex and challenging. Nebraska has a long history of innovative programs to incentivize training in primary care and rural health care. We should seek to continue and expand such programs by taking advantage of opportunities provided by the ACA. We should also consider the opportunities provided by the ACA for pilot programs in new models of health care delivery.

Thank you for your interest and support.

LR467 Select Committee  
Interim Hearing- Patient Protection & Affordable Care Act  
September 16, 2010

Comments on Health Workforce Issues  
Pam Bataillon, Assistant Dean, College of Nursing  
University of Nebraska Medical Center

Of the more than \$4 trillion the world expends on healthcare each year, nearly 60% is spent on the clinical workforce—the physicians, nurses, pharmacists, and other health professionals who provide patient care. America's 5 million health care professionals directly influence the cost and quality of healthcare through their diagnosing, prescriptions and treatments. But there are too few health professionals and demand already outstrips supply. Few systems have the right number of the right clinicians in the right places---nor have they found their way to predicting their future workforce needs accurately and developing a strategy that keeps demand and supply near equilibrium (McKinsey Quarterly, December 2009).

The resulting supply/demand imbalances impair patient care, demoralize clinicians, and make service delivery inefficient. While workforce shortages are a challenge for the entire health care system, they are most pronounced in rural and other underserved areas.

### **The Nebraska Health Workforce**

Health workforce demand in Nebraska already outstrips supply:

- 18 counties are without a physician of any kind
- one-half of our counties have a shortage of primary care physicians
- more than 33 counties have no nurse practitioners
- 81% of our counties have a shortage of non-physician primary care providers
- 9 counties have no Registered Nurses and 23 counties have a shortage of RNs

-A Critical Match: Nebraska's Health Workforce  
Planning Project, 2008

If those statistics are not bleak enough, 55% of the state's nurses and one-third of the state's physicians and dentists will retire over the next 10 to 15 years.

UNMC and other educational programs recognized the need for an increased number of healthcare professionals more than a decade ago, initiating new programs to boost enrollment, recruitment and subsequent retention in rural area---with special efforts to expand the primary care workforce. But those efforts have not been enough, and will not be enough, especially with increased numbers of insured coming into the system in the coming years.

### **The Special Role of Primary Care**

Since its introduction in 1961, the term primary care has been defined in various ways, often using one or more of the following categories to describe what primary care is or who provides it. These categories include:

- the care provided by certain clinicians. Some suggest listing medical specialties of primary care as family medicine, general internal medicine, general pediatrics, and

obstetrics and gynecology. Some experts and groups have included nurse practitioners and physicians assistants.

- a set of activities whose functions define the boundaries of primary care—such as curing or alleviating common illnesses and disabilities.
- a level of care or setting—an entry point into the system that includes secondary care (by community hospitals) and tertiary care (by medical centers and teaching hospitals)
- a set of attributes, as in the 1978 definition of the Institute of Medicine—care that is accessible, comprehensive, coordinated, continuous and accountable

### **Education and Training of Health Professionals: Role in Expanding the Workforce**

Interprofessional education and practice may be the key to meeting future healthcare workforce objectives. Curricula in schools of nursing, medicine and pharmacy have already begun evolving toward interprofessional education. The law supports further evolution through such mechanisms for the practice arena as bundled payments, medical homes, independence at home demonstration projects, and others.

Interprofessional education is defined as students from two or more health professions being taught together, faculty from two or more professions teaching together, or both (Out of Order, Out of Time: The State of the Nation's Health Workforce, Association of Academic Health Centers, 2008). Historically, nurses have been educated with nurses, physicians with physicians and so on, so future health professionals may only have a vague sense of what the other members of the health team do and whom to contact for various expertise. By learning early in their professional education about other roles, a future health care professional can understand ways in which each can function individually and together as a team to enhance patient care.

Studies of teams of care providers have demonstrated that use of these teams can lead to improvements in the quality of primary care. Patients with a medical home—that is, a primary source of care that ensures ease of access and communication, is efficiently coordinated, and engages in continuous quality improvement—are more likely to receive higher quality care and experience fewer medical errors—all at a lower cost (How Physician Practices Could Share Personnel and Resources to Support Medical Homes, Abrams et al, Health Affairs, 2010)

Evidence suggests that these teams may also expand the nation's capacity to provide primary care services. (In Focus: Using Pharmacists, Social Workers, and Nurses to Improve the Reach and Quality of Primary Care, in Quality Matters, Aug/Sept 2010) Many medical practices, health centers and other primary care settings are experimenting with innovative models of care that both extend the reach of the primary care physicians and the increase of ambulatory care services.

Interpersonal teams in primary care settings 'allow far more intensive intake and assessments than a physician alone could do,' said Robert J. Master, M.D., president and CEO of Commonwealth Care Alliance, a Boston based nonprofit health plan and delivery network that has introduced nurse practitioners to 25 community based medical practices in Massachusetts. Community health workers, durable medical equipment coordinators, physical therapists and social workers are added in various combinations to meet the needs of patients with one or more physical disabilities, frail elderly patients who may be homebound, and Medicaid eligible

patients with chronic complex illnesses and behavioral or substance abuse issues. The pilot has produced results such as reductions in hospitalizations for preventable conditions and delays in nursing home placements.

One health system in Minnesota has been piloting a team-based model of care which includes health coaches, nurses, pharmacists and social workers or psychologists who help manage chronic conditions such as hypertension following protocols established by the physicians. Health coaches use motivational techniques to find ways to encourage patients to pursue overdue mammograms or to quit smoking. And instead of seeing a succession of patients in one-on-one visits, physicians have begun to proactively manage a panel of patients, looking for high risk ones in need of care. "It's expanding a clinician's ability to serve a population of patients," says the executive medical director for the system. Because the pay of clinic staff is based on their performance on measures of cost, quality and patient satisfaction, rather than productivity more care has migrated to the internet and telephone. And cost appears to be holding steady.

### **Conclusions**

While addressing health workforce supply requires a multifaceted approach involving many stakeholders, state governments are key players in many states. In recent years a number of states have recognized the emergent need to ensure an adequate health workforce. Among the outcomes are these;

- centralized health workforce effort at the state level
- resources for distance education programs, telecommunications and capital infrastructure
- statewide recruitment and retention efforts with incentives to encourage health professionals to locate in underserved areas
- loan repayment and scholarships, providing students and medical residents financial support in return for an agreement to provide services for a specified period in an underserved area.
- additional resources to education institutions to increase faculty of health professions students.
- resources to support team-based models of care in the Medicaid populations, and support for greater mainstreaming of these pilot efforts
- differential Medicaid reimbursement for providers in certain areas
- low or no cost capital financing for new practices
- improved collaboration among state agencies that employ health care professionals and engage in workforce planning to avoid duplication, eliminate unnecessary competition and respond more effectively and quickly to emerging needs
- encouraging cooperation among legislature, licensing and regulatory boards to structure and coordinate efforts to study state licensing processes and make recommendations that would simplify and consolidate processes
- pilot programs to demonstrate the efficacy of expanding scope of programs in narrow ways.

Thank you for providing this opportunity. We will be happy to answer any questions.

#1 02

Testimony and Briefing to the  
Interim Committee to Study the Affordable Care Act on the Impact on Nebraska  
September 16, 2010  
Senator Gay, Chair

Good Afternoon

I am Judy Baker, Regional Director of the Department of Health and Human Services Region 7. I am here today with CAPT Jose Belardo, Acting Regional Health Administrator for Region 7. We are honored to be here today and thank Senator Gay for the invitation.

Today, I would like to present to you an overview of the Affordable Healthcare Act with two goals in mind. One is to address what is to be accomplished by 2014 and two, the bridge programs that are key steps toward 2014. Following that, I will outline the implications to state governments leaving time for questions and answers.

On March 23<sup>rd</sup> the Patient Protection and Affordable Care Act was signed into law. The unsustainable status quo was the primary reason for the need to pass the law.

### **Statement of the Problem**

Health care costs in this country have been increasing much faster than inflation in the past decade, making it difficult for individuals and families to afford health insurance. Since 1999, family premiums for employer-sponsored insurance have increased at over four times the rate of inflation, squeezing the middle class and working families. In 2007, 45 million non-elderly adults went without health insurance, and 8 in 10 of those adults were in households with at least one worker. The percentage of large firms providing workers with retiree coverage dropped from 66 percent in 1988 to 31 percent in 2008. Nine percent of Missouri's children were uninsured in 2008. The insurance coverage gap has been widening for quite some time, whether it be because of pre-existing conditions, employers who no longer provide insurance, or patients' inability to find affordable options on the open market.

All of us can understand that health insurance status greatly impacts the wellbeing of an individual. You know that people without comprehensive health insurance rarely have access to the health care they need, and that treatable conditions can escalate into life-threatening disease as a result of lack of access to care and severely increase costs in the long run. This dangerous escalation has been illustrated to me all too starkly in my visits to Area Agencies on Aging in the past few months. I've heard from multiple caseworkers that when seniors have reached the so-called 'donut hole' in Medicare coverage, some will try to stretch their medications by cutting pills in half or not taking them at all. The caseworkers told me that those seniors often end up in the emergency room with life-threatening and costly conditions as a result of not taking their medication as prescribed by their doctor. This underinsurance in Medicare poses a grave threat to the health of our seniors and exponentially increases our nation's health care costs. The Affordable Care Act was designed to address the problem of uninsurance and underinsurance in America and thereby stem the rising costs of health care.

To understand the current system and where the ACA points us toward can be illustrated visually.

On the lower level we have the working poor, disabled, elderly on Medicaid, and families below the 133% of the poverty level that had access to healthcare through safety net clinics, hospitals, and other institutions.

Mid to upper income citizens largely had insurance from their employers or Medicare.

The middle area as that time was relatively small and insurance could be purchased or with a job the time without coverage would be short.

This middle section, instead of remaining small started to widen. The cost to cover the uninsured started to increase the cost for the upper level and insurance companies needed to increase their rates and with increasing costs many employers started to drop employer-based insurance or charged the employees higher contributions. Access to the lower level was not an option.

The ACA as written is largely market-based, state run, and consumer centric.

- ACA preserves the uniquely American system of private and public insurance.

- The ACA provides for state controlled Health Insurance Exchanges, that regulate health insurance rates, and states and organizations receive grant opportunities for innovative care expansion and improvement.
- The ACA also protects consumers from insurance rate hikes and pre-existing condition exclusions, increases access to affordable health care, and improves health care quality.

By 2014 three major horizons are established: Health Insurance Exchanges, the expansion of Medicaid, and Guarantee Issue of insurance with new consumer protection.

The Affordable Care Act helps create a new competitive private health insurance market – through state-run health insurance Exchanges -- that will give millions of Americans and small businesses access to affordable coverage, and the same choices of insurance that members of Congress will have. Today, many individuals and small businesses are on their own when trying to find affordable health insurance. Because they lack purchasing power and the ability to pool risk, individuals and small businesses too often pay higher rates when it comes to insurance. The Affordable Care Act changes that by putting greater control and greater choice in the hands of individuals and small businesses through Exchanges.

Starting in 2014, improved choices will be offered through Health Insurance Exchanges – new, competitive, state-run and consumer-centered health insurance marketplaces. The Exchanges will make purchasing health insurance easier by providing eligible consumers and businesses with “one-stop-shopping” where they can compare and purchase health insurance coverage. In the Exchanges, Americans who choose to use them will also have access to a wide range of customer assistance tools – including information about prices, quality, and physician and hospital networks – to help them make the best choice for themselves, their families, or their employees. HHS has announced the availability of the first round of funding - up to \$1 million for each State and the District of Columbia.

Although state Exchanges are not required to be up and running until 2014, work is already underway to conduct the necessary market research and planning. These grants will give states the resources to conduct the research and planning needed to build a better health insurance marketplace and determine how their Exchanges will be operated and governed.

Until ACA, Medicaid beneficiaries generally have needed both to have a low income and to be in certain specific categories, such as being pregnant or having a disability. But in 2014, ACA will provide coverage of all individuals under age 65 (children, parents, and childless adults) with incomes at or below 133% of the federal poverty level regardless of disability or other category.

Starting September 23<sup>rd</sup>, full elimination of discrimination due to pre-existing or gender is accomplished and annual limits on coverage will also be eliminated.

Other consumer protections include new regulations that give consumers in new health plans in every State the right to appeal decisions, including claims denials and rescissions, made by their health plans.

The rules issued by the Departments of Health and Human Services, Labor, and the Treasury give consumers the right to appeal decisions made by their health plan through the plan’s internal process.

For the first time, the right to appeal decisions made by their health plan to an outside, independent decision-maker, no matter what State they live in or what type of health coverage they have. States will work to establish or update their external appeals process to meet new standards, and consumers who are not protected by a State law will have access to a Federal external review program.

Medicare will be stronger and offer new benefits. The Act preserves the guaranteed benefits under Medicare, makes recommended preventive services available with no cost-sharing, and provides an annual wellness visit. It closes the Medicare Part D prescription drug program “donut hole” over time, beginning with a \$250 rebate to seniors who reach that limit in 2010. By lowering cost-sharing, the Act empowers providers, who will have to worry less about patients being unable to afford needed treatments.

ACA is also designed to reduce paperwork and increase administrative simplification that will bring down the cost of care.

With the horizon set at 2014 the ACA addresses the uninsured with a series of bridge programs. These programs addressed the needs of small business, individuals with pre-existing conditions, early retirees, and young adults, and children.

### **Small Business**

- Up to 4 million small businesses are eligible for tax credits to help them provide insurance benefits to their workers. The first phase of this provision provides a credit worth up to 35% of the employer's contribution to the employees' health insurance. Small non-profit organizations may receive up to a 25% credit. 38,300 small businesses in Nebraska could be helped by a new small business tax credit that makes it easier for businesses to provide coverage to their workers and makes premiums more affordable.

### **The Pre-Existing Condition Insurance Plan (PCIP):**

- The PCIP is administered by either your state or the U.S. Department of Health and Human Services. Nebraska elected to have HHS run the program.
- It will provide a new health coverage option for citizens if they have been uninsured for at least six months, have a pre-existing condition, or have been denied health coverage because of a health condition, and are a U.S. citizen or are residing here legally.
- The plans are active from 2010-2014.
- The plans will cover primary and specialty care, hospital stays, and prescription drugs.

### **Early Retirees**

- The percentage of large firms providing workers with retiree coverage has dropped from 66 percent in 1988 to 31 percent in 2008.
- The Affordable Care Act will provide \$5 billion in financial assistance to employers to help them maintain coverage for early retirees age 55 and older who are not yet eligible for Medicare.
- Employers can use the savings to either reduce their own health care costs, provide premium relief to their workers and families or a combination of both.
- This temporary program will make it easier for employers to provide coverage to early retirees.
- Employers who are accepted into the program will receive reinsurance reimbursement for medical claims for retirees age 55 and older who are not eligible for Medicare, and their spouses, surviving spouses, and dependents.

### **Young adults and children**

- Under the new law, young adults will be allowed to stay on their parent's plan until they turn 26 years old. (In the case of existing group health plans, this right does not apply if the young adult is offered insurance at work.) Some insurers began implementing this practice early.
- The new law includes new rules to prevent insurance companies from denying coverage to children under the age of 19 due to a pre-existing condition.
- The Children's Health Insurance Program has been extended through September 30, 2015 and provides states with additional funding to ensure children have access to this proven successful program. The funding increases outreach and enrollment grants to help reach more eligible children.

As I have mentioned throughout my briefing, the states are definitely involved in the implementation of ACA. I have highlighted some of the provisions of ACA that are already in effect and I started my testimony with the end horizon that is expected by 2014. Currently state legislatures are beginning to consider what initial steps should be taken to implement some of the measures needed.

ACA does provide the state opportunity to address:

- Future health care costs, such as maximizing receipt of federal funds, and reducing the cost of care for high-cost individuals.
- New strategies could bolster health care quality and outcomes. Keep in mind that ACA does not make changes to the health care delivery system but it does make available grants and demonstration project opportunities to assist states in addressing certain problems in a gradual manner. Just like the implementation of ACA.
- The legislature may need to consider the state's response to workforce and infrastructure capacity and ACA provides for grants for state level workforce planning.
- State may need to consider enhancements to insurance oversight and regulation at the state level. A \$30 million grant program to establish and strengthen consumer assistance offices in States and Territories. The new Consumer Assistance Grants Program will help States establish consumer assistance offices or strengthen existing ones. The new funds will be used to provide consumers with the information they need to pick from a range of coverage options that best meets their needs.
- States can now apply for the first round of funding – up to \$1 million for each State and the District of Columbia. These grants will give states the resources to conduct the research and planning needed to build a better health insurance marketplace and determine how their Exchanges will be operated and governed. Future funding will support development and implementation activities that States will undertake through 2014.
- New programs could generate additional federal health care funds. There are costs in the state's implementation of ACA, however, ACA also establishes a number of new federal grant programs—some monies distributed by formula, others awarded through a grant application process. It will be important for the state to ensure that state agencies maximize their opportunity to obtain additional federal funds, particularly in cases where doing so could offset state costs.
- States will also have a role in policy-making around the enrollment and eligibility provisions of ACA. States must consider coordination of enrollment, data sharing, the role of state agencies, HIT standards, income methodology requirements, and integration of current programs and proposed exchanges. ACA provides for administrative simplification around these issues.

These topics may be touched on by other presenters for consideration to this committee. Again, these short term implications may vary from state to state but are items that the State of Nebraska may need to consider.

As part of this testimony, I will include the long term implications for State health programs.

Mentioned earlier, the Medicaid 1115 waivers allow flexibility and provide federal funding.

New federal funding opportunities to offset enrollment of person currently eligible but not enrolled OR the success of the state health insurance exchanges include:

Medical homes are for persons with significant health needs. Medical homes are proposed as a model of care where a person's care is coordinated through a central hub rather than a person being directed to seek care from a jumbled network of providers. Support is available at a 90% federal and 10% state funding rate beginning in 2011.

Optional Attendant Services Benefit can be included.

Bundled payments are an alternative to fee-for-service payments, in which each physician receives reimbursement for the individual services provided.

The intent of an ACO is to reduce costs by delivering coordinated care.

The new federal funds could help relieve fiscal pressure on the state to maintain funding for uncompensated care historically provided by these clinics.

Prevention and Public Health Funds are to be used to promote community-based preventive health activities as well as other activities permitted under the previously enacted Public Health Services Act (such as immunizations, public health preparedness, and cancer detection programs.)

Maternal, Infant, and Early Childhood Home Visiting Programs authorizes grants for home visitation programs following models that have been proven to improve health outcomes for mothers and babies. Home visitation programs provide low-income pregnant and parenting families such services as smoking cessation programs, advice on nutrition and exercise, basic information on newborn care and child development and family planning.

- There could be a redirection of Disproportionate Share Hospital Fund payments to those hospitals that serve a larger percentage of Medicaid beneficiaries and uninsured. States will need to consider the impact of this.
- The Legislature does have policy options on the design and role of the Exchange. The state will need to answer these questions...Should the State establish an exchange? How would an exchange be governed? And what role should the exchange play in the health insurance market?

As a committee you have much to consider and I applaud the time you have set aside to study this most important piece of legislation. You do have the opportunity now to impact the lives of Nebraskans for years to come.

Explanation of Portal

One of the more innovative and useful outcomes of the ACA is the Healthcare.gov portal.

In closing, I thank you again for this opportunity to come before you. We do have time to for some questions and I will respond to the best of my ability.



Take health care into your own hands

Find Insurance Options

Learn About Prevention

Compare Care Quality

Understand the New Law

Information for You

## Explore your coverage options

Find out which private insurance plans, public programs and community services are available to you.

Pick Your State 



## Your Health Care, Explained

Families with Children

Individuals

People with Disabilities

Seniors

Young Adults

Employers



## New Pre-Existing Condition Insurance Plan

Under the new law, people who have been denied coverage due to a pre-existing condition and who have been uninsured for at least six months may qualify to buy insurance. Learn more about the plan.

IN FOCUS

### Coming Soon: Preventive Care



After Sept. 23, new policies must cover evidence-based preventive services, including screenings and vaccinations, at no cost to you.



## 5 Things to Know

- 1. HEALTH INSURANCE EXCHANGES:** What are health insurance Exchanges, and when do they launch?
- 2. PATIENT BILL OF RIGHTS:** What is the Patient Bill of Rights and how does it affect me?
- 3. YOUNG ADULTS:** How is coverage for young adults expanding?
- 4. SMALL BUSINESS:** Which small businesses qualify for health insurance tax credits?
- 5. SENIORS:** What actions are being taken to strengthen Medicare?



## HealthCare Notes

- September 13, 2010  
The Affordable Care Act and People Living with HIV or AIDS
- September 09, 2010  
Secretary Sebelius Calls on Health Insurers to Stop Misinformation and Unjustified Rate Increases
- September 09, 2010  
2:30 PM ET (11:30 AM PT) - Open for Questions: Video Chat on Latinos and Health Care
- September 08, 2010  
Announcing CuidadodeSalud.gov
- September 08, 2010  
Menu Labeling Provisions: Getting Americans the Facts
- [Read Blog](#)



## Videos & Chats

- WEBSITE OVERVIEW:**  
Introducing HealthCare.gov: Take a Video Tour of the Website
- September 9, 2010  
Early Retiree Reinsurance Program
- August 19, 2010  
Insurance Company Accountability
- August 12, 2010  
**WEBCHAT:**  
Small Businesses and the Affordable Care Act
- August 9, 2010  
Community Health Centers
- August 2, 2010  
Marking the Anniversaries of Medicaid & the ADA
- [View Video Archive](#)

# Find Insurance Options

See which public, private and community programs meet your needs

## Let's get started.

(Just two quick steps)

This tool will help you find the health insurance best suited to your needs, whether it's private insurance for individuals, families, and small businesses, or public programs that may work for you. It was created to help consumers under the health insurance reform law, the Affordable Care Act.

### STEP 1 of 2 - Please Answer All Questions

Which state do you live in?

Which best describes you?

(Select one.)

Please select which best describes you?

- Family / Children
- Healthy Individual
- Individual with Medical Condition
- Pregnant Woman
- Person with Disability
- Senior
- Young Adult (under 26)
- Small Employer / Self-Employed

Your privacy is protected. Read our [privacy policy](#).

## Just a few more questions...

- I live in GA
- I am an Individual with Medical Condition

### STEP 2 of 2 - Please Answer All Questions

Which best fits your situation?

Select option that best fits your situation?



I'm losing the health insurance I had through work.

I've tried to get health insurance, but I was rejected for coverage because of my disability.

I need health insurance.

How old are you?

Select age group:

18 or under

19-25

26-64

65 or older

Do any of the following apply?

(Check all that apply.)

Select all conditions that apply:

Disability

Breast or cervical cancer

Dependent under 21

Nursing home or long term care

Special healthcare need

Pregnancy

Veteran status

American Indian or Alaskan Native

Do you find it difficult to afford insurance?

Is it difficult to afford insurance?

Yes

No

# OK. Based on your choices, there are 9 options you should look into:

## Explore these options:

1. Coverage for Young Adults Under Age 26

[Learn More](#)

If your parent's insurance offers dependent coverage, you may be eligible to be covered on their policy until age 26.
2. Special Enrollment in Spouse's Job-based Health Plan

[Learn More](#)

If you involuntarily lose coverage, you may be eligible for a special opportunity to sign up for a job-based health plan.
3. COBRA Coverage

[Learn More](#)

You may be able to keep the coverage you had at work for a limited time through a program called COBRA.
4. Health Insurance Plans for Individuals & Families

[Learn More](#)

If you do not have job-based or other coverage, you may want to buy a policy from a private insurer.
5. Special Options for Individual Health Insurance

[Learn More](#)

If you're losing job-based coverage and meet other qualifications, you may be eligible for a HIPAA policy or a conversion policy. You may have other options.
6. Pre-Existing Condition Insurance Plan (PCIP)/High Risk Pool

[Learn More](#)

You may qualify for a pre-existing condition insurance plan or a high risk pool, which helps people who have a hard time getting insurance find coverage.
7. Medicaid

[Learn More](#)

Medicaid provides coverage for low income children, families, the elderly, and people with disabilities. Pregnant women may qualify with higher incomes.
8. Breast and Cervical Cancer Prevention and Treatment Programs (BCCPT) through Medicaid

[Learn More](#)

These programs are available to eligible women diagnosed with breast and/or cervical cancer. Higher incomes may qualify.
9. Finding Care You Can Afford

[Learn More](#)

There may be local facilities that provide free or reduced-cost care, whether you're insured or not. What you pay depends on your income.



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Understand the New Law

Information for You

# Implementation Center

Home

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Regulations

## Implementation Center

Authorities

Here you'll find materials related to the implementation of the Affordable Care Act, including regulations, authorities and requests for comment.



Yes

No

Councils & Groups

This area includes information published by the Office of Consumer Information and Insurance Oversight (OCIO), the office within the U.S. Department of Health and Human Services responsible for implementing the law.

Letters

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## The Affordable Care Act: Immediate Benefits for Nebraska

- **Small business tax credits.** 38,300 small businesses in Nebraska could be helped by a new small business tax credit that makes it easier for businesses to provide coverage to their workers and makes premiums more affordable.<sup>1</sup> Small businesses pay, on average, 18 percent more than large businesses for the same coverage, and health insurance premiums have gone up three times faster than wages in the past 10 years. This tax credit is just the first step towards bringing those costs down and making coverage affordable for small businesses.
- **Closing the Medicare Part D donut hole.** Last year, roughly 23,100 Medicare beneficiaries in Nebraska hit the donut hole, or gap in Medicare Part D drug coverage, and received no extra help to defray the cost of their prescription drugs.<sup>2</sup> Medicare beneficiaries in Nebraska who hit the gap this year will automatically be mailed a one-time \$250 rebate check. These checks will begin to be mailed to beneficiaries in mid-June and will be mailed monthly throughout the year as new beneficiaries hit the donut hole. The new law continues to provide additional discounts for seniors on Medicare in the years ahead and completely closes the donut hole by 2020.
- **Support for health coverage for early retirees.** An estimated 9,820 people from Nebraska retired before they were eligible for Medicare and have health coverage through their former employers. Unfortunately, the number of firms that provide health coverage to their retirees has decreased over time.<sup>3</sup> Beginning June 1, 2010, a \$5 billion temporary early retiree reinsurance program will help stabilize early retiree coverage and help ensure that firms continue to provide health coverage to their early retirees. Companies, unions, and state and local governments are eligible for these benefits.
- **New consumer protections in the insurance market beginning on or after September 23, 2010.**
  - Insurance companies will no longer be able to place lifetime limits on the coverage they provide, ensuring that the 1.1 million Nebraska residents with private insurance coverage never have to worry about their coverage running out and facing catastrophic out-of-pocket costs.
  - Insurance companies will be banned from dropping people from coverage when they get sick, protecting the 127,000 individuals who purchase insurance in the individual market from dishonest insurance practices.
  - Insurance companies will not be able to exclude children from coverage because of a pre-existing condition, giving parents across Nebraska peace of mind.
  - Insurance plans' use of annual limits will be tightly regulated to ensure access to needed care. This will protect the 1 million residents of Nebraska with health insurance from their employer, along with anyone who signs up with a new insurance plan in Nebraska.
  - Health insurers offering new plans will have to develop an appeals process to make it easy for enrollees to dispute the denial of a medical claim.
  - Patients' choice of doctors will be protected by allowing plan members in new plans to pick any participating primary care provider, prohibiting insurers from requiring prior authorization before a woman sees an ob-gyn, and ensuring access to emergency care.
- **Extending coverage to young adults.** Beginning on or after September 23, 2010, plans and issuers that offer coverage to children on their parents' policy must allow children to remain on their parents' policy until they turn 26, unless the adult child has another offer of job-based coverage in some cases. This provision will bring relief to roughly 5,830 individuals in Nebraska who could now have quality affordable coverage through their parents.<sup>4</sup> Some employers and the vast majority of insurers have agreed to cover adult children immediately.
- **Affordable insurance for uninsured with pre-existing conditions.** \$22.6 million federal dollars are available to Nebraska starting July 1 to provide coverage for uninsured residents with pre-existing medical conditions through a new transitional high-risk pool program, funded entirely by the Federal government. The program is a bridge to 2014 when Americans will have access to affordable coverage options in the new health insurance exchanges and insurance companies will be prohibited from denying coverage to Americans with pre-existing conditions. If states choose not to run the program, the Federal government will administer the program for those residents.
- **Strengthening community health centers.** Beginning October 1, 2010, increased funding for Community Health Centers will help nearly double the number of patients seen by the centers over the next five years. The funding could not only help the 26 Community Health Centers in Nebraska but also support the construction of new centers.
- **More doctors where people need them.** Beginning October 1, 2010, the Act will provide funding for the National Health Service Corps (\$1.5 billion over five years) for scholarships and loan repayments for doctors, nurses and other health care providers who work in areas with a shortage of health professionals. This will help the 5% of Nebraska's population who live in an underserved area.
- **New Medicaid options for states.** For the first time, Nebraska has the option of Federal Medicaid funding for coverage for all low-income populations, irrespective of age, disability, or family status.

<sup>1</sup> [http://www.irs.gov/pub/newsroom/count\\_per\\_state\\_for\\_special\\_post\\_card\\_notice.pdf](http://www.irs.gov/pub/newsroom/count_per_state_for_special_post_card_notice.pdf)

<sup>2</sup> Office of the Actuary, Centers for Medicare and Medicaid Services. Number represents only non-LIS seniors.

<sup>3</sup> Kaiser Family Foundation. 2009 Employer Health Benefits Survey.

<sup>4</sup> U.S. Census Bureau, Current Population Survey. Annual Social and Economic Supplements, March 2009; and 45 CFR Parts 144, 146, and 147. [http://www.hhs.gov/ocio/regulations/pru-omnibus\\_final.pdf](http://www.hhs.gov/ocio/regulations/pru-omnibus_final.pdf)



## U.S. Department of Health and Human Services



- Regional Health Administrators (RHAs)
- Offices:
  - Minority Health
  - HIV/AIDS
  - Women's Health
  - MRC
  - Commissioned Corps
  - Family Planning

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## History of the ACA

- H.R. 3590 became Public Law 111-148
  - Called the "Patient Protection and Affordable Care Act"
- H.R. 4782 became Public Law 111-152
  - Called the "Health Care and Education Reconciliation Act of 2010"
  - The bill makes a number of health-related financing and revenue changes to the Patient Protection and Affordable Care Act (enacted by H.R. 3590) and also modifies higher education assistance provisions

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## Prevention Provisions

- Community Prevention
- Clinical Prevention
- Strategy and Planning

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## Community Prevention

- National Prevention, Health Promotion and Public Health Council
  - Advisory Group on Prevention, Health Promotion, and Integrative and Public Health
- Community Preventive Services Task Force

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## Community Prevention

- Prevention and Public Health Fund
  - Education and outreach campaigns regarding preventive benefits
  - Community Transformation Grants
- Nutrition Labeling

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## Clinical Prevention - General

- Preventive Services Task Force
- Emphasis on personalized prevention plans
- Remove barriers to preventive services
- Improved coverage across lifespan
- Expands primary care workforce

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## Clinical Prevention

- Maternal and Child Health Services
  - Grants to eligible entities for early childhood home visitation programs
  - Grants to eligible entities to carry out personal responsibility education programs to educate adolescents on:
    - both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections
    - certain adulthood preparation subjects

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## Clinical Prevention - Medicare

- Annual Wellness Visit
- Eliminates cost-sharing on preventive services
- Expands alternative primary care workforce eligible for Medicare reimbursement
- Enhances workforce in geriatrics

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## Clinical Prevention - Medicaid

- Expanded access
  - Better coordination with CHIP and Medicare for dual eligibility
- Smoking cessation
- Limits barriers to preventive services
  - Including vaccinations
- Grant program to provide incentives for prevention activities

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## Clinical Prevention – Private Plans

- Expands prevention services
  - Requires health plans to provide coverage for, and to not impose any cost sharing requirements for:
    - (1) specified preventive items or services
    - (2) recommended immunizations; and
    - (3) recommended preventive care and screenings for women and children.
- Expands coverage
  - Requires a health plan that provides dependent coverage of children to make such coverage available for an unmarried, adult child until the child turns 26 years of age.

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## Strategy and Planning - General

- Transparency
- Dissemination of information
- Collaboration across Federal agencies

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## Strategy and Planning

- National Prevention, Health Promotion and Public Health Council
  - Advisory Group on Prevention, Health Promotion, and Integrative and Public Health
- National Strategy to Improve Health Care Quality
  - Interagency Working Group on Health Care Quality
- Center for Medicare and Medicaid Innovation
- National Health Care Workforce Commission
- Patient-Centered Outcomes Research Institute

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## References

- Public Law 111-148
- Public Law 111-152
- [http://www.healthreform.gov/health\\_reform\\_and\\_hhs.html](http://www.healthreform.gov/health_reform_and_hhs.html)
- Bill Summary and Status
  - <http://thomas.loc.gov/cgi-bin/bdquery/z?d111:HR03590:@@D&summ2=3&>

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Vivianne M. Chaumont, Director  
Division of Medicaid & Long-Term Care  
Department of Health and Human Services

LR 467 Testimony  
Health and Human Services Committee  
September 16, 2010

Good afternoon Senator Gay and members of the LR 467 Select Committee. My name is Vivianne Chaumont (V-I-V-I-A-N-N-E C-H-A-U-M-O-N-T), I am the Director of the Division of Medicaid and Long-Term Care for the Department of Health and Human Services. I am here to provide you a high level overview of the Affordable Care Act (ACA), which includes the Patient Protection and Affordable Care Act and the corresponding Reconciliation Act, and its impact on the Division of Medicaid & Long-Term Care.

As I am sure you are aware, the Department of Health and Human Services, in order to get a better idea of the fiscal impact of the changes required under the Affordable Care Act (ACA), contracted with Milliman, Inc., an actuarial firm, to provide a fiscal impact estimate of the costs of preparing for and implementing the ACA. The Milliman Report only examined the fiscal impact of the ACA on the Medicaid program. A copy of the Milliman Report is included in your handouts. The changes required to Medicaid as a result of the ACA are numerous. I am going to address some of the larger changes with you in some level of specificity. Each of these changes involves some level of resource dedication from the Division of Medicaid & Long-Term Care to assess the change, develop a plan, and implement the required change. Most, if not all, of the changes also require some level of IT resource dedication for associated system changes.

Likely, the most significant change to Medicaid is the addition of a new category of Medicaid eligible individuals. Under the ACA, on January 1, 2014, Medicaid eligibility is extended to childless adults. This group will be eligible for Medicaid up to 133% of the Federal Poverty Level (FPL) with a 5% income disregard. Therefore, eligibility will actually be at 138% of the FPL. Under the ACA, the federal government will fully fund the cost of services for individuals who are newly eligible for Medicaid through 2016, at which time the percentage of Federal Financial Participation (FFP) decreases to 95% in 2017, 94% in 2018, 93% in 2019, and 90% from 2020 onward. Beginning in 2016, States will have to pay the increased match necessary to cover this population under Medicaid.

Due to the increased FFP for the new eligibility group, the Division will need to make system changes to identify those newly eligible clients in order to determine which clients are eligible for the higher FFP. The higher FFP amounts are only available for clients who are eligible as a result of the ACA expansions. The standard FFP will still apply for those individuals who would have been eligible for Medicaid under the standards in place prior to the ACA. Currently, that match is approximately 60% federal and 40% General Fund. This means that when making eligibility determinations, there

will have to be two processes in place. One process that applies to the new eligibility category and one process that applies to the current categories of eligibility under the current guidelines.

States are to provide coverage for this expansion group under a benchmark or benchmark equivalent plan. Nebraska Medicaid does not currently have a benchmark plan. A benchmark plan, as currently defined by federal requirements, is a benefit package that is based on (1) the standard Blue Cross Blue Shield preferred provider option under the Federal Employee Health Benefit Plan, (2) the HMO plan with the largest commercial, non-Medicaid enrollment in the State, (3) any generally available State employee plan, or (4) any plan that the Secretary of the federal Department of Health and Human Services determines is appropriate. The Division of Medicaid & Long-Term Care (MLTC) will have to undertake an assessment to determine what type of benchmark plan should be developed for this population. Development and implementation of a benchmark plan will result in significant costs to the Medicaid program. These costs include analysis of the options and potential population as well as system and program costs. For example, the claims system will need to deal with two benefit packages rather than one. This will result in significant costs to the eligibility system and to Nebraska's already cumbersome MMIS system, the system that pays Medicaid claims.

In addition to the costs of covering the services for this new expanded population, it is anticipated that there will be costs of covering the services of additional populations who become Medicaid eligible as a result of other changes in the ACA. You will hear this population commonly referred to as the woodwork population. This includes persons who are currently insured through the private market or who are uninsured but seek insurance coverage as a result of the mandates of the ACA. There is no enhanced federal funding for this population since they could otherwise have been eligible for Medicaid prior to the ACA but chose not to apply for the program.

In addition to mandating coverage of childless adults effective January 1, 2014, the ACA mandates Nebraska to add another new population effective January 1, 2014. States will be required to provide Medicaid eligibility to children who are in foster care on their 18<sup>th</sup> birthday until their 26<sup>th</sup> birthday. Clients who qualify for Medicaid through this eligibility group will receive all benefits under Medicaid, including benefits under EPSDT, the Early and Periodic Screening, Diagnosis and Treatment benefit. Currently, Nebraska provides this coverage for former foster care children to age 19. This new federal mandate results in an expansion of eligibles and has a fiscal and system impact. State Plan and regulatory changes will also be necessary.

Under the ACA, in order to be eligible for the higher match for the childless adult population, States are prohibited from changing the eligibility standards, methodologies, and procedures they had in place on the date of ACA enactment, March 23, 2010. This requirement applies to adult populations until December 31, 2013 and to children in Medicaid and CHIP effective until September 30, 2019. This results in the inability of the State to implement changes to Medicaid coverage which would make eligibility

determinations more restrictive or eliminate certain groups from coverage, thereby limiting flexibility for budget purposes.

Along with the necessary programmatic and system changes, there will also be increased administrative costs to the Department related to the new category of Medicaid eligibles and the anticipated increase in the Medicaid population resulting from the ACA and the effects of the ACA. More eligibles result in the need for more staff to process more claims, work with providers, and ensure compliance with different program requirements. Statutory changes will be necessary during the 2012 Legislative Session. Significant State Plan and regulatory changes will need to be made. All of these changes will need to be in place by January 1, 2014.

Another requirement of the ACA relates to the interplay between the Medicaid program and the insurance exchange that each state will be required to have in place. Because Medicaid will be one option of insurance available to persons, the exchange will need to be able to make Medicaid eligibility determinations and there will need to be an interchange of information between the Medicaid program and the insurance exchange in order to provide seamless enrollment for all programs. This issue represents major fiscal and systems impact for the Department, as the Department's eligibility and MMIS systems will need to be changed in order to interface with the Exchange. I am just beginning conversations and planning with Ann Frohman and her Department on the exchange issue. Many of these details would be examined under the auspices of the federal exchange planning grant that Nebraska is seeking.

The increase in eligibles is probably the largest but certainly not the only significant change required by the ACA. Effective January 1, 2010, the rebate percentages for covered outpatient drugs provided to Medicaid clients increased. The minimum rebate percentage increased from 15.1% to 23.1% for brand name drugs and from 11% to 13% for generic drugs. The impact of the increased rebate accrues 100% to the Federal government. It is anticipated that this increase in the rebate will result in a significant reduction in Nebraska's supplemental rebates, or a loss of roughly \$74 million from 2011 to 2020.

The ACA requires Medicaid programs to pay physicians for certain primary care services at 100% of the Medicare fee schedule for services provided between January 1, 2013 and January 1, 2015. During that time period, the increased costs of that federally required rate increase will be paid with 100% federal funds. These changes will result in increased workload and system impacts to Medicaid and IT staff. The ACA provides that States will have the option of reducing payment for these codes on January 1, 2015.

Nebraska Medicaid currently participates in making payments to hospitals under the Disproportionate Share Hospital (DSH) program. Under DSH, if hospitals exceed the statewide average threshold for uncompensated care, they are eligible to receive a DSH payment, which helps offset the cost of a portion of the uncompensated care provided. The ACA reduces DSH allotments to states as their uninsured rates decline. This

reduction begins in 2013. This will have a fiscal impact and will result in State Plan and regulatory changes.

As you know, Nebraska operates a Medicaid expansion CHIP program. Under the ACA, States are required to maintain income eligibility levels for CHIP through September 30, 2019. Nebraska's current income eligibility level for CHIP is 200% FPL. Beginning on October 1, 2015 and ending September 30, 2019, states will receive a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent. Based on Nebraska's current federal match for CHIP, this would bring the Federal Financial Participation (FFP) to roughly 93% for that period of time. This will result in a savings.

There are a number of other issues of particular significance that I would like to point out at this time. Many include requirements that impact the current, already taxed, MMIS system.

The ACA requires States to implement the National Correct Coding Initiative (NCCI) for use in processing Medicaid claims by October 1, 2010. NCCI is a group of edits used in the claims processing system to detect fraud. These edits are currently used by Medicare in processing claims. This change has a major impact on our claims processing system. Guidance related to the NCCI requirements was provided by CMS on September 1, 2010, which gives States little time to implement the changes.

States must provide coverage for freestanding birth center services. These providers are not currently enrolled in Medicaid and therefore, this will result in an expansion. This requires program and system changes.

Medicaid must provide concurrent care for children who are eligible to receive hospice services. This allows children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness.

The Secretary will be creating regulations to ensure that States develop service systems designed to eliminate barriers to providing home and community-based services. This includes allocation of resources to maximize beneficiary independence, including the use of client-employed providers, supporting the beneficiary in designing an individualized, self-directed, community-supported life, and improving coordination among providers. The regulations issued by the Secretary will be reviewed for a determination of impact at that time. Many questions that state Medicaid programs have remain unanswered because details must be promulgated as federal regulations by CMS.

Beginning on January 1, 2012, States are responsible for the collection of adult health quality measures, similar to the CHIP pediatric quality measures. Effective September 30, 2014, States will have to provide annual reporting to the Secretary of HHS related to adult health quality measures. Collection of the required quality health information is limited by our current MMIS. This will result in policy changes and have a system impact.

The Secretary of HHS will be providing the States regulations that prohibit Medicaid payment for services related to health care-acquired conditions. The Secretary will develop a list of health care-acquired conditions for Medicaid. When this direction is made available to States, this change will have a program and system impact.

Provider screening and other enrollment requirements under Medicaid, CHIP, and Medicare are being reviewed by the Secretary of HHS and the Office of the Inspector General to determine screening procedures for enrolling providers and suppliers in Medicaid, CHIP, and Medicare. The level of screening will be determined according to the risk of fraud, waste and abuse for a category of providers or suppliers. Screening procedures must include a licensure check, and may include, at the Secretary's discretion, a criminal background check, fingerprinting, unscheduled and unannounced site visits, database checks, and other screening as deemed appropriate. To pay for the new screening measures, the Secretary is required to impose a fee of \$500 for institutional providers. The new screening procedures will apply to those providers and suppliers revalidating their enrollment beginning September 19, 2010. It will apply to new providers and suppliers beginning March 23, 2011 and to current providers and suppliers March 23, 2012. Additional information is necessary prior to the implementation of this Section.

Recovery Audit Contractor (RAC) program audits are being expanded to Medicaid effective December 31, 2010. States must contract with a RAC to identify and recoup underpayments and overpayments in Medicaid and Waiver programs. RACs are paid on a contingency basis. Additional information is required from CMS before Nebraska Medicaid can move forward in implementing this program.

Providers who are terminated from participation under Medicare or another State plan must be terminated from participation under Medicaid. States must terminate individuals or entities from Medicaid participations if individuals or entities are terminated from Medicare or another State's Medicaid program. This is effective January 1, 2011.

Medicaid must exclude individuals or entities from participation in Medicaid for a specified period of time if the entity or individual owns, controls, or manages, and entity that has failed to repay overpayments during the period as determined by the Secretary, is suspended, excluded or terminated from participation in any Medicaid program, or is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.

It is clear that Health Reform results in sweeping changes to the Medicaid program in Nebraska and that it will take significant effort to assess, develop, and implement these changes. Thank you for the opportunity to provide you with this information.



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August 16, 2010

Ms. Vivianne Chaumont, Director  
Division of Medicaid & Long-Term Care  
Department of Health and Human Services  
State of Nebraska  
P.O. Box 95026  
Lincoln, NE 68509-5026

**RE: PATIENT PROTECTION AND AFFORDABLE CARE ACT WITH HOUSE  
RECONCILIATION – FINANCIAL ANALYSIS**

Dear Vivianne:

Milliman, Inc. (Milliman) has been retained by the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care (DHHS) to provide consulting services related to the financial review of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (Affordable Care Act) as they relate to the provisions impacting the State's Medicaid program and budget. This correspondence documents the results of our analysis.

**SUMMARY OF RESULTS**

Milliman has developed two estimates of the enrollment and fiscal impact associated with the Medicaid expansion and other related provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act. We have developed (1) a mid-range participation scenario and (2) a full participation scenario. We have prepared our fiscal analysis to reflect the state impact for state fiscal years 2011 through 2020. We have adjusted all data to reflect the three month offset between the federal fiscal year and the state fiscal year as appropriate.

Enclosures 1 and 2 provide the fiscal impact results of the Affordable Care Act under a mid-range participation scenario (Enclosure 1) and a full participation scenario (Enclosure 2). The total fiscal impact to the Nebraska Medicaid budget during the next 10 years would be estimated to be in the range of approximately \$526.3 million to \$765.9 million based upon the assumptions outlined in this document. Table 1 illustrates the anticipated expenditure impacts to the Nebraska Medicaid budget for the period of SFY 2011 through SFY 2020 under each scenario.

**Table 1**

**Nebraska Department of Health and Human Services**  
**Division of Medicaid and Long-Term Care**  
  
**Patient Protection and Affordable Care Act**  
**as Amended by the Health Care and Education Reconciliation Act**  
  
**State Budget Fiscal Impact – SFY 2011 through SFY 2020**  
**(Values Illustrated in Millions)**

Component	Estimated Fiscal Impact – State Only	
	Mid-Range Participation Scenario	Full Participation Scenario
Adults/Parents/Children Expansion to 138% FPL	\$465.1	\$617.3
Administration	82.4	106.8
Pharmacy Rebate Loss for Nebraska	68.1	74.4
Physician Fee Schedule Increase to Medicare Rates	0.0	56.8
Foster Children Coverage to Age 26	15.1	15.1
Medically Needy Expansion to 138% FPL	5.6	5.6
DSH Reduction	(18.8)	(18.8)
CHIP Enrollment Shift and FMAP Increase	(30.9)	(30.9)
State Disability Shift to Medicaid and Expansion to 138% FPL	(60.5)	(60.5)
<b>Total</b>	<b>\$526.3</b>	<b>\$765.9</b>

Note: Values have rounded

**Estimated Medicaid Enrollment Impact**

Table 2 illustrates the projected increase in Medicaid enrollment reflecting a 138% Federal Poverty Level (FPL) limit. The 138% FPL limit reflects the 133% FPL indicated in the Affordable Care Act with the 5% income disregard allowance. The values in Table 2 were derived from the 2009 Current Population Survey (2009 CPS) data from the U.S. Census Bureau collected in 2009 (representing 2008 insurance and income data) as well as Medicaid enrollment data provided by DHHS. Children were defined as ages 0 through 19. The Adult and Parent populations were defined as ages 20 through 64.

**Table 2**
**Nebraska Department of Health and Human Services  
 Division of Medicaid and Long-Term Care**
**Patient Protection and Affordable Care Act  
 as Amended by the Health Care and Education Reconciliation Act**
**State Budget Enrollment Impact – 2009 CPS Census Data**

Population	FPL Range	Enrollment Full Participation Scenario	Mid-Range Participation Assumption	Enrollment Mid-Range Participation Scenario
Uninsured Adults	0% - 138%	36,779	80%	29,423
Newly Eligible Parents	50% - 138%	20,510	85%	17,433
Woodwork Parents	< 50%	4,623	70%	3,236
Woodwork Children	<138%	23,119	80%	18,496
Insured Switchers – Adults	0% - 138%	23,916	50%	11,958
Insured Switchers – Parents	0% - 138%	21,429	75%	16,071
Insured Switchers – Children	0% - 138%	14,538	75%	10,903
State Disability <sup>(1)</sup>	0% - 138%	154	DHHS 133% FPL Assumption+ 5%	154
Medically Needy <sup>(2)</sup>	43% - 138%	229	DHHS 133% FPL Assumption +5%	229
Sub-total		145,297		107,903

Notes: (1) State Disability currently covered with state funds to 100% FPL. Enrollment reflects shift to Medicaid and FPL expansion estimated as of 2014.

(2) Enrollment reflects FPL expansion estimated as of 2014.

The mid-range participation rates in Table 2 were reviewed for consistency with participation in the Medicare program which exceeds 95% and the Medicaid/CHIP programs for children which exceeds 85%. Actual participation in the Medicaid program after the expansion may exceed the participation rates noted in these other programs, since there will be an individual mandate for health insurance coverage under federal health care reform legislation.

**Percentage increase in Medicaid in relation to the total number of Nebraskans**

- Calendar Year 2008 Nebraska Census Estimate 1,783,000
- Increase would be approximately 6.1% to 8.2% more Nebraska residents on Medicaid
- Increase from 11.6% to range of 17.7% - 19.8% - or nearly 1 in 5 Nebraskans

The remainder of this letter discusses each of the Medicaid components of health care reform as listed in Table 1.

**a. Adults/Parents/Children Expansion to 138% FPL**

The fiscal impact associated with the Adults, Parents, and Children expansion to 138% FPL includes both currently insured and uninsured individuals below the 138% FPL amount and children not currently covered under Medicaid, who are also below the 138% FPL limit. The 138% FPL limit reflects the 133% FPL indicated in the Affordable Care Act with the 5% income disregard allowance. The analysis presented in this report reflects full participation (full participation scenario) as well as an alternate participation assumption (mid-range participation scenario). The participation assumptions by population are presented in Table 2. The assumed average annual cost per enrollee by population as of State fiscal year 2009 is provided in Table 3.

**Table 3**

**Nebraska Department of Health and Human Services  
 Division of Medicaid and Long-Term Care**

**Patient Protection and Affordable Care Act  
 as Amended by the Health Care and Education Reconciliation Act**

**Average Cost per Enrollee as of SFY 2009**

<b>Population</b>	<b>Average Annual Cost</b>
Uninsured Adults	\$5,467
Newly Eligible Parents	\$4,881
Woodwork Parents	\$4,881
Woodwork Children	\$2,654
Insured Switchers – Adults	\$5,900
Insured Switchers – Parents	\$5,268
Insured Switchers – Children	\$2,950
State Disability <sup>(1)</sup>	\$78,107
Medically Needy – Disabled <sup>(1)</sup>	\$85,390
Medically Needy – Long-Term <sup>(1)</sup>	\$109,932

Notes: (1) State Disability and Medically Needy costs provided by DHHS for FFY 2014.

The cost estimates for the State Disability and Medically Needy populations were obtained from the health care reform projection provided by DHHS. All other annual cost estimates were developed from SFY 2009 enrollment and expenditures provided in the *Nebraska Medicaid Reform Annual Report* dated December 1, 2009 with appropriate adjustments. The values in Table 3 reflect the age/gender mix of each population based upon the 2009 CPS census data. For example, the insured switcher adult population does not have the same age distribution as the uninsured adult population which impacts expected average cost. Milliman additionally used internally available data from other Medicaid expansion analyses to develop the cost relationship between adults and parents. Milliman assumed a composite annual trend of 3.0% to project the claim cost for the expansion population into future years. The 3.0% trend reflects the impact of enrollment growth as well as projected trend for utilization and intensity of services.

The Affordable Care Act reflects the following Federal Medical Assistance Percentages (FMAP) for the expansion populations.

- 100% FMAP in CY 2014, 2015, and 2016
- 95% FMAP in CY 2017
- 94% FMAP in CY 2018
- 93% FMAP in CY 2019
- 90% FMAP in CY 2020+

Milliman assumed that the projected FFY 2012 FMAP rate of 57.64% for Medicaid and 70.35% for CHIP would continue through 2020 for non-expansion populations.

**b. Administration**

In addition to the expenditures associated with providing medical services, Nebraska will incur additional administrative expenditures. The expenditures for the initial modifications to the current administrative systems, as well as establishment of an Exchange, are estimated to be \$25 million (State and Federal) or \$12.5 million (State only). On-going costs for the coverage of the additional 108,000 to 145,000 Medicaid enrollees are estimated to be \$21.5 to \$29.0 million per year (State and Federal) or \$10.8 to \$14.5 million per year (State only). The on-going costs were developed assuming approximately \$200 per recipient per year or approximately 3.75% of total expected medical expenditures. Based on my experience with Medicaid programs, the state Medicaid administrative costs range from 3.5% to 6.0% of the total medical costs. The administrative expenses would be anticipated to be incurred in calendar years 2012 and 2013 for the initial administrative expenditures and in calendar year 2014 forward for the on-going expenditures.

**c. Pharmacy Rebate Loss for Nebraska**

The Affordable Care Act includes increased rebate percentages for covered outpatient drugs provided to Medicaid patients. The minimum rebate percentage is increased from 15.1% to 23.1% for most brand name drugs and from 11% to 13% for generic drugs effective January 1, 2010. However, the Affordable Care Act indicates that the impact will be accrued 100% to the Federal government. Milliman has modeled that this could reduce Nebraska's rebates by 20.7% to 22.6% or more beginning on January 1, 2010. The 20.7% assumption used for the mid-range participation scenario corresponds to a 75%/25% distribution of brand-name/generic pharmacy expenditures. An 8% reduction for brand-name drugs and a 2% reduction for generic drugs equates to an average 6.5% reduction under the 75%/25% assumption. The 6.5% reduction is approximately 20.7% of the current 31.5% assumed rebate level. The 22.6% assumption used for the full participation scenario corresponds to an 85%/15% distribution of brand-name/generic pharmacy expenditures.

**d. Physician Fee Schedule Increase to Medicare Rates**

According to an April 2009 report by the Urban Institute's Health Policy Center, the current Nebraska Medicaid fee schedule reimburses at approximately 82% of the Medicare fee schedule for primary care services. The Affordable Care Act requires an increase in the Medicaid physician fee schedule for a

limited set of primary and preventive care services to 100% of the Medicare physician fee schedule. 100% Federal funding is available for calendar years 2013 and 2014. No additional funding is available for other physician services.

*Full Participation Scenario –*

The full participation scenario assumes that DHHS will increase the fee schedule for the required services for both primary care and specialty care providers and will continue the increased fee schedule after calendar year 2014 to assure continued access to physician care. In addition to increasing the expected cost of corresponding existing expenditures by approximately 22%, the analysis reflects an additional \$120 per year for the dual eligible population since Medicare only pays 80% of the fee schedule for Part B services.

Under the full participation scenario, the increased cost would be an estimated \$27 million (State and Federal) per year for the current Medicaid program and expansion populations. During calendar years 2013 and 2014, the state would have to pay the standard state portion of the increase for specialty providers for the existing Medicaid population. Therefore, the state share in these two calendar years would be approximately \$2.8 million (State only) per year. In 2015, the State only cost for the fee schedule expansion would grow to an estimated \$9 million (State only).

*Mid-Range Participation Scenario –*

The mid-range participation scenario assumes that DHHS will only increase the fee schedule for primary care providers, not specialty care providers. The mid-range participation scenario further assumes that the fee schedule increase will only continue through calendar year 2014 and will terminate when the Federal funding level decreases. The annual cost would be approximately \$18 million and reflects 100% Federal funding for the calendar year 2013 and 2014 period.

**e. Foster Children Coverage to Age 26**

It is Milliman's understanding that Nebraska currently provides Medicaid eligibility coverage to Foster Children to age 19. The Affordable Care Act includes mandatory coverage for Foster Children to age 26 beginning on January 1, 2014. Milliman has estimated the annual cost at \$5.5 million per year (State and Federal) or approximately \$2.3 million per year (State only).

**f. Medically Needy Expansion to 138% FPL**

The Medically Needy population is currently covered to 43% FPL. The population is limited to non-Dual eligibles under age 65. Effective January 1, 2014, the population will be covered to 138% FPL including the 5% income disregard allowance. Milliman has utilized the DHHS expenditure estimate for the Medically Needy population for fiscal year 2014 assuming expansion to 133% FPL under the Medicaid enhanced FMAP rate. Our projection adjusts the DHHS estimate by a factor of 1.05 to reflect expansion to the 138% FPL level. We have additionally adjusted the estimate provided by DHHS from a Federal fiscal year basis to a State fiscal year basis. Although these individuals would theoretically be included in the 2009 CPS data, the cost intensity needs to be additionally reflected.

**g. DSH Reduction**

Based upon the aggregate Disproportionate Share Hospital (DSH) payment reductions indicated in the Affordable Care Act, Milliman developed average Federal fiscal year DSH reduction percentages. Milliman adjusted the Federal fiscal year percentages to a State fiscal year basis. The baseline DSH expenditures of \$44.0 million provided by DHHS were ultimately reduced to two-thirds of the National reduction percentage. The reduction was reduced to two-thirds of the National percentage to reflect that Nebraska is a low DSH state.

Federal Fiscal Year	DSH Percentage Reduction	
	National Percentage	Nebraska Percentage
2014	4.4%	2.9%
2015	5.3%	3.5%
2016	5.3%	3.5%
2017	15.9%	10.6%
2018	44.1%	29.4%
2019	49.4%	32.9%
2020	35.3%	23.5%

Note: Nebraska percentage reduction was estimated at 2/3 of National percentage reduction since Nebraska is a low DSH state.

**h. CHIP Enrollment Shift and FMAP Increase**

Under the Affordable Care Act, the CHIP program is required to continue to 2019. However, the legislation provides an additional Federal matching rate of 23% beginning on October 1, 2015 and ending September 30, 2019. The additional 23% FMAP will increase the total FMAP for the CHIP program to approximately 93.35%. The enhanced FMAP will decrease expenditures for Nebraska and increase expenditures for the Federal share.

The projection additionally reflects that approximately 30% of current CHIP program enrollees will shift to Medicaid eligibility effective January 1, 2014. The 30% reflects CHIP enrollees <138% FPL.

**i. State Disability Shift to Medicaid and Expansion to 138% FPL**

Nebraska currently covers the State Disability population to 100% FPL with 100% state funds. Milliman has utilized the DHHS expenditure estimate for the State Disability population for Federal fiscal year 2014 assuming expansion to 133% FPL under the Medicaid enhanced FMAP rate. Our projection adjusts the DHHS estimate by a factor of 1.05 to reflect expansion to the 138% FPL level. We have additionally adjusted the estimate provided by DHHS from a Federal fiscal year basis to a State fiscal year basis. Although these individuals would theoretically be included in the 2009 CPS data, the cost intensity needs to be additionally reflected.

**OTHER CHANGES TO CURRENT PROGRAMS**

Milliman anticipates potential savings from the following populations even if the programs are not discontinued. However, savings estimates have not been included in the total impact projection for either the full participation scenario or mid-range participation scenario.

***Pregnant Women above 138% FPL***

The State of Nebraska currently provides eligibility for pregnant women up to 185% FPL. It would be anticipated that the majority of pregnant women between 138% FPL and 185% FPL will receive care through the insurance exchange. We have estimated that approximately 10% of the current expenditures for the pregnant women population will no longer be incurred by the Nebraska Medicaid program. We have estimated the annual savings to be approximately \$3.4 million (State and Federal) per year or \$1.4 million (State only) per year beginning on January 1, 2014.

***Breast and Cervical Cancer Program***

The State of Nebraska currently provides eligibility under the Breast and Cervical Cancer program. The total annual expenditures under the program are approximately \$5.0 million (State and Federal) or \$1.5 million (State only). It is not anticipated that this program will be required to be continued with the expansion requirements below 138% FPL and insurance reforms for individuals above 138% FPL. Therefore, we have estimated that this program could be terminated beginning on January 1, 2014; although, some of these individuals will become eligible under the new Medicaid eligibility requirements.

**LIMITATIONS**

The information contained in this correspondence, including any enclosures, has been prepared for the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care and their advisors. These results may not be distributed to any other party without the prior consent of Milliman. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling that will allow appropriate use of the data presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for DHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.



Ms. Vivianne Chaumont  
August 16, 2010  
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Milliman has relied upon certain data and information provided by DHHS as well as enrollment and expenditure data obtained from the Medicaid Statistical Information System (MSIS) State Summary Datamart and the *Nebraska Medicaid Reform Annual Report* dated December 1, 2009 as retrieved from the DHHS website. The values presented in this correspondence are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented will need to be reviewed for consistency and revised to meet any revised data. The data and information included in the report has been developed to assist in the analysis of the financial impact of Nebraska Medicaid Assistance expenditures. The data and information presented may not be appropriate for any other purpose. It should be emphasized that the results presented in this correspondence are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this letter.



If you have any questions or comments regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

A handwritten signature in cursive script that reads "Robert M. Damler". The signature is written in black ink and is positioned above the printed name.

Robert M. Damler, FSA, MAAA  
Principal and Consulting Actuary

RMD/lrb  
Enclosures



**ENCLOSURE 1**

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Division of Medicaid and Long-Term Care  
 Health Care Reform Projection - Mid-Range Participation Scenario  
 (Values in Millions)

8/16/2010  
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EXPENDITURES	<u>SFY 2011</u>	<u>SFY 2012</u>	<u>SFY 2013</u>	<u>SFY 2014</u>	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	SFY 2011 - <u>SFY 2020</u>
<b>Current Programs</b>											
<b>Medicaid</b>											
Total (State and Federal)	\$1,745.1	\$1,792.5	\$1,841.2	\$1,891.3	\$1,942.7	\$1,995.5	\$2,049.7	\$2,105.4	\$2,162.6	\$2,221.4	\$19,747.6
Federal Funds	\$1,029.1	\$1,036.8	\$1,061.3	\$1,090.1	\$1,119.8	\$1,150.2	\$1,181.5	\$1,213.6	\$1,246.5	\$1,280.4	\$11,409.3
State Funds	\$716.0	\$755.7	\$780.0	\$801.2	\$822.9	\$845.3	\$868.3	\$891.9	\$916.1	\$941.0	\$8,338.3
<b>CHIP</b>											
Total (State and Federal)	\$63.2	\$65.1	\$67.0	\$69.0	\$71.1	\$73.3	\$75.4	\$77.7	\$80.0	\$82.4	\$724.4
Federal Funds	\$45.0	\$45.9	\$47.2	\$48.6	\$50.0	\$51.5	\$53.1	\$54.7	\$56.3	\$58.0	\$510.3
State Funds	\$18.1	\$19.2	\$19.9	\$20.5	\$21.1	\$21.7	\$22.4	\$23.0	\$23.7	\$24.4	\$214.1
<b>State Disability</b>											
Total (State and Federal)	\$8.1	\$8.4	\$8.6	\$8.9	\$9.2	\$9.4	\$9.7	\$10.0	\$10.3	\$10.6	\$93.3
Federal Funds	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
State Funds	\$8.1	\$8.4	\$8.6	\$8.9	\$9.2	\$9.4	\$9.7	\$10.0	\$10.3	\$10.6	\$93.3
<b>All Programs</b>											
Total (State and Federal)	\$1,816.4	\$1,866.0	\$1,916.9	\$1,969.2	\$2,023.0	\$2,078.2	\$2,134.9	\$2,193.2	\$2,253.0	\$2,314.4	\$20,565.3
Federal Funds	\$1,074.1	\$1,082.7	\$1,108.5	\$1,138.7	\$1,169.8	\$1,201.7	\$1,234.6	\$1,268.2	\$1,302.9	\$1,338.4	\$11,919.6
State Funds	\$742.3	\$783.3	\$808.5	\$830.5	\$853.2	\$876.5	\$900.4	\$924.9	\$950.1	\$976.0	\$8,645.7

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Division of Medicaid and Long-Term Care  
 Health Care Reform Projection - Mid-Range Participation Scenario  
 (Values in Millions)

8/16/2010  
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EXPENDITURES	<u>SFY 2011</u>	<u>SFY 2012</u>	<u>SFY 2013</u>	<u>SFY 2014</u>	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	SFY 2011 - <u>SFY 2020</u>
<b>Health Care Reform</b>											
<b>Adults/Parents/Children - Expansion to 138% FPL</b>											
Total (State and Federal) - Newly Eligible				\$142.6	\$293.7	\$302.5	\$311.6	\$320.9	\$330.5	\$340.5	\$2,042.2
Total (State and Federal) - Woodwork				\$37.6	\$77.5	\$79.8	\$82.2	\$84.7	\$87.2	\$89.8	\$538.7
Total (State and Federal) - Insured Switchers				\$108.6	\$223.8	\$230.5	\$237.4	\$244.5	\$251.8	\$259.4	\$1,556.0
Federal Funds				\$265.0	\$545.8	\$562.2	\$566.4	\$567.6	\$579.3	\$585.6	\$3,671.8
State Funds				\$23.8	\$49.1	\$50.6	\$64.8	\$82.4	\$90.3	\$104.1	\$465.1
<b>Administrative Expenses</b>											
Total (State and Federal)		\$6.3	\$12.5	\$17.0	\$21.5	\$21.5	\$21.5	\$21.5	\$21.5	\$21.5	\$164.8
Federal Funds		\$3.1	\$6.3	\$8.5	\$10.8	\$10.8	\$10.8	\$10.8	\$10.8	\$10.8	\$82.4
State Funds		\$3.1	\$6.3	\$8.5	\$10.8	\$10.8	\$10.8	\$10.8	\$10.8	\$10.8	\$82.4
<b>Pharmacy Rebate Loss for Nebraska</b>											
Total (State and Federal)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Federal Funds	(\$5.0)	(\$5.5)	(\$5.8)	(\$6.2)	(\$6.5)	(\$6.9)	(\$7.4)	(\$7.8)	(\$8.3)	(\$8.8)	(\$68.1)
State Funds	\$5.0	\$5.5	\$5.8	\$6.2	\$6.5	\$6.9	\$7.4	\$7.8	\$8.3	\$8.8	\$68.1
<b>Physician Fee Schedule Increase to Medicare Rates</b>											
Total (State and Federal)			\$7.2	\$18.3	\$9.4	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$34.9
Federal Funds			\$7.2	\$18.3	\$9.4	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$34.9
State Funds			\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
<b>Foster Children Coverage to Age 26</b>											
Total (State and Federal)				\$2.8	\$5.5	\$5.5	\$5.5	\$5.5	\$5.5	\$5.5	\$35.8
Federal Funds				\$1.6	\$3.2	\$3.2	\$3.2	\$3.2	\$3.2	\$3.2	\$20.6
State Funds				\$1.2	\$2.3	\$2.3	\$2.3	\$2.3	\$2.3	\$2.3	\$15.1
<b>Medically Needy Expansion to 138% FPL</b>											
Total (State and Federal)				\$10.6	\$21.8	\$22.5	\$23.2	\$23.9	\$24.6	\$25.3	\$151.9
Federal Funds				\$10.6	\$21.8	\$22.5	\$22.6	\$22.6	\$23.0	\$23.2	\$146.2
State Funds				\$0.0	\$0.0	\$0.0	\$0.6	\$1.3	\$1.6	\$2.2	\$5.6
<b>DSH Reduction</b>											
Total (State and Federal)				(\$1.0)	(\$1.5)	(\$1.6)	(\$3.9)	(\$10.9)	(\$14.1)	(\$11.4)	(\$44.3)
Federal Funds				(\$0.6)	(\$0.9)	(\$0.9)	(\$2.2)	(\$6.3)	(\$8.1)	(\$6.6)	(\$25.5)
State Funds				(\$0.4)	(\$0.6)	(\$0.7)	(\$1.7)	(\$4.6)	(\$6.0)	(\$4.8)	(\$18.8)

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Division of Medicaid and Long-Term Care  
 Health Care Reform Projection - Mid-Range Participation Scenario  
 (Values in Millions)

8/16/2010  
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EXPENDITURES	<u>SFY 2011</u>	<u>SFY 2012</u>	<u>SFY 2013</u>	<u>SFY 2014</u>	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	<u>SFY 2011 - SFY 2020</u>
<b>CHIP Enrollment Shift and FMAP Increase</b>											
Total (State and Federal)				\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Federal Funds				(\$1.3)	(\$2.7)	\$6.1	\$9.3	\$9.5	\$9.8	\$0.2	\$30.9
State Funds				\$1.3	\$2.7	(\$6.1)	(\$9.3)	(\$9.5)	(\$9.8)	(\$0.2)	(\$30.9)
<b>State Disability Shift to Medicaid and Expansion to 138% FPL</b>											
Total (State and Federal)				\$1.6	\$3.4	\$3.5	\$3.6	\$3.7	\$3.8	\$3.9	\$23.6
Federal Funds				\$6.1	\$12.6	\$12.9	\$13.0	\$13.0	\$13.2	\$13.3	\$84.0
State Funds				(\$4.4)	(\$9.2)	(\$9.4)	(\$9.4)	(\$9.3)	(\$9.4)	(\$9.4)	(\$60.5)
<b>All Programs - After Expansion</b>											
Total (State and Federal)	\$1,816.4	\$1,872.2	\$1,936.6	\$2,307.3	\$2,678.0	\$2,742.4	\$2,815.9	\$2,886.9	\$2,963.9	\$3,049.0	\$25,068.7
Federal Funds	\$1,069.1	\$1,080.3	\$1,116.1	\$1,440.7	\$1,763.2	\$1,811.5	\$1,850.1	\$1,880.8	\$1,925.7	\$1,959.2	\$15,896.7
State Funds	\$747.3	\$791.9	\$820.5	\$866.6	\$914.8	\$930.9	\$965.8	\$1,006.1	\$1,038.2	\$1,089.8	\$9,172.0
<b>All Programs - Fiscal Impact</b>											
Total (State and Federal)	\$0.0	\$6.3	\$19.7	\$338.1	\$655.0	\$664.2	\$681.0	\$693.8	\$710.9	\$734.5	\$4,503.4
Federal Funds	(\$5.0)	(\$2.3)	\$7.6	\$302.0	\$593.4	\$609.8	\$615.5	\$612.6	\$622.8	\$620.8	\$3,977.1
State Funds	\$5.0	\$8.6	\$12.1	\$36.1	\$61.6	\$54.4	\$65.5	\$81.2	\$88.0	\$113.7	\$526.3
<b>Optional Changes to Current Programs</b>											
<b>Pregnant Women (133% - 185%)</b>											
Total (State and Federal)				(\$1.6)	(\$3.3)	(\$3.4)	(\$3.5)	(\$3.6)	(\$3.7)	(\$3.8)	(\$22.8)
Federal Funds				(\$0.9)	(\$1.9)	(\$2.0)	(\$2.0)	(\$2.1)	(\$2.1)	(\$2.2)	(\$13.2)
State Funds				(\$0.7)	(\$1.4)	(\$1.4)	(\$1.5)	(\$1.5)	(\$1.6)	(\$1.6)	(\$9.7)
<b>Breast &amp; Cervical Cancer</b>											
Total (State and Federal)				(\$2.4)	(\$5.0)	(\$5.2)	(\$5.3)	(\$5.5)	(\$5.6)	(\$5.8)	(\$34.8)
Federal Funds				(\$1.7)	(\$3.5)	(\$3.6)	(\$3.7)	(\$3.8)	(\$3.9)	(\$4.0)	(\$24.4)
State Funds				(\$0.7)	(\$1.5)	(\$1.5)	(\$1.6)	(\$1.6)	(\$1.7)	(\$1.7)	(\$10.3)



**ENCLOSURE 2**

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Division of Medicaid and Long-Term Care  
 Health Care Reform Projection - Full Participation Scenario  
 (Values in Millions)

8/16/2010  
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EXPENDITURES	<u>SFY 2011</u>	<u>SFY 2012</u>	<u>SFY 2013</u>	<u>SFY 2014</u>	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	SFY 2011 - SFY 2020
<b>Current Programs</b>											
<b>Medicaid</b>											
Total (State and Federal)	\$1,745.1	\$1,792.5	\$1,841.2	\$1,891.3	\$1,942.7	\$1,995.5	\$2,049.7	\$2,105.4	\$2,162.6	\$2,221.4	\$19,747.6
Federal Funds	\$1,029.1	\$1,036.8	\$1,061.3	\$1,090.1	\$1,119.8	\$1,150.2	\$1,181.5	\$1,213.6	\$1,246.5	\$1,280.4	\$11,409.3
State Funds	\$716.0	\$755.7	\$780.0	\$801.2	\$822.9	\$845.3	\$868.3	\$891.9	\$916.1	\$941.0	\$8,338.3
<b>CHIP</b>											
Total (State and Federal)	\$63.2	\$65.1	\$67.0	\$69.0	\$71.1	\$73.3	\$75.4	\$77.7	\$80.0	\$82.4	\$724.4
Federal Funds	\$45.0	\$45.9	\$47.2	\$48.6	\$50.0	\$51.5	\$53.1	\$54.7	\$56.3	\$58.0	\$510.3
State Funds	\$18.1	\$19.2	\$19.9	\$20.5	\$21.1	\$21.7	\$22.4	\$23.0	\$23.7	\$24.4	\$214.1
<b>State Disability</b>											
Total (State and Federal)	\$8.1	\$8.4	\$8.6	\$8.9	\$9.2	\$9.4	\$9.7	\$10.0	\$10.3	\$10.6	\$93.3
Federal Funds	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
State Funds	\$8.1	\$8.4	\$8.6	\$8.9	\$9.2	\$9.4	\$9.7	\$10.0	\$10.3	\$10.6	\$93.3
<b>All Programs</b>											
Total (State and Federal)	\$1,816.4	\$1,866.0	\$1,916.9	\$1,969.2	\$2,023.0	\$2,078.2	\$2,134.9	\$2,193.2	\$2,253.0	\$2,314.4	\$20,565.3
Federal Funds	\$1,074.1	\$1,082.7	\$1,108.5	\$1,138.7	\$1,169.8	\$1,201.7	\$1,234.6	\$1,268.2	\$1,302.9	\$1,338.4	\$11,919.6
State Funds	\$742.3	\$783.3	\$808.5	\$830.5	\$853.2	\$876.5	\$900.4	\$924.9	\$950.1	\$976.0	\$8,645.7

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Division of Medicaid and Long-Term Care  
 Health Care Reform Projection - Full Participation Scenario  
 (Values in Millions)

8/16/2010  
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EXPENDITURES	<u>SFY 2011</u>	<u>SFY 2012</u>	<u>SFY 2013</u>	<u>SFY 2014</u>	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	SFY 2011 - <u>SFY 2020</u>
<b>Health Care Reform</b>											
<b>Adults/Parents/Children - Expansion to 138% FPL</b>											
Total (State and Federal) - Newly Eligible				\$174.6	\$359.6	\$370.4	\$381.5	\$393.0	\$404.8	\$416.9	\$2,500.8
Total (State and Federal) - Woodwork				\$48.6	\$100.2	\$103.2	\$106.3	\$109.5	\$112.8	\$116.2	\$696.8
Total (State and Federal) - Insured Switchers				\$172.1	\$354.5	\$365.1	\$376.1	\$387.4	\$399.0	\$411.0	\$2,465.2
Federal Funds				\$364.2	\$750.2	\$772.7	\$778.3	\$779.9	\$795.9	\$804.4	\$5,045.5
State Funds				\$31.1	\$64.1	\$66.1	\$85.6	\$109.9	\$120.7	\$139.7	\$617.3
<b>Administrative Expenses</b>											
Total (State and Federal)		\$6.3	\$12.5	\$20.8	\$29.0	\$29.0	\$29.0	\$29.0	\$29.0	\$29.0	\$213.5
Federal Funds		\$3.1	\$6.3	\$10.4	\$14.5	\$14.5	\$14.5	\$14.5	\$14.5	\$14.5	\$106.8
State Funds		\$3.1	\$6.3	\$10.4	\$14.5	\$14.5	\$14.5	\$14.5	\$14.5	\$14.5	\$106.8
<b>Pharmacy Rebate Loss for Nebraska</b>											
Total (State and Federal)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Federal Funds	(\$5.5)	(\$6.0)	(\$6.4)	(\$6.7)	(\$7.1)	(\$7.6)	(\$8.0)	(\$8.5)	(\$9.0)	(\$9.6)	(\$74.4)
State Funds	\$5.5	\$6.0	\$6.4	\$6.7	\$7.1	\$7.6	\$8.0	\$8.5	\$9.0	\$9.6	\$74.4
<b>Physician Fee Schedule Increase to Medicare Rates</b>											
Total (State and Federal)			\$10.1	\$27.3	\$28.1	\$28.9	\$29.7	\$30.5	\$31.3	\$32.2	\$218.0
Federal Funds			\$8.9	\$24.5	\$22.7	\$20.3	\$20.6	\$20.9	\$21.4	\$21.8	\$161.3
State Funds			\$1.2	\$2.8	\$5.4	\$8.6	\$9.0	\$9.5	\$9.9	\$10.4	\$56.8
<b>Foster Children Coverage to Age 26</b>											
Total (State and Federal)				\$2.8	\$5.5	\$5.5	\$5.5	\$5.5	\$5.5	\$5.5	\$35.8
Federal Funds				\$1.6	\$3.2	\$3.2	\$3.2	\$3.2	\$3.2	\$3.2	\$20.6
State Funds				\$1.2	\$2.3	\$2.3	\$2.3	\$2.3	\$2.3	\$2.3	\$15.1
<b>Medically Needy Expansion to 138% FPL</b>											
Total (State and Federal)				\$10.6	\$21.8	\$22.5	\$23.2	\$23.9	\$24.6	\$25.3	\$151.9
Federal Funds				\$10.6	\$21.8	\$22.5	\$22.6	\$22.6	\$23.0	\$23.2	\$146.2
State Funds				\$0.0	\$0.0	\$0.0	\$0.6	\$1.3	\$1.6	\$2.2	\$5.6
<b>DSH Reduction</b>											
Total (State and Federal)				(\$1.0)	(\$1.5)	(\$1.6)	(\$3.9)	(\$10.9)	(\$14.1)	(\$11.4)	(\$44.3)
Federal Funds				(\$0.6)	(\$0.9)	(\$0.9)	(\$2.2)	(\$6.3)	(\$8.1)	(\$6.6)	(\$25.5)
State Funds				(\$0.4)	(\$0.6)	(\$0.7)	(\$1.7)	(\$4.6)	(\$6.0)	(\$4.8)	(\$18.8)

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Division of Medicaid and Long-Term Care  
 Health Care Reform Projection - Full Participation Scenario  
 (Values in Millions)

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EXPENDITURES	<u>SFY 2011</u>	<u>SFY 2012</u>	<u>SFY 2013</u>	<u>SFY 2014</u>	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	SFY 2011 - <u>SFY 2020</u>
<b>CHIP Enrollment Shift and FMAP Increase</b>											
Total (State and Federal)				\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Federal Funds				(\$1.3)	(\$2.7)	\$6.1	\$9.3	\$9.5	\$9.8	\$0.2	\$30.9
State Funds				\$1.3	\$2.7	(\$6.1)	(\$9.3)	(\$9.5)	(\$9.8)	(\$0.2)	(\$30.9)
<b>State Disability Shift to Medicaid and Expansion to 138% FPL</b>											
Total (State and Federal)				\$1.6	\$3.4	\$3.5	\$3.6	\$3.7	\$3.8	\$3.9	\$23.6
Federal Funds				\$6.1	\$12.6	\$12.9	\$13.0	\$13.0	\$13.2	\$13.3	\$84.0
State Funds				(\$4.4)	(\$9.2)	(\$9.4)	(\$9.4)	(\$9.3)	(\$9.4)	(\$9.4)	(\$60.5)
<b>All Programs - After Expansion</b>											
Total (State and Federal)	\$1,816.4	\$1,872.2	\$1,939.5	\$2,426.7	\$2,923.6	\$3,004.8	\$3,085.9	\$3,164.7	\$3,249.7	\$3,343.0	\$26,826.5
Federal Funds	\$1,068.6	\$1,079.8	\$1,117.2	\$1,547.4	\$1,984.1	\$2,045.4	\$2,085.7	\$2,117.1	\$2,166.7	\$2,202.8	\$17,414.9
State Funds	\$747.8	\$792.4	\$822.3	\$879.2	\$939.6	\$959.3	\$1,000.1	\$1,047.6	\$1,083.0	\$1,140.3	\$9,411.6
<b>All Programs - Fiscal Impact</b>											
Total (State and Federal)	\$0.0	\$6.3	\$22.6	\$457.4	\$900.7	\$926.6	\$951.0	\$971.5	\$996.7	\$1,028.6	\$6,261.2
Federal Funds	(\$5.5)	(\$2.8)	\$8.8	\$408.7	\$814.3	\$843.7	\$851.2	\$848.8	\$863.8	\$864.4	\$5,495.3
State Funds	\$5.5	\$9.1	\$13.8	\$48.7	\$86.4	\$82.9	\$99.8	\$122.7	\$132.8	\$164.2	\$765.9
<b>Optional Changes to Current Programs</b>											
<b>Pregnant Women (133% - 185%)</b>											
Total (State and Federal)				(\$1.6)	(\$3.3)	(\$3.4)	(\$3.5)	(\$3.6)	(\$3.7)	(\$3.8)	(\$22.8)
Federal Funds				(\$0.9)	(\$1.9)	(\$2.0)	(\$2.0)	(\$2.1)	(\$2.1)	(\$2.2)	(\$13.2)
State Funds				(\$0.7)	(\$1.4)	(\$1.4)	(\$1.5)	(\$1.5)	(\$1.6)	(\$1.6)	(\$9.7)
<b>Breast &amp; Cervical Cancer</b>											
Total (State and Federal)				(\$2.4)	(\$5.0)	(\$5.2)	(\$5.3)	(\$5.5)	(\$5.6)	(\$5.8)	(\$34.8)
Federal Funds				(\$1.7)	(\$3.5)	(\$3.6)	(\$3.7)	(\$3.8)	(\$3.9)	(\$4.0)	(\$24.4)
State Funds				(\$0.7)	(\$1.5)	(\$1.5)	(\$1.6)	(\$1.6)	(\$1.7)	(\$1.7)	(\$10.3)

**PUBLIC HEARING  
SEPTEMBER 17**

**LR 467 INTERIM STUDY REPORT**

**PATIENT PROTECTION AND  
AFFORDABLE CARE ACT**

**Department of Insurance Testimony**

Good morning. My name is Ann Frohman, spelled A-N-N F-R-O-H-M-A-N. I am the director of insurance, here today to discuss some of the issues we see regarding the implementation of the federal affordable care act, which we refer to as "PPACA". First, I'd like to thank you for introducing the interim study resolution so we can have a chance to discuss this outside of the context of specific legislation. Hopefully this will allow us to better get a handle on all of the challenges posed by this federal legislation.

PPACA has already and will in the future create substantial workload for the Department of Insurance. At more than 2000 pages of statutory language, plus the hundreds of pages of regulations interpreting PPACA, simply getting a handle on all of the provisions is a challenge. Fortunately, Department staff has been able to rearrange their workloads to meet these newly enacted federal demands. My staff and I meet on a regular basis to implement the Federal law and to work on issues as they develop.

At an extremely high level, as it relates to health insurance, PPACA restructures the way health care is financed in this country by requiring all persons to buy insurance. This mandate takes effect in 2014. After that date insurers will no longer be able to decide who they will and will not provide coverage to, they will not be able to base rates on the basis of health status, or limit the amount of coverage they will provide. The law goes on to prescribe the details, exceptions, additions, and interim provisions, some of which must be implemented after September 23, 2010.

One of our current challenges is that the federal government has significant rulemaking to do to implement PPACA. Several issues posed by PPACA will not be able to be resolved until those federal rules are adopted. For example, federal rulemaking has not even started in the area of what an "essential health benefit" is that all plans must eventually have within them. Additionally, the Federal Government will examine the NAIC's proposal on the Medical Loss Ratio (MLR). This is a key component of the Federal Law that mandates that a company spend a certain percentage of premium collected on the medical costs. This sounds easy enough but it is a complicated formula that has taken the NAIC some time to develop. This poses an obvious challenge both to the Department as it seeks to implement federal requirements and to insurers as they seek to do business in this new environment.

In this same environment, the federal government has been issuing a number of grant opportunities. These grant applications have had very short turnaround time. Generally federal HHS issues a press release announcing the grant to the public and simultaneously to the entities that are expected to apply for the grant and we have a little more than a month to develop a description of an entirely new program or system. Under these conditions, we have requested funding for two grants. We will review further grant funding opportunities as they arise, avoiding those that require ongoing state funding when the grant expires.

The first \$1 million federal grant was awarded in August. It allows us to improve our current health insurance rate review and approval processes. Because the grants will expire after two years, our grant request was designed to allow us to improve existing processes with actuarial recommendation on how to improve rate reviews, as well as improve training and computer software that we will benefit from on an ongoing basis. The second grant, applied for the first of this month, is a "plan to plan grant" that Nebraska can use to determine whether or not it should create a health insurance exchange, an issue I'll return to later.

Moving from process related matters to specific issues; I'd like to discuss an early decision point, the decision of whether or not to operate a state High Risk Pool or leave it to the federal government. As an interim first step, the federal government allocated \$5 billion nationally, in total, to fund a High Risk Pool for people who had not had coverage in the previous six months of eligibility. If you had coverage in the prior six months you were ineligible. On conference calls, the federal government would not commit to further funding, asserting instead in the face of their own actuarial concerns, that the funding was adequate and, if it was not, steps such as placing enrollment caps or other measures would need to be implemented by the Secretary of Health and Human Services. Nebraska was given the choice to run this new pool as a state entity or allow the federal government to do so. As this committee is aware, Nebraska currently operates the CHIP pool in response to another federal mandate. It is worth noting that under federal law our current CHIP policyholders are ineligible for coverage under this new heavily subsidized federal pool because they had taken upon themselves the responsibility for obtaining coverage, no matter how expensive. With that in mind, and questionable funding adequacy, Nebraska opted to vest the requirement to create the new pool to the federal government.

The Department understands that the federal government has created the alternative pool, using the federal employee health plan as a platform. While there have been the foreseeable problems in getting this new enterprise up and running, it is up and running.

An early mandate in PPACA to the federal Health and Human Services Secretary was to create a web portal allowing Nebraskans to compare pricing information from all admitted health insurers. The Nebraska Department submitted a considerable amount of information to the federal website, but we were not asked to verify information that federal HHS had received from other parties. Rather, the Federal Government accepted not our submission but the submission of all comers into the web portal. It has come to our attention that information in other states has reflected information on health finance entities that are less than legitimate. In other words, in some states the web portal provides information on entities that are likely fraudulent.

Over the course of the summer, the Department has given a great deal of time and attention to the issue of the medical loss ratio that insurers must maintain on their health insurance plans or pay a penalty. Under PPACA, 85% of premium of large groups must be spent on claims and expenses allowed by federal HHS rulemaking. PPACA gave the NAIC the opportunity make the initial recommendation to the Secretary of HHS, and so this issue has generated a great deal of inquiry at the Department.

For plans taking effect September 23<sup>rd</sup> 2010, six months after passage of PPACA, a series of new federal requirements come into effect for so called non-grandfathered plans, which is most of the insurance market. A so called "grandfathered" plan is simply one that has not made enough changes to its provisions that would PPACA application to it. It is expected that very few plans, less than five to ten percent will be eligible to grandfather under PPACA. The number of these grandfathered plans will sharply decline over time. As regards these September 23<sup>rd</sup> changes, of particular note to insurance consumers, are limits on rescissions, requirements for external review, prohibition on cost-sharing for preventive services, no lifetime limits, restrictions on annual limits, no pre-existing conditions exclusions for minors, requiring dependent coverage for persons under 26. These new conditions are to be reflected in policy contract language, so we will be able to enforce them as a market compliance matter.

Perhaps the biggest challenge Nebraska faces is the question of Exchanges. Effective in 2014, PPACA creates these Exchanges as a place for buyers and sellers of health insurance

products to come together a "Travelocity" sort of web based tool for buying and selling coverage for individuals and small groups. States may opt to operate the Exchange themselves, enter arrangements with nonprofit third party entities, create regional Exchanges, or leave the entire project to the federal government. These Exchanges are required to be self supporting, after a start up period in which they will be funded with federal grants. Once operational, people interested in purchasing individual or small group health insurance plans will be able to access the Exchange online and select from a number of products offered that meet federal standards and complete the purchase at that point. The Exchanges will also be the place for persons to obtain Medicaid coverage and determine if new subsidies are available. Think of it as a web based system that uses income verification to trigger where you are sent for health benefits.

While a fairly straightforward thing to explain, creation of these Exchanges will involve a lot of research. To that end, the State has applied for a grant that will allow the State to determine whether to create an Exchange, and if so on what basis. Should Nebraska receive the grant, NDOI will be working with Nebraska government's Chief Information Officer and the Nebraska Department of Health and Human Services to convene stakeholders, as required under the grant, to formulate a recommendation or recommendations for Governor Heineman on a proposed course of action and, if appropriate, beginning the business operational planning for such an entity. Several other issues regarding governance of the Exchange, the status of policies, if any, outside of the Exchange and the costs of the technology involved in creating the Exchange will also be examined under the grant if Nebraska receives it.

PPACA gives rise to many, many issues. I have focused today on the issues that we have been working on this summer, and the issues that will be confronting the State in the short term. Other issues, such as required changes to the Medicare supplement policies take place further in time and will be great sources for new briefings in the future. But rather than take you further into details, I will wrap up for now and answer any questions that you might have.

**PUBLIC HEARING**

**OCTOBER 7, 2010**

**LR 467 INTERIM STUDY REPORT**

**PATIENT PROTECTION AND  
AFFORDABLE CARE ACT**

**Testifier List**  
**LR 467 Interim Study Hearing**  
**October 7, 2010**  
**9:00- 4:00**

**9:00- 12:00**

AARP -JoAnn Lamphere, DrPH, Director, State Government Relations & Advocacy, Health & Long-term Care

Topics: Impact of PPACA on Medicare beneficiaries and changes that may affect state programs; Exchanges from elder consumer perspective; Integration of Medicaid and health insurance exchanges; PPACA and long-term care- Balancing Incentive Payment and Community First Choice Option

NHA- Bruce Rieker

Topics: PPACA implementation considerations and timelines for: 1) patients and payers, 2) delivery system reform and quality, 3) wellness and workforce, and 4) reimbursement and revenue

UNMC- Steve Pitkin, Assistant Dean, College of Nursing, Kearney Division

Darwin Brown, PA-C, MPH, Clinical Coordinator of the Physician Assistant Program

Jeffrey D. Harrison, MD, Assist Dean Admissions, Program Director, Family Medicine Residency

Topic: Rural Health Workforce

Appleseed – Jennifer Carter

**1:00- 4:00**

Creighton University- Dr. Fry

NABHO- Topher Hansen

Topic: Mental Health Parity under the PPACA

NPA- Joni Cover

Center for Rural Affairs- Melissa Florell, RN

Topic: Exchanges and Rural Health considerations

Friends of Public Health-Kay Oestmann

Topic: Funding Opportunities for Public Health under the PPACA

Nebraska Academy for Family Physicians- Dr. Rob Rauner

Topic: Family Physician workforce needs over the next decade

Nebraskans for Public Health Funding- Korby Gilbertson

NMA- Dr. David Filipi

Topics: 1. A brief overview of the health care reform principles from the NMA's task force; 2. The need and incentives for transparency in medical outcomes; 3. The importance of lowering the demand for health care services by: Creating a healthier population through public health initiatives; Decreasing defensive medicine through malpractice reform; Reducing duplicative testing through electronic data interchanges

Open Testimony

## October 7<sup>th</sup> LR 467 Hearing Bios

**JoAnn Lamphere**, DrPH, AARP, Director, State Government Relations & Advocacy, Health & Long-term Care, leads a team of legislative experts and serves as a main strategy advisor to AARP's fifty-three state offices. Dr. Lamphere provides political and analytic guidance to support enactment of national and state legislative priorities in areas of health care reform; long-term services and supports; effective, quality health care; and prescription drug affordability. Since passage of national health care reform, her priority is to assure the successful implementation of the Affordable Care Act across the states.

Dr. Lamphere rejoined AARP in 2006 after serving six years as a senior consultant with The Lewin Group, where her areas of expertise included public sector financing, state health reform, long-term care policy, and tax credits for health coverage. From 1997 to 2000, she was Senior Policy Advisor for AARP's Public Policy Institute. Her professional experience also includes Senior Associate, Alpha Center, Washington, DC; Research Associate and Lecturer, Department of Health Policy and Management, University of North Carolina at Chapel Hill; Administrative Manager, New England Medical Center, Boston; and Health Policy Analyst and Program Director, New York State Department of Health.

She earned her doctorate in Health Policy and Management from Columbia University and is an Adjunct Associate Professor at the University of Maryland. In addition to being a noted author and frequent lecturer, she is a founding member of the Campaign for Effective Patient Care.

**Dr. Bob Rauner** earned a bachelor's degree in philosophy from Creighton University, a medical degree from the University of Nebraska Medical Center, and a master's degree in public health from the Johns Hopkins School of Public Health. He completed his residency in family medicine at the Lincoln Family Medicine Program. He spent 5 years as a rural family physician in Sidney, Nebraska followed by 7 years on the faculty of the Lincoln Family Medicine Program. He is past president of the Nebraska Academy of Family Physicians and currently serves as the chair of the Nebraska Medical Association's public health and medical home committees. He is employed with Partnership for a Healthy Lincoln and Wide River Technology Extension Center (

**David Filipi**, MD, served as President of the Nebraska Medical Association for 2009-10 and serves as the Director for Quality Advancement of BlueCross BlueShield of Nebraska. Dr. Filipi received his medical degree from the University of Nebraska Medical Center where he then completed a residency in family medicine. He joined Physicians Clinic where he practiced full time until he was named medical director, retiring in 2009. In 1996 he earned a master's of business administration at the University of Omaha. He continues to volunteer as medical director of Hope Medical Outreach Coalition, which coordinates health care to the underserved in the Omaha area. Dr. Filipi also serves on the Douglas County Board of Health and consults with physician groups and payers on quality issues and practice management. He is past president of the Nebraska Academy of Family Physicians and of the Metro Omaha Medical Society.



# State Opportunities as Federal Health Law is Implemented

NE Select Committee on Health Care Reform  
October 7, 2010

JoAnn Lamphere, DrPH  
Director, State Government Relations  
Health & Long-term Care Issues  
AARP

## Presentation Overview

- > Leading the Way in the Midwest
- > An Evolving Landscape
- > Driving Efficiencies & Value through Medicaid Improvements
- > Medicaid Link to a Pro-Consumer Health Exchange
- > Using Medicaid to Transform Health Care
- > Long-term Care Opportunities
- > Federal Grant Opportunities
- > Emerging Policy Challenges
- > Qs & As

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## **Leading the Way in the Midwest**

- > Tradition of civic commitment to social well-being
- > Long-standing state health policy engagement and experimentation, with resulting collective expertise
- > Stable, thoughtful, and respected public health and private sector leadership, with stakeholder involvement
- > Nebraska ahead of the curve on many key health indicators
- > A state grounded in Midwestern values and sensibilities

## **Nebraska Facts**

- > FMAP in Nebraska is 68.76% (2010)
- > LTSS Medicaid Spending – 18% for older people and adults with physical disabilities on HCBS vs. 82% for institutional
- > 12.6% uninsured (2008)
- > Medicaid spending growth 2004-2007: 1.7%
- > Medicaid as Percent of State Budget: 18.7%
- > Medicaid provider payments as percentage of Medicare: 1.01

## An Evolving Landscape -- Favorable Policy Elements

Large Bipartisan Majorities Favor Specific Policy Elements of New Health Law

Favor Reform Policy	Republicans	Democrats	Independents
Tax credits for small businesses	84	91	85
Make it harder for insurers to drop coverage when individual has major health problems	79	85	80
Requiring plans to offer preventive care with no cost-sharing	71	92	78
Rebate for seniors in the Medicare doughnut hole	66	90	74
Children on parents' plan until 26	64	86	71
No coverage denials for children	61	79	68
Temporary high-risk pools	60	88	73
Ban on lifetime spending limits	56	75	63
Rebate for overspending on admin costs/profits	52	78	66

SOURCE: Kaiser Family Foundation, 4/9-14/10

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## Medicaid Expansions

- > Kaiser/Urban Institute Study – 110,820 Nebraskans will receive coverage as a result of expansions
- > Majority of cost will be picked up by feds (\$2.7 Billion); state will have to make much smaller contribution (\$155 Million)
- > Nebraska's actions to implement the law will affect the ultimate reach of the program.

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## **Driving Efficiencies and Value Through Medicaid Improvements**

- > Medicaid expansions for adults by 2014 will reduce uninsured
- > Barriers to receiving prompt necessary medical care will be reduced
- > State administrative systems will be challenged
  - > Simplify eligibility rules & processes to conform to federal law
  - > Simplify enrollment to achieve efficiencies
  - > Design effective outreach
  - > Harmonize Medicaid, CHIP, HIP -- "no wrong door"
- > Assess IT infrastructure within state policy guidelines and Exchange requirements
- > Investments can foster delivery system improvements and individual behavior change

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## **Medicaid Link to a Pro-Consumer Exchange**

- > Consider Medicaid policy development within context of larger health policy objectives for Exchange: benefit design, negotiated prices, consumer service, quality, etc.
- > Must assure seamless transition between Medicaid and Exchange
  - Assess eligibility processes, technical capabilities, IT infrastructure
  - Streamline and harmonize approaches
  - Make specific plans for addressing service risks of outdated systems
- > Overarching leadership across divisions can maximize effective program design and minimize risk and costs

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## Policies to Assure a Pro-Consumer Health Exchange

	Weak Exchange	Strong Exchange
Governance	Consumers & businesses not majority Wasteful spending	Fully transparent Stakeholder & public input Strong relationships with employers Frugal spending
Oversight	Takes prices set by insurers No standards for benefit design, call centers, quality, & costs	Negotiates rates & benefits Sets high & realistic standards that improve value
Usefulness	Exchange is invisible Too many options & few tools for comparison Customer service limited & underfunded Awkward eligibility mechanisms	Robust outreach to consumers/business Manageable number of meaningful choices for consumers Culture of problem solving & quality service Seamless, as personal circumstances change
Integration	Connection across Medicaid, plans, and subsidies is cumbersome/confusing IT system and business processes antiquated	Provides consistency & stability in coverage as individuals' circumstances change Links seamlessly to Medicaid and subsidies IT platform enables communication
Sustainability	Allows outside market to offer products on favorable terms Fails to keep up with market & clinical change	Protects against adverse selection Adjusts to medical breakthroughs of health transactions Cuts waste & raises efficiency
Size	Too small to drive significant value improvements in market or achieve cost savings	Large enough to enable quality improvements & cut costs Large enough to assure risk pool stability & economies of scale

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Note: Chart builds on *Delivering the Promise*, by CALPIRG Education Fund, June 2010

## Using Medicaid to Transform Health Care Delivery

- > Health Homes – States taking up option get 90% FMAP for two years (1/1/2011)
- > Incentives for Healthy Lifestyles
- > Bundled Payments – demonstration to reward quality care
- > Health Care Workforce – training, residencies, physician payment

### Considerations:

- > Keep eyes open for funding opportunities
- > Use leadership positions to foster delivery system improvements



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## Why are Medicaid Home and Community-Based Services (HCBS) Important?

- > It's what people want
  - 89% of those 50+ say they want to stay in their homes and communities as long as possible
- > It's more cost-effective than institutional care
  - Medicaid dollars spent on HCBS can support nearly three adults and individuals with disabilities, on average, for every one person in a nursing home (*AARP Public Policy Institute*)
  - States that invest in HCBS can *slow their rate of growth in Medicaid spending on LTC*. While expansion of HCBS does require an up front investment, a reduction in institutional spending and *long-term cost savings* results (*Kaye, LaPlante, and Harrington, 2009*)

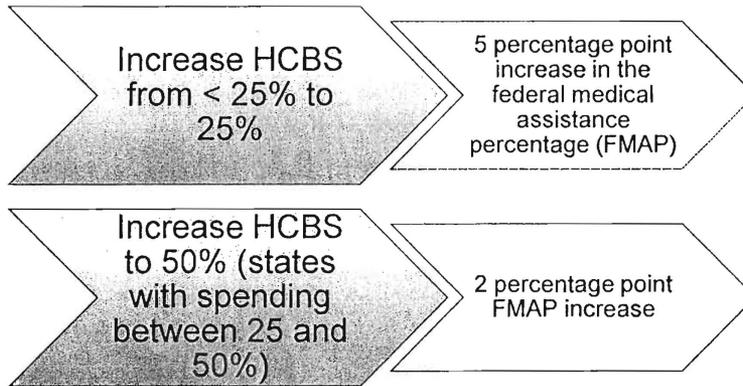
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## HCBS Provisions under ACA

- > The Affordable Care Act offers two Medicaid initiatives that offer financial incentives to states to improve access to HCBS.
  - > Balancing Incentives Payment Program
  - > Community First Choice

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## State Balancing Incentives Payment Program (BIPP)



NE current Medicaid LTC \$\$s to HCBS is 18% vs. 82% for institutional (2007)  
Enhanced FMAP available for non-institutional Long-term Services and Supports  
Expenditures between 10/1/2011 and 9/30/2015

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## BIPP Recommendations

- > Work to lay groundwork for BIPP
  - > Structural changes including conflict free case management and statewide SPE
  - > SPE: Nebraska established ADRC in September 2009 – not statewide

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## Medicaid Community First Choice Option (CFC)

- > New state plan option to provide HCBS attendant services & supports
- > May require institutional level of care (unclear)
- > May provide coverage for certain transition costs
- > Must offer statewide; no limits on ## of participants; assistance with ADLs, IADLs, health-related tasks, etc.
- > Financial eligibility requirements for participation
- > Incentive: 6% enhanced FMAP (no end date)
- > Begins effective Oct. 1, 2011

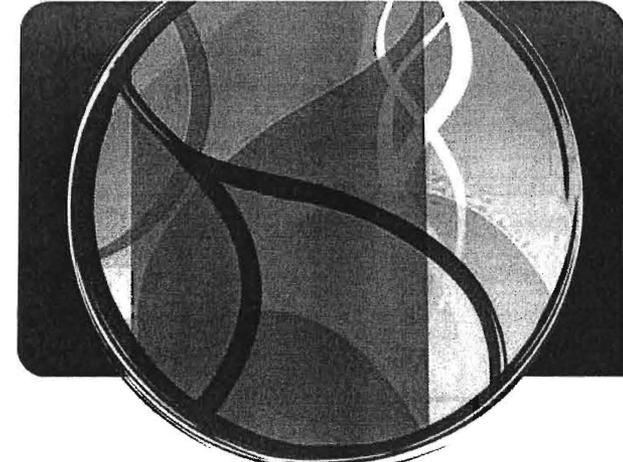
## Medicaid Community First Choice Option (CFC)

- > States must:
  - > Make services available regardless of age, disability, form of services/supports required
  - > Provide services in "most integrated setting..."
  - > Maintenance of effort (only 1 year)
  - > Establish a Development and Implementation Council
  - > Assist federal govt. in evaluating program by collecting and reporting data
  - > Must have quality assurance and appeals system

## **Emerging Policy Challenges to State Implementation**

- > The economy as it affects federal and state policymaking and priorities
- > Public anxiety about level of mandatory and discretionary federal spending
- > State budget shortfalls and program sustainability
- > Health and insurance expertise leaving state service
- > Aging IT infrastructure
- > Caution about the impact of lawsuits and nullification
- > Uncertain leadership and will

## **Qs & As**



## HEALTH CARE *and you*

### The New Health Care Law: Key Improvements to Health Insurance Practices

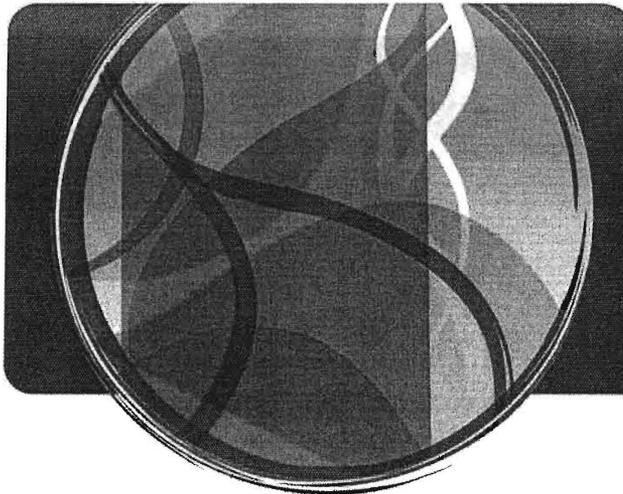
The health care law passed by Congress includes stronger consumer protections against a number of discriminatory insurance practices. No longer can your insurance company drop your health coverage when you become sick. Nor can it place lifetime dollar limits on coverage you may need.

Many of these protections will take effect this year. Others will be phased in over the next several years.

The new law:

- **Stops insurance companies from dropping coverage:** Prohibits health insurance companies from dropping your health coverage if you become sick. (Effective September 2010.)
- **Bans lifetime limits on coverage:** Prohibits health plans from placing limits on how much they will pay for medical benefits over your lifetime. (Effective September 2010.)
- **Bans annual limits on coverage:** Prohibits health plans from placing arbitrary limits on how much they will pay for your medical benefits during each calendar year. (Effective 2014.)
- **Adds free preventive care under new private health insurance plans:** Requires new private health insurance plans to cover more preventive services free of charge. (Effective September 2010.)
- **Extends coverage for young adults:** Allows parents to keep their young adult children covered under their health insurance until they reach age 26. (Effective September 2010.)
- **Ends denial of coverage based on pre-existing conditions:** Stops health plans from denying coverage to children with pre-existing conditions. (Effective September 2010.) In 2014, this protection will be extended to **everyone**.

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.



## HEALTH CARE *and you*

# The New Health Care Law Timeline: When Changes Come About

**Congress enacted a new health care law which brings a number of benefits for all Americans, including people over 50. Some of these changes you will see this year. Others phase in over the next several years.**

### 2010

- Those who reach the Medicare Part D coverage gap or “doughnut hole” receive a \$250 rebate to help pay for prescription drugs.
- Employers providing retiree health insurance get funding to encourage continued coverage to early retirees.
- Temporary insurance, also known as “high risk pools,” begins covering people who have a pre-existing condition and have been without insurance for the last 6 months.
- Young adults up to age 26 can remain on their family’s health insurance plan.
- Individuals with new employer-based or individual insurance plans do not have to pay a deductible and other out of pocket costs for certain preventive care services.
- Insurance companies can’t drop your coverage if you become sick.
- Insurance companies can’t place lifetime limits on health coverage. They are also restricted from using arbitrary annual limits on your health coverage.

## 2011

- Those who reach the Medicare doughnut hole receive a 50 percent discount on brand-name prescription drugs.
- Medicare benefits expand to include free coverage for wellness and preventive care.
- It becomes easier to file complaints about the quality of care in a nursing home. Better access to information on nursing home quality and resident rights is available.
- Workers start participating in a voluntary national insurance program to help pay for future long-term care services and supports.

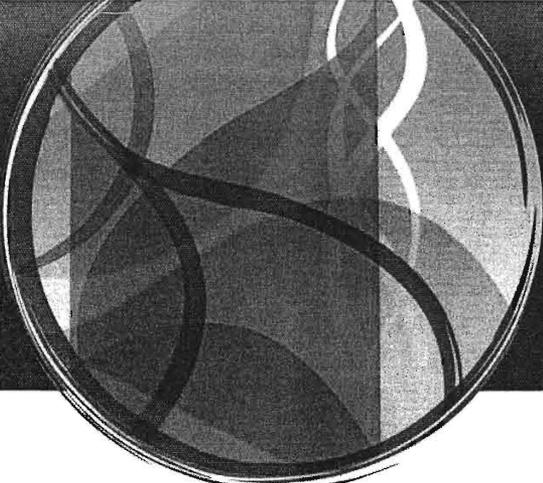
## 2014

- Exchanges begin offering health insurance coverage with comprehensive benefits.
- Premium subsidies are available for those with limited incomes who purchase health insurance through an exchange.
- Children, parents, and childless adults who do not have Medicare and who have a limited income are able to apply for Medicaid.
- Insurance companies are banned from putting annual limits on health coverage.
- Insurance companies can't deny anyone health coverage because of a pre-existing condition.
- Spouses of people on Medicaid who receive care services at home get the same protections for income and other resources as spouses of those on Medicaid who live in nursing homes.

## 2020

- Medicare Part D coverage gap or “doughnut hole” is completely closed.

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.



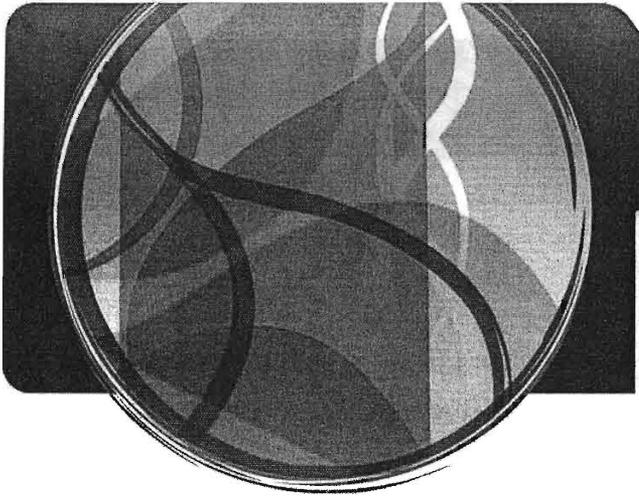
## HEALTH CARE *and you*

# The New Health Care Law: Insurance Coverage for Young Adults

**The new health care law allows you to keep your young adult children on your health insurance policy until they are age 26. In the past, young adults frequently were forced off their parents' policies once they reached 18 or 21, or graduated from college. Now they can stay on your policy or be added to your family policy even if they have left home or are no longer a student.**

- If you currently include your children on your health insurance, you can keep them on your family policy until they reach age 26. This means you can make sure they have health insurance even if they no longer live with you, are married, or are no longer in school. You do not have to claim them as a dependent on your tax return. You will not be able to include their spouse or their children on your policy.
- Although this new provision does not become a requirement until September, more than 65 insurance companies have agreed voluntarily to continue to insure new college graduates and other young adults who would otherwise lose their coverage this year.
- If you do not now include your adult children on your health insurance and you want to, you will be able to add them to your policy by September 23, 2010 if your insurer provides dependent coverage. Your insurance company will be sending you a written notice about this special enrollment opportunity. You will have 30 days to add any adult children younger than age 26. Your insurance company will not be able to charge you more to insure your young adult than they charge for younger children nor will they be able to provide them fewer benefits.
- Insurance companies and employer-based plans are not required to offer dependent coverage. If you are in a group plan that does not provide family coverage, you will not be able to include your young adult children. Also if they have access to employer-based coverage on their own, you will not be able to add them to your plan.

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.



## HEALTH CARE *and you*

# The New Health Care Law: What it Means for People Ages 50-64

**If you are 50-64, the new health care law may benefit you in several ways. It makes it easier to get coverage, helps make coverage more affordable and helps you pay for long term-care. The law also aids small business owners and supports early retirees. By knowing what's in the law you can take advantage of these changes. Some of these changes start this year. Others will phase in over the next several years.**

### **Makes it easier to obtain health insurance:**

- The new law creates health insurance exchanges for those who can't get coverage through their job. Exchanges will be set up in every state to provide "one stop shopping" so it will be easier to compare plans and prices. If you are eligible for insurance through an exchange and do not purchase it, you will be subject to a penalty. Exchanges start offering insurance in 2014.
- All health plans in the exchanges must cover a range of benefits. These include medical, mental health, prescription drugs, and rehabilitative services. You will be able to pick among four levels of coverage to fit your needs.

- If you have been uninsured for six months and have a pre-existing condition, you may be able to get coverage. This coverage – also known as "high risk pools" – should be available in your state in the next few months. It will continue until the exchanges start in 2014.

### **Helps make coverage more affordable:**

- Starting in 2010 for new plans, you will not have to pay some of the costs for preventive care. This includes services such as mammograms, immunizations, and screenings for cancer and diabetes.
- The Medicaid program will cover more people. In 2014 Medicaid will expand to children, parents, and childless adults who do not have Medicare and who have a limited income. (The income limit as of 2010 is about \$14,400 for a single person and \$20,000 for a couple.).
- Starting 2014, you may be able to get tax credits to help pay your premiums for insurance purchased through an exchange. You will qualify if you earn less than \$58,280 for a couple or \$43,320 for an individual.

- Starting in 2010, some small businesses can get tax credits to help buy health insurance. This applies to businesses with fewer than 25 employees whose average wage is below \$50,000.

### **Expands insurance coverage for children and young adults:**

- Beginning this year, your adult son or daughter may be able to be included on your insurance policy until he or she turns 26.
- By July 2010, insurers must cover children under age 19 who have pre-existing conditions.

### **Helps protect health benefits for early retirees:**

- If you are between 55 and 64 and have retiree health coverage through your work, you have added protection. Starting in 2010, new federal funds will encourage your employer to continue offering health benefits until you become eligible for Medicare.

### **Makes key improvements in insurance practices:**

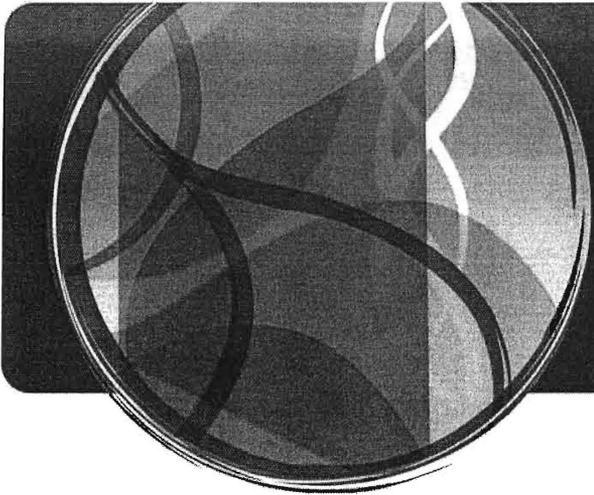
- As of 2010, insurance companies can't drop your health coverage if you become sick. Your health insurance is guaranteed, as long as you pay your premiums.
- Insurance companies can no longer place lifetime or restrictive annual limits on your health coverage. This change will ensure that your benefits won't run out when you need them the most. The ban on lifetime limits begins in 2010, while the ban on annual limits begins in 2014.

- Starting in 2014, you cannot be denied health insurance because of a pre-existing condition.

### **Helps pay for long-term care:**

- A new voluntary long-term care insurance program will be available to you if you are working. This program will help you pay for some of your future long-term care services. It will give you a cash benefit if you have a qualifying disability and have paid into the program for at least five years. If your employer participates in the program, you will automatically be enrolled unless you choose to opt out. You will also be able to buy this insurance if your employer doesn't participate or if you are self-employed. This program could start as early as 2011.

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.



## HEALTH CARE *and you*

# The New Health Care Law: What it Means for People 65+

If you are age 65 or over, or under 65 but on Medicare, the new health care law may benefit you in several ways. The new law lowers prescription drug costs, strengthens Medicare, and improves long-term care services. By knowing what's in the law you can take advantage of these changes. Some of these benefits start this year. Others will phase in over the next several years.

### Lowers out-of-pocket prescription drug costs:

- If you have Medicare Part D prescription drug coverage and reach the coverage gap (“doughnut hole”) this year, you will automatically receive a \$250 rebate to help pay drug costs. You will not need to request or apply for the payment.
- Next year, if you reach the doughnut hole, you will receive discounts on your prescription drugs. You'll get a 50% discount on brand name drugs and a 7% discount on generics while you are in the coverage gap.
- The Part D coverage gap will gradually narrow until it disappears in 2020.

### Strengthens Medicare:

- The law expands coverage for preventive care. If you have Medicare, you will qualify for a new annual wellness visit, mammograms, and other screenings for cancer and diabetes—at no charge. These new benefits start in 2011.
- Medicare Advantage plans that give better quality care will receive additional bonus payments. Plans are required to use some of this bonus money to offer you added health benefits.
- New rules will stop Medicare Advantage plans from charging people more than Original Medicare for certain services. These services include chemotherapy administration, renal dialysis, and skilled nursing care. These changes start in 2011.
- Beginning in 2014, Medicare Advantage plans must limit how much they spend each year on administrative costs. This means plans will have to spend more money on benefits and services that improve the quality of care.

## **Reduces waste, fraud and abuse:**

- The law cracks down on waste, fraud and abuse in Medicare and the health care system as a whole. It cuts inefficient care and reduces overpayments to insurance companies.
- To guard against fraud, the law also protects the privacy of your personal information.

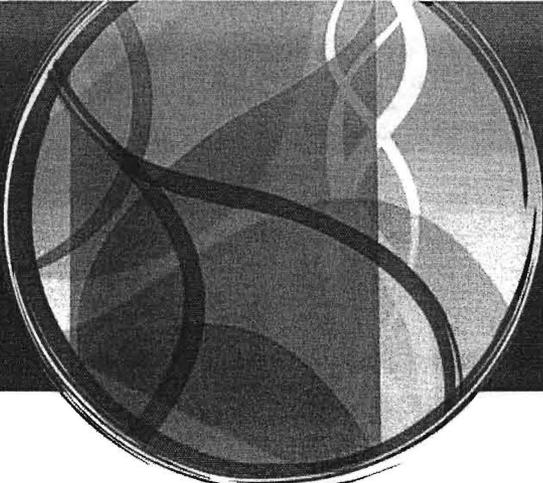
## **Improves long-term care services and information:**

- Starting in 2011, Consumers will have more information about nursing home inspections, complaints against facilities, and consumer rights. This information will help you make decisions when selecting a nursing home.
- Your state may receive more funds to expand home and community-based services. For example, under the Community First Choice Option, participating states would get more federal dollars to provide certain home and community-based services to certain people with disabilities who live at home but need an institutional level of care. These changes begin in 2011.
- A new voluntary long-term care insurance program – called CLASS – will be available to you if you are working. This program will help you pay for some of your future long-term care services. It will give you a cash benefit if you have a qualifying disability and have paid into the program for at least five years. If your employer participates in the program, you will automatically be enrolled unless you choose to opt out. You will also be able to buy this

insurance if your employer doesn't participate or if you are self-employed. This program is scheduled to start as early as 2011.

- Starting in 2014, the law extends financial protections to more spouses of people on Medicaid. If you're married to someone on Medicaid who gets long-term care services at home, you will have the same protections for your income and other resources as you would if your spouse lived in a nursing home.

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.



## HEALTH CARE *and you*

# The New Health Care Law: What it Means for People with Moderate or Low Incomes

**The new health care law helps people with moderate or low incomes by making many more people eligible for Medicaid and by making private insurance more available and affordable.**

### **Expands Medicaid**

Medicaid is the joint state and federal government program that pays the health care costs for people with very limited incomes. Before the new health care law, only certain very specific groups of people who had low incomes and very few resources were eligible for Medicaid. Childless adults in most states, including millions of uninsured 50-64 year old Americans, were not eligible no matter how low their incomes.

- By 2014 many more people will be eligible for Medicaid. If you are under the age of 65, not eligible for Medicare and earn less than about \$15,000, you may be eligible to have Medicaid pay most of your health care costs. Couples earning less than about \$20,000 will also be eligible. This new group includes children, pregnant women, parents, and adults without dependent children. States can start offering Medicaid coverage to this group beginning this year, but most

states are likely to take until 2014 to fully implement this change.

- You will need to show how much income you receive, but you will not have to prove how much you have in resources. States will also have to make it easier for you to apply for Medicaid and cut back on how much paper work you will need to prove that you are eligible.

### **Helps People with Moderate Incomes**

The new health care law also provides help for people with moderate incomes. Starting in 2014, purchasing pools – or exchanges – will be set up in states to offer insurance coverage for those with moderate incomes who are self employed, work for businesses that don't offer health insurance to their employees, and others who have not been able to buy insurance.

Exchanges create one-stop-shopping so it will be easier for you to compare private plans and prices for health insurance. Also buying your insurance through an exchange instead of on your own will give you the advantage of group rates, which tend to be much lower.

- Once an exchange is set up in your state, all health insurance plans in the exchanges must offer a set of basic comprehensive benefits. Those benefits include medical, mental health, prescription drugs, and rehabilitation services. Standardizing benefit levels will make it easier for you to compare benefits and costs. Plans cannot refuse to sell you a policy because of your health status and must comply with many new consumer protections.
- People eligible to shop in the exchanges will be able to pick among several levels of coverage. This will allow you to find a plan that fits your needs.
- Depending on your income you may receive subsidies or tax credits to reduce the cost of buying insurance through an exchange. This help will be based on a sliding scale, if your income is below a certain income level. For example, individuals with incomes between about \$14,400 and \$43,300 and families of four with incomes between about \$29,300 and \$88,200 would be eligible. The exact income ranges and amount of the help will be announced as the exchange details are worked out.
- What policies will cost is not yet known, but there will be annual limits on how much you have to spend on deductibles and co-payments for insurance purchased through an exchange. For example, a family of four

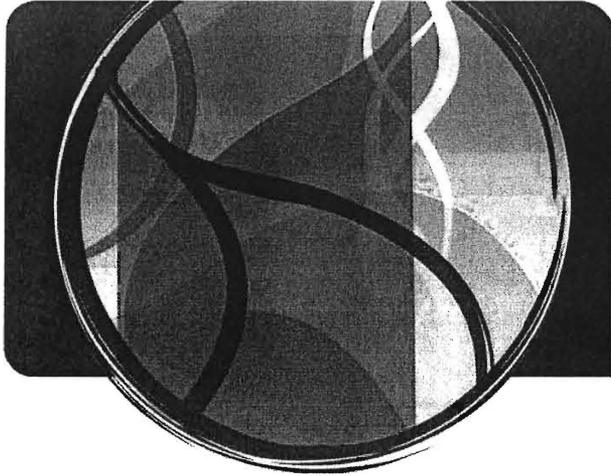
now earning \$60,000 could spend no more than \$11,900 out-of-pocket (excluding premiums) for health care in a year.

## Help for This Year

People who have been uninsured for the past six months and have a pre-existing condition will be able to get temporary insurance starting in mid-summer through high risk pools. These high-risk pools will be set up either by your state or by the federal government. This coverage will be available until the exchanges start in 2014. Then, all insurance plans will be required to cover pre-existing conditions.

- Watch for announcements from your state government about how to apply for this insurance coverage.

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.



## HEALTH CARE *and you*

### **The New Health Care Law: Temporary Coverage for Uninsured People with Pre-existing Conditions**

**An important provision in the new health care law provides five billion dollars in funding to offer temporary health insurance to many who cannot get health insurance through other means.**

This federal high-risk pool, officially known as the Pre-existing Condition Insurance Plan (PCIP), is a first step to help people with pre-existing health conditions get the insurance coverage they need. This temporary program will operate until January 1, 2014, when individuals will be able to buy health insurance through state-based exchanges.

States can operate their own high-risk pool or have the federal government carry out the program. Twenty-one states have asked the federal government to run their high-risk pools. The remaining states have chosen to operate their own plans.

#### **Who is eligible?**

To be eligible for the federal Pre-existing Condition Insurance Plan or the high-risk pool in your state, you must have been uninsured for six months, have a pre-existing condition, and be a United States citizen or national, or be lawfully present in the United States. Individuals will be accepted on a first-come, first-served basis.

#### **What benefits are covered?**

The federal Pre-existing Condition Insurance Plan and state high-risk pools cover a range of benefits, including primary and specialty care, hospital care and prescription drugs. All of these health plans are required to cover pre-existing medical conditions.

## **What is the cost?**

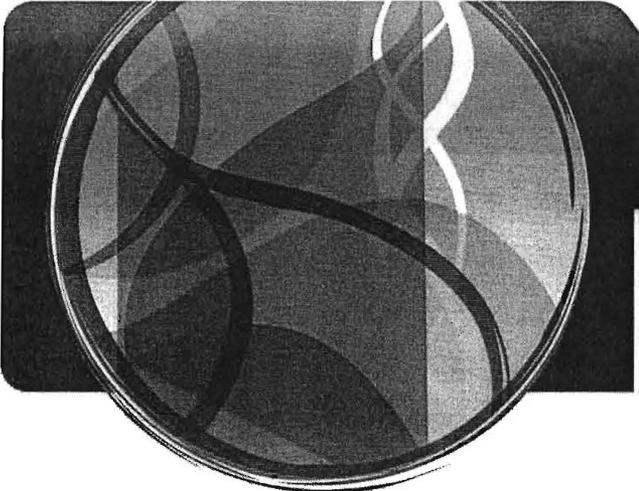
Premiums are determined by a number of factors, such as your age and the state where you live. Yearly out-of-pocket costs will be limited to \$5,950 for individuals, not including the premiums you have to pay.

## **When can you apply for this type of health insurance?**

The federal Pre-existing Condition Insurance Plan began accepting applications on July 1, 2010. States operating their own high-risk pools also aim to begin coverage soon, but some may start later. The high-risk pool coverage will stop on January 1, 2014 when individuals will be able to buy insurance through state-based exchanges.

You can find more information on the federal Pre-existing Condition Insurance Plan or the high-risk pool in your state, and get an application for this temporary insurance coverage at [www.healthcare.gov](http://www.healthcare.gov).

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.



## HEALTH CARE *and you*

# The New Health Care Law: Improvements to Preventive and Wellness Benefits

**The new health care law includes new prevention and wellness provisions that could help keep you healthy, catch health problems early, and save individuals and families hundreds of dollars a year. Under the new law insurers must offer proven preventive services – like immunizations, cancer screenings and checkups – to you at no additional out-of-pocket charge.**

### **For People with Insurance:**

The health care law requires all new health plans to cover important preventive and wellness benefits with no deductibles and co-payments. Examples include services such as immunizations and screenings for cancer or diabetes. This requirement applies to new individual and group insurance plans and is effective this year.

### **For People with Medicare:**

Starting in 2011, Medicare will pay for an annual wellness visit and a personalized prevention plan.

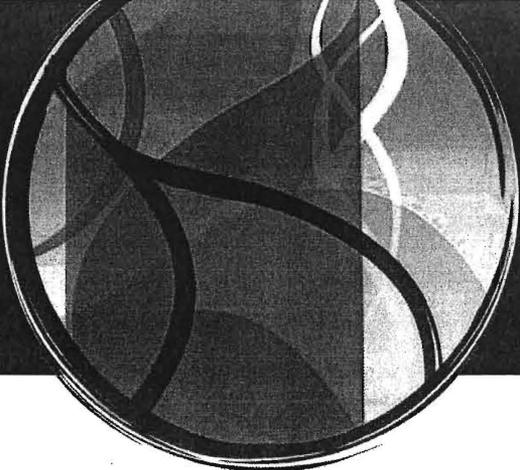
The personalized prevention plan may include the following:

- An assessment of your health risks
- Your updated medical history
- A list of your current health care providers
- A list of your current prescription medications
- Your height, weight, and blood pressure measurements
- A screening schedule for appropriate preventive services for you to follow over the next five to ten years
- A list of your health risk factors along with treatment options

Medicare will also continue to cover a Welcome to Medicare physical exam for people who are new to the Medicare program. The Welcome to Medicare exam is free, with no deductibles and co-payments. Those who are new to Medicare cannot get both the Welcome to Medicare exam and the annual wellness visit during their first 12 months of enrollment. The Welcome to Medicare exam is available during the first 12 months of enrollment into the Medicare program. The annual wellness visit takes place each year after that.

For those with a Medicare Advantage plan, most of these plans offer Medicare-covered preventive services with no deductibles and co-payments. The new health care law does not require Medicare Advantage plans to offer preventive services free of charge. If you have a Medicare Advantage plan you should check with your plan to confirm what the deductibles and co-payments are for preventive services, if any.

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.



## HEALTH CARE *and you*

### The New Health Care Law:

### What It Means for Employees of Small Businesses

**If you work for a small business that does not offer employee health insurance, the new health care law could help you get the coverage you need for yourself and your family.**

#### **Greater access to insurance**

Starting in 2014, individuals will be able to buy health insurance through state-based purchasing pools, called exchanges. These exchanges will make it easier to compare plans and prices to find the health care coverage that fits your needs.

- All health insurance plans in the exchanges must offer a standard set of benefits. These include medical, mental health, prescription drug, and rehabilitation services. You will be able to choose from several levels of coverage.
- Health insurance plans cannot refuse to sell you a policy because of your current health condition and must

comply with many new consumer protections.

- You may be able to get help paying for the insurance you get through an exchange. This help will be given to people on a sliding scale, if your income is below a certain level. Currently, for example, that would include those individuals with incomes of about \$14,400 to \$43,300, or \$29,300 to \$88,200 for a family of four. The exact income ranges and amount of the help will be announced as the exchange details become available in each state.

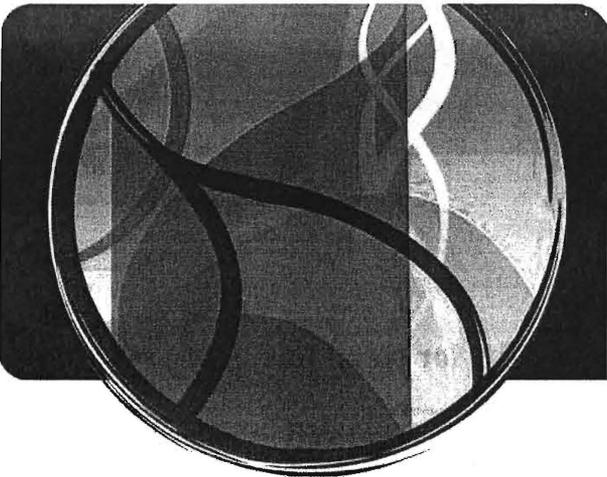
If you are eligible for insurance through an exchange and do not buy it, you will be subject to a penalty. For an individual the penalty starts at \$95, or up to 1% of your income, whichever is greater. It increases to \$695 or 2.5% of income by 2016. The maximum penalty for a family that chooses

to not have health insurance is \$2,085. Some people will be exempt from the insurance requirement – and will not have to pay a penalty – because of financial hardship or other reasons. The penalties start in 2014 and will be enforced when you file your annual income tax return.

### **New employee benefit option**

Starting in 2011, small businesses with up to 100 employees can offer “simple cafeteria” plans. These plans will allow you to save part of your salary in an account that you can use later to pay for medical expenses. This will save you money because you will not have to pay taxes on the money you contribute to this account. Check with your employer to see if this benefit will be available to you.

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.



## HEALTH CARE *and you*

# The New Health Care Law: What It Means for Small Business Owners

**If you're a small business owner and do not offer health insurance to your employees, you will have more choices under the new health care law. Some small businesses may also qualify for tax credits to offset part of the cost of insurance.**

### **More insurance options for small businesses**

Starting in 2014, businesses with up to 100 workers may be able to buy health insurance for their employees through state-based purchasing pools, called exchanges.

- The exchanges will offer a range of health plans. Plans available through the exchanges must include standard benefits including medical, mental health, prescription drug, and rehabilitation services.
- Some states will offer insurance plans tailored to meet the needs of small businesses. These exchange plans will

be called the Small Business Health Options Program (SHOP).

If you have a business with fewer than 50 employees, you will not face any penalties if you do not offer health insurance. Starting in 2014, businesses with more than 50 employees may have to pay an annual penalty if they do not offer health insurance.

### **Small business tax credits to help pay for health insurance**

If you operate a small business, you may be able to get tax credits to offset part of the cost of offering health insurance to your employees. An estimated 2.8 to 4 million small businesses will be eligible for the credits.

To be eligible for the tax credit, your business must have 25 or fewer employees with average annual wages under \$50,000. Your business must also pay for at least 50%

of the cost of health care coverage for your employees.

The tax credits are retroactive to January 1, 2010. The amount of the tax credit depends on how many employees you have and their average wage.

- The full credit is available to businesses with 10 or fewer employees and average annual wages up to \$25,000. The full credit will help pay for 35% of your premium expenses. In 2014, the value of the credit will increase to 50% of premiums.
- Tax credits are also available to firms with 10-25 employees and average annual wages between \$25,000 and \$50,000. The amount of the credit will be based on the number of employees and their wages.
- Small nonprofit organizations are also eligible for the tax credit, but the amount of the credit is limited to 25% of health insurance premiums. The credit will increase to 35% of premiums in 2014.

To learn more about guidelines for the small business tax credit, visit [www.irs.gov](http://www.irs.gov). You can find a Healthcare Tax Credit Calculator at [www.SmallBusinessMajority.org](http://www.SmallBusinessMajority.org).

## **Other benefits for small business**

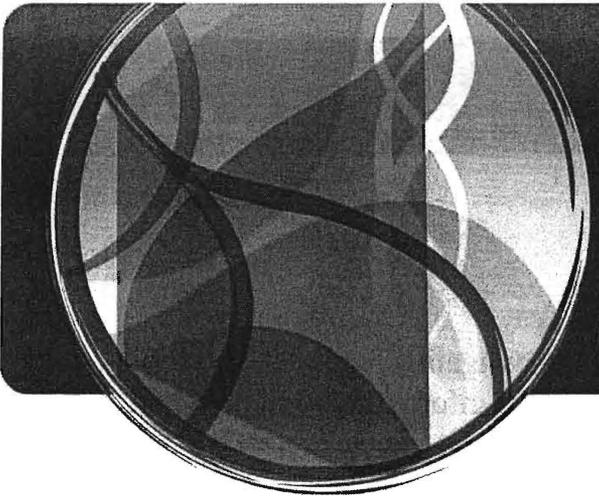
Starting in 2011, small businesses with up to 100 employees can offer “simple cafeteria” plans. These plans will allow employees to save part of their paycheck in an account that they can use to pay for medical expenses. This will save your employees money because they do not have to pay taxes on the money they contribute to this account.

The new health care law also creates grants to help small businesses provide workplace wellness programs. Starting in 2011, a total of \$200 million in grants will be available over a five-year period.

To apply for a grant, a business must have fewer than 100 employees. Only new wellness programs—those started after March 23, 2010, the date the health care law was enacted—are eligible.

The grants will be administered by the U.S. Department of Health and Human Services (HHS) and must meet HHS criteria. Under the grant guidelines, a wellness program should offer a range of activities to help employees stay healthy, such as preventive screenings, promotion of healthy lifestyles, and help in changing unhealthy behaviors.

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.



## HEALTH CARE *and you*

# The New Health Care Law: What it Means for Family Caregivers

**If you are a family caregiver, the new health care law may benefit you and the person you care for in several ways. The law makes it easier to get health coverage, helps make it more affordable, improves insurance practices, and expands access to long-term care services and information.**

Some of these changes start this year. Others will phase in over the next several years. By knowing what's in the law many of these changes can help you with your own care and as a family caregiver for your relative or friend.

### **Makes it easier to get health insurance**

- If you or the person you care for have been uninsured for six months and have a pre-existing condition, you may be able to get temporary health insurance coverage. This coverage – called the Pre-existing Condition Insurance Plan (PCIP) – is a first step to help people with pre-existing health conditions get the coverage they need. Applications for this temporary insurance program started on July 1, 2010 and will continue until January 1, 2014. Beginning in 2014, health insurance will then be available through a new health insurance exchange in your state. You'll find more information about how to apply for PCIP at [www.healthcare.gov](http://www.healthcare.gov).

- The new law creates health insurance exchanges for people who don't have coverage through their job. Exchanges will provide "one stop shopping" so it will be easier for you to compare plans and prices for yourself and the person you care for. Anyone who is eligible for insurance through an exchange but does not purchase it will be subject to a penalty. Health insurance exchanges will start offering insurance in 2014.
- All plans offered through the health insurance exchanges must include medical and mental health care benefits, prescription drugs, and rehabilitation services. You will be able to pick among four levels of coverage to fit your needs or the needs of the person you care for.

### **Helps make health coverage more affordable**

- Starting in 2010, if you have a new health insurance plan you will not have to pay some of the costs for preventive care. This may include services such as mammograms, immunizations, and screenings for diabetes and many cancers.

- The Medicaid program will help more people have health insurance. In 2014 Medicaid will expand to children, parents, and adults without children who do not have Medicare and who have a limited income. Currently, to qualify for Medicaid you must have an income under about \$14,400 if you are single or under \$20,000 for a couple.
- Starting 2014, you may be able to get tax credits to help pay for health insurance purchased through a health insurance exchange. You will qualify if you earn less than \$58,280 for a couple or \$43,320 as an individual.

## **Improves insurance practices**

- As of 2010, insurance companies can't drop your health coverage if you become sick. Your health insurance is guaranteed as long as you pay your premiums.
- Insurance companies can no longer place lifetime or restrictive annual limits on your health coverage. This change will ensure that your benefits won't run out when you need them the most. The ban on lifetime limits begins in 2010, while the ban on annual limits begins in 2014.
- Starting in 2014, you or the person you care for cannot be denied health insurance because of a pre-existing condition.

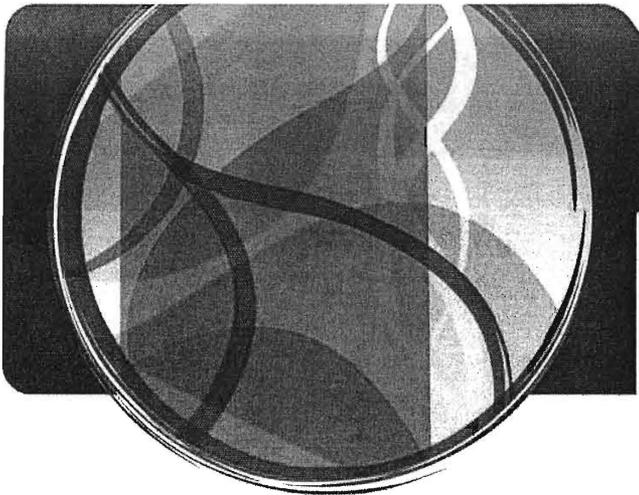
## **Expands access to long-term care services and information**

- Starting in 2011, you can get more information about nursing home inspections,

complaints against facilities, and resident rights. This information will help you make decisions if you need to select a nursing home for the person you care for.

- States can receive more money to expand home and community-based services. For example, under the Community First Choice Option, states choosing to participate will get more federal dollars to provide certain home- and community-based services to people with disabilities who live at home but need long-term services and supports. These changes also begin in 2011.
- If you are working, you can get long-term care insurance. This new voluntary insurance will provide a cash benefit to help you pay for some of your future long-term services and supports. You will be able to get the cash benefit after you have paid the premiums for at least five years, have worked at least three of those initial five years and have met other requirements. If your employer participates in the program, you will be enrolled automatically unless you choose not to participate. You will also be able to buy this insurance if your employer doesn't participate, if you have more than one employer or if you are self-employed. This program should start in 2012 or 2013.

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.



## HEALTH CARE *and you*

# The New Health Care Law: What it Means for Nursing Home Care

**The new health care law gives consumers more information about nursing homes so they can make better choices when selecting a nursing home, or monitoring the care of loved ones who reside in nursing homes. Nursing home residents will also have more protections from abuse.**

Provides more information about nursing home care:

- You will have easier access to more information on nursing homes to help you select a nursing home or monitor the care of a friend or loved one in a nursing home.
- You will be able to get information about many things such as who owns the nursing home, how much the nursing home spends on resident care compared to administrative costs, the hours of nursing care residents receive, staff turnover rates, and the number of complaints and violations.

- Your state must have a comprehensive nursing home website where you can find information about local nursing homes, including inspection and complaint reports. Information like this will help you and your family evaluate your care options.
- You will find more useful information on Medicare's Nursing Home Compare website, [www.medicare.gov/NHcompare](http://www.medicare.gov/NHcompare). This online tool has detailed information to help you find a nursing home that best fits your needs. In addition to what you currently find on that site, you will find links to state nursing home websites and inspection information, a resident rights page, staffing information, and a standardized complaint form you can use.

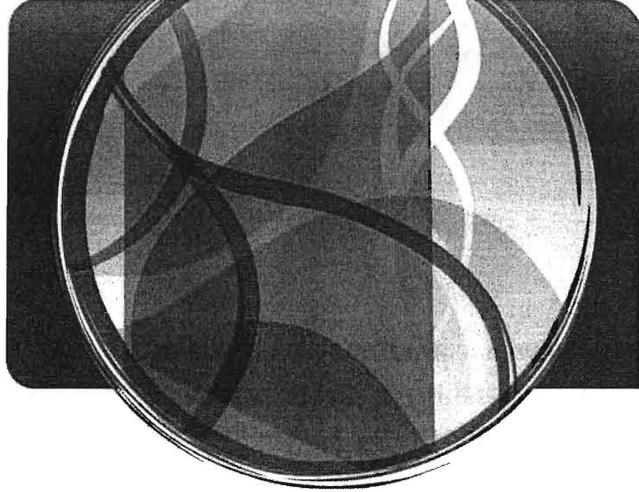
Increases consumer protections:

- It will be easier for you to file complaints about the quality of care in a nursing

home. Your state will be required to have a process in place to resolve complaints about nursing homes. The process must ensure that you are not retaliated against if you file a complaint. You must be notified that your complaint has been received and how it has been resolved.

- Nursing homes in your state will have to meet new requirements if the facility will be closed. Residents and their family must be told of the closure far enough in advance so they will have time to make other plans for relocation. Your state also has to ensure that all residents have been successfully relocated prior to the closure.
- Your state can participate in a new national grant program to expand criminal background checks to more long-term care employees. Currently, most states require some form of background checks on certified nursing assistants who work in nursing homes. The new grant opportunity will provide funding for states to do background checks of additional types of long-term care employees who come in direct contact with patients and residents. If your state participates, it will receive funding to conduct background checks of employees such as health aides who come into your home, assisted living workers, and more nursing home staff.

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for more information.



## HEALTH CARE *and you*

# The New Health Care Law: What it Means for Women

There are many ways which the new health care law benefits women and their families. It provides better access to affordable coverage, ends insurance practices that discriminate because of gender, expands coverage for children, and helps pay for long-term care. By knowing what's in the law you can take advantage of these changes. Some of these start this year. Others will phase in over the next several years.

### **Provides greater access to affordable health coverage:**

- The new law creates health insurance exchanges for those who can't get coverage through their job. Exchanges will be set up in every state to provide "one stop shopping" so it will be easier to compare plans and prices. If you are eligible for insurance through an exchange and do not purchase it, you will be subject to a penalty. Exchanges start offering insurance in 2014.
- Insurance plans sold in the exchanges must cover a range of benefits, including maternity care, prescription drugs and mental health care. You will be able to pick among four levels of coverage to fit your needs.

- If you have been uninsured for six months and have a pre-existing condition, you may be able to get coverage this year. This coverage – also known as "high risk pools" – should be available in your state in the next few months. It will continue until the exchanges start in 2014.

### **Ends insurance practices that discriminate because of gender:**

- As of 2010, insurance companies can't drop your health coverage if you become sick. Your health insurance is guaranteed, as long as you pay your premiums.
- Beginning in 2014, the law ends the common practice of "gender rating." In other words, an insurer will no longer be able to charge women more than men for the same coverage. This applies to those with individual coverage and to small businesses with up to 100 employees.
- Starting in 2014, insurance companies will no longer be able to deny you coverage because of a pre-existing condition such as breast or cervical cancer, pregnancy, or C-section.

## **Ensures that women receive the benefits they need to stay healthy:**

- Starting in 2010 for new plans, you will not have to pay some of the costs for preventive care. This includes services such as mammograms, immunizations, and screenings for cancer and diabetes.
- Also starting in 2010, health plans can no longer require pre-authorization or referral for OB-GYN care.

## **Improves access to providers that specialize in women's health:**

- The new law provides better access to doctors and nurse practitioners who provide primary care services. This will help improve care for women with chronic health conditions who often require ongoing health care. These provisions start in 2011 and will phase in over time.

## **Expands insurance coverage for children and young adults:**

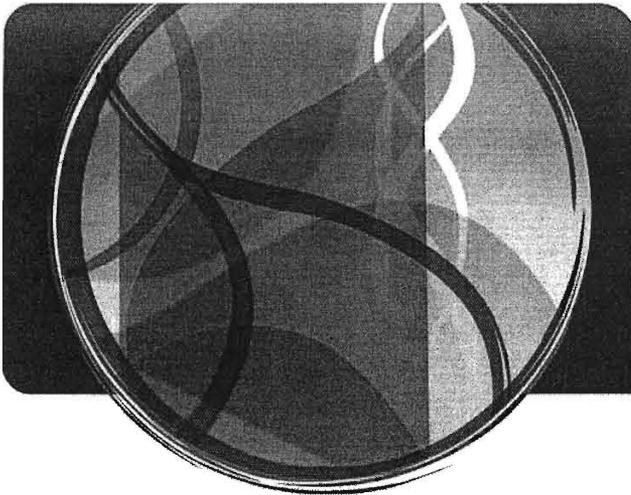
- Beginning in 2010, your adult son or daughter may be able to be included on your insurance policy until he or she turns 26.
- By July 2010, insurers must cover children under age 19 who have pre-existing conditions.

## **Helps pay for long-term supports and services:**

- A new voluntary long-term care insurance program will be available to you if you are working. This program will help you pay for some of your future long-term care services. It

will give you a cash benefit if you have a qualifying disability and have paid into the program for at least five years. If your employer participates in the program, you will automatically be enrolled unless you choose to opt out. You will also be able to buy the insurance if your employer doesn't participate or if you are self-employed. This program could start as early as 2011.

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.



## HEALTH CARE *and you*

# The New Health Care Law: Helping You Pay for Long-Term Care

**Under the new health care law, you will be able to participate in a voluntary national insurance program that will provide cash benefits to you if you have a qualifying disability that limits your day-to-day living. You can use this insurance to help pay for non-medical services and supports such as home modification, assistive technology, transportation, and personal care. You can also use it to pay part of the cost of assisted living or nursing home care.**

### **How the CLASS Independence Benefit Plan Works**

If you are age 18 or older, employed, and your employer participates in the program, you will be enrolled in the CLASS Independence Benefit Plan automatically unless you or your employer choose not to participate, or “opt out.” The program begins as soon as January 2011, with the premiums paid through payroll deductions. You will be able to purchase this insurance even if your employer doesn’t participate in the program, or if you are self-employed.

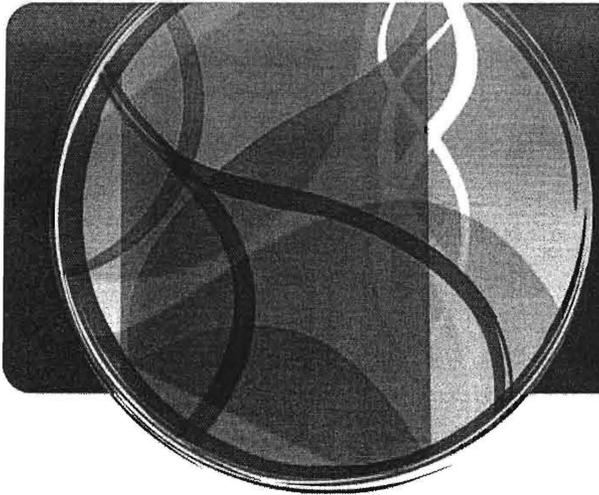
Once you have paid the premiums for five years and have worked at least three of those years,

you will be eligible for program benefits. Cash benefits will be made if you have a qualified disability expected to last more than 90 days and your health care provider certifies this. These payments will continue as long as you remain eligible, which could be for your lifetime.

Over the next several months, federal officials will provide additional details about the program. These include premium costs and the amount of cash benefits. AARP is closely monitoring how health insurance reform is implemented to protect our members.

This program increases your options to live more independently if you have or develop a qualifying disability and meet the other eligibility requirements. You can use the cash benefit, along with other public programs and private long-term care insurance, to help protect your financial security.

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.



## HEALTH CARE *and you*

### The New Health Care Law: Medicare Prescription Drug Benefit & Closing the Doughnut Hole

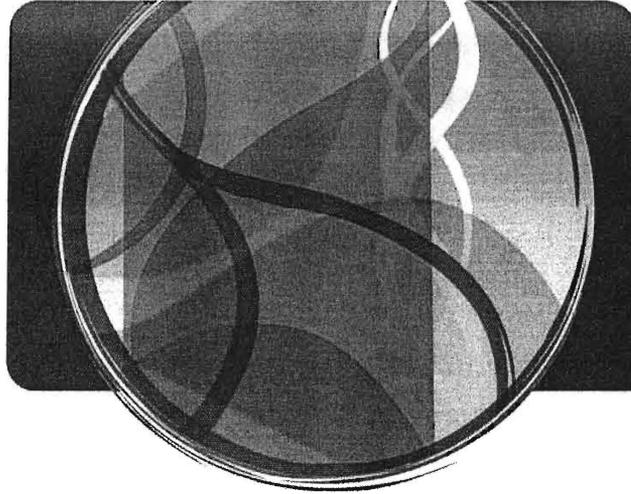
**Under the new health care law, people enrolled in Medicare Part D this year who fall into the coverage gap, or “doughnut hole,” will get an extra \$250 to help pay for their drug costs. This is the first step toward closing the doughnut hole, which will be eliminated in 2020.**

Medicare will continue to offer prescription drug plans through Part D to help reduce your out-of-pocket costs for medications. You will still pay premiums each month in exchange for this benefit but, once the new law is fully implemented, there will be no coverage gap.

Under prior law, once your total drug costs (what you and your plan have paid) for the year exceeded a certain amount, you fell into the doughnut hole. During this gap in coverage, you would pay the full price for your drugs until your total costs were high enough that you qualify for catastrophic coverage. After that point, you would be responsible for only 5 percent of your prescription drug costs for the rest of the year.

Under the new law, if you reach the doughnut hole in 2010, you will get a one-time rebate of \$250 to reduce your out-of-pocket costs. Also, starting in 2011, you will get a 50 percent discount on brand-name prescription drugs and a 7 percent discount on generic prescription drugs while you are in the coverage gap. The gap will gradually narrow until it disappears in 2020. As before, after a certain amount of drug spending (by you and the plan), you will qualify for catastrophic coverage and only be responsible for 5 percent of your prescription drug costs for the rest of the year.

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.



## HEALTH CARE *and you*

### The New Health Care Law:

## The \$250 Doughnut Hole Rebate

**People with Medicare Part D who reach the gap in their prescription drug coverage this year will automatically receive a \$250 rebate check. This one-time payment in 2010 will help three million people to pay for the prescription drugs they need.**

The Secretary of Health and Human Services has announced that the first group of rebate checks will be mailed starting June 10, 2010. Checks will continue to be mailed about every six weeks as more people reach the coverage gap, also called the “doughnut hole.”

These rebate checks will go to people on Medicare Part D once they have spent \$2830 (“the initial coverage limit”) in total drug costs for the year. Total drug costs include the full amount you and your plan spend on your drugs, including your deductible, co-payments, and coinsurance, but not the amount you pay in premiums.

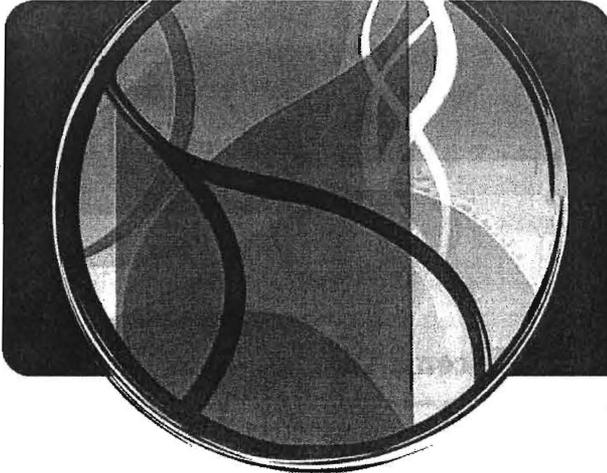
### Some Things You Need to Know

- You do not need to do anything to get your check. The check will come to you automatically after you reach the Medicare Part D coverage gap.
- You do not have to do anything to prove that you and your plan have paid more than \$2830 in total drug costs. Your Medicare Part D plan tracks these costs for you.
- Because the checks are sent automatically, avoid anyone who promises to “help” you get your check. Scammers may say you can get your check more quickly if you pay them a fee. Immediately report this scam or any similar fraud to the police or to your Attorney General. You can find the Attorney General’s phone

number in the blue pages of the telephone book or online at [www.naag.org/current-attorneys-general.php](http://www.naag.org/current-attorneys-general.php).

- A paper check will be mailed to the address Social Security uses to reach you. If you need to change your address, please call Social Security at 1-800-772-1213. If you prefer, a change of address may also be reported by calling or visiting your location Social Security office. You can find contact information at [www.ssa.gov/locator](http://www.ssa.gov/locator).
- You may be able to avoid the gap in your coverage and save money on your drugs. Use AARP's Doughnut Hole Calculator at [www.aarp.org/doughnuthole](http://www.aarp.org/doughnuthole). The calculator will show you if you will fall into the doughnut hole this year. It also identifies less costly drugs available in your Part D plan. This may help you save money by delaying when you reach the doughnut hole or by keeping you out of the coverage gap altogether.
- Starting in 2011, if you reach the coverage gap you will get a 50 percent discount on brand-name drugs and a 7 percent discount on generic prescription drugs, but the full cost of the drugs will be applied toward getting you through the doughnut hole. By 2020, the gap will be eliminated entirely. That means that people who now pay 100 percent of their drug costs in the doughnut hole instead will pay a copayment or coinsurance of no more than 25 percent. Rather than the doughnut hole, you should pay a fairly consistent co-payment or co-insurance all the way up to the catastrophic limit. If your drug needs go beyond the catastrophic limit, your portion will be limited to a 5 percent coinsurance for your drug costs.

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.



## HEALTH CARE *and you*

# The New Health Care Law: Tax Implications for Individuals

**The new health care law makes several changes to taxes that mostly affect families with incomes over \$200,000. Some of the changes will take effect in 2011; others will be phased in over several years.**

The most noticeable tax change for the vast majority of Americans under the new health law will be on your W-2 Form. The law requires your employer to disclose the cost of health insurance benefits provided to you beginning in 2011. This new reporting requirement **will not** affect the taxes you pay. The value of health insurance benefits reported on your W-2 should not be included in your income when you file your taxes. You will also not have to pay any FICA taxes on this amount.

### Medicare Taxes

For those earning less than \$200,000 (or \$250,000 for a couple) your Medicare taxes **will not** increase. If you earn more than \$200,000 as an individual taxpayer, or if you earn more than \$250,000 and file a joint tax return with your spouse, you will see an increase in part of your Medicare Part A tax rate beginning in 2013. The tax rate will go from its current level of 1.45% to 2.35%. However, you will pay the 2.35% rate only on the portion of your earnings that is over \$200,000 for individuals or over \$250,000 for a couple. This means that your earnings

that are less than \$200,000 (or \$250,000 for a couple) will continue to be taxed at 1.45%. Also, the 1.45% Medicare tax that your employer pays on your behalf will not change. The change in the tax rate will increase the amount withheld from your salary or wages, or the tax you pay on self-employment income only if you earn over \$200,000.

### Flexible Spending Accounts

Some employers offer flexible spending accounts that allow you to set aside part of your salary before it is taxed to help pay for some of your medical expenses. If you have one, the most you will be able to contribute to a flexible spending account will be \$2,500 starting in 2013. The \$2,500 limit will be increased in future years with increases in the cost of living. Also, starting in 2011 you will not be able to get reimbursement from your flexible spending account for over-the-counter medications, such as aspirin or cough and cold medications, unless they are prescribed by your doctor.

### Medical Expense Deductions

You can deduct some medical expenses from your taxable income. Currently you can deduct the

amount of medical expenses that exceeds 7.5% of your taxable income. Beginning in 2013 you will be able to deduct only those medical expenses that exceed 10% of your adjusted gross income. For example, if your adjusted gross income is \$100,000 and your medical expenses are \$11,000, you could deduct \$3,500 under the old law ( $\$11,000 - [\$100,000 \times 7.5\% \text{ or } \$7,500] = \$3,500$ ). Starting in 2013 you will be able to deduct \$1,000 in medical expenses  $\$11,000 - [\$100,000 \times 10\% \text{ or } \$10,000] = \$1,000$ ). The percentage will remain at 7.5% for persons 65 and older until 2016.

## **New Tax on “Cadillac” Health Plans**

Starting in 2018, if your health benefits are worth more than \$10,200 for individual plans and \$27,500 for family plans, your **insurers** will pay a new tax. They will have to pay a 40% tax on the amount that your benefits exceed these threshold levels. These levels are increased to \$11,850 and \$30,950 for some retirees who are 55 or older and not eligible for Medicare, as well as people in high-risk occupations. They will also increase for companies that pay higher premiums due because of the age and gender of their workers. All threshold levels will be indexed for the cost of living after 2018. If you are self-employed and are covered through a group health plan, the insurer of your plan will also have to pay the tax.

You won't directly pay this so-called “Cadillac tax” since the tax is on your insurer. For the purposes of this law, an insurer could be an insurance company, your employer, or a third party that handles your employer's self-insured plan, flexible spending account, or health savings account. It will be up to your insurer to determine if it will pass the cost of the tax on to you or your employer.

## **Investment Income Tax**

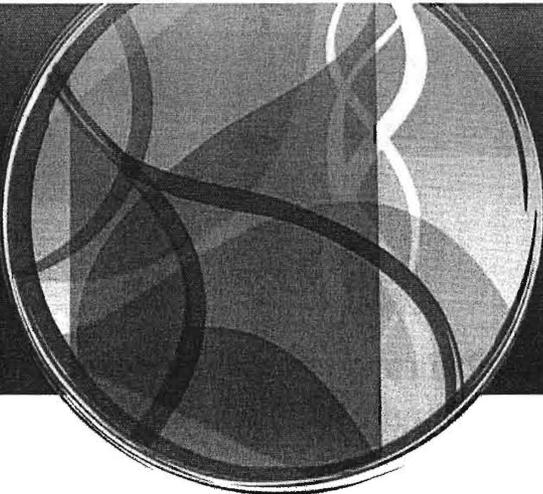
Taxpayers earning less than \$200,000 (or \$250,000 for a couple) **will not** pay higher taxes on their investment income. Starting in 2013, if you earn more than \$200,000 as an individual taxpayer, or if you earn more than \$250,000 and file a joint tax return with your spouse, you will pay a 3.8% tax on your net investment income. Net investment income includes interest, dividends, annuities, royalties, rents, and capital gains. It does not include income from Social Security, pensions, or IRA distributions. Payments from qualified IRA annuities are also not counted as net investment income.

Not all investment income is taxed. To figure out the amount of the tax, subtract \$200,000 (for an individual) or \$250,000 (for married couples filing jointly) from your taxable income. Then compare the result with your net investment income. Multiply the **lesser** amount by 3.8% to get the amount of the tax.

For example, a married couple with a modified adjusted gross income of \$275,000 and a net investment income of \$10,000 would pay \$380 in taxes on their net investments income:

$\$275,000 - \$250,000 = \$25,000$  which is larger than  
 $\$10,000$  for a tax of  $\$10,000 \times 3.8\% = \$380$

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for more information.



## HEALTH CARE *and you*

# The New Health Care Law: Protect Against Health Care Fraud

Scam artists have already hit the streets, airwaves and phone lines trying to take advantage of the confusion about what the new health care law means. As AARP frequently cautions its members and all older Americans, criminals use the news headlines as inspiration for clever sales pitches that defraud the public and pad their own pockets.

Law enforcement officials have already spotted and stopped three scams. One television commercial urged people to call a toll-free number to sign up for new government insurance during the “limited enrollment period.” Other scammers, claiming they were with the government, went door-to-door trying to sell fake insurance. A state attorney general reported that telemarketers were seeking personal information so they could send a new

Medicare card required by the new law. Another scam to watch out for is promising to help collect – for a fee – the \$250 rebate for Medicare Part D recipients who fall into the coverage gap.

Each of these pitches is a fraud. But scam artists are slick, so it is hard to predict all the ways they will try to twist the new law for their own profit.

### What You Should Do

#### Watch for official communications.

Government officials do not sell insurance policies door-to-door or over the phone. As new insurance benefits take effect, rely on trusted sources to tell you what you may need to do.

**Know who you are dealing with.** You will not need middlemen to help you apply for new benefits or to receive the \$250 “doughnut hole” rebate check. If you are

eligible, the rebate check will come to you automatically. You do not need to take any action—no requests, no applications, no fees.

**Be skeptical.** If you receive a visit, call or email from anyone claiming to want to help you sign up for new programs created by the new law, they may not be who they say they are. Do not pay anyone to help you receive your new benefits. And do not reveal any of your personal information to them, such as your full name, date of birth, or Social Security number. If someone requests this information, it's more likely they're "out to get you" than out to help you.

**Report fraud.** Law enforcement officials need you to report your concerns. The new health care law includes extra resources for fighting health care fraud. Contact your state insurance commission, your state attorney general, or local law enforcement about any suspicious promotions.

**Stay informed.** AARP keeps you up-to-date at [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) with accurate and timely information as the details of the new law are made public.

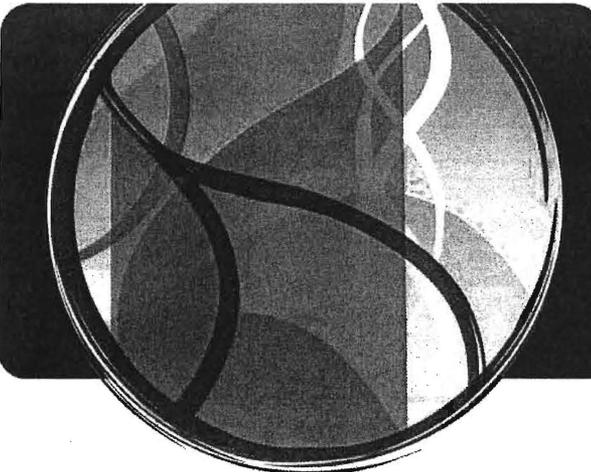
There is a lot packed into the new health care law and AARP will continue to be here

for our members and for all Americans, educating them on what the new law means for them.

#### Resources:

You will find contact information for your state insurance commission at [www.naic.org/state\\_web\\_map.htm](http://www.naic.org/state_web_map.htm).

You can locate your state attorney general at [www.naag.org/current-attorneys-general.php](http://www.naag.org/current-attorneys-general.php).



## HEALTH CARE *and you*

# The New Health Care Law: How it Impacts Hispanics/Latinos

**Congress enacted a new health care law which provides several new benefits to all Americans. Many of the benefits and protections in the new health care law are particularly critical to Hispanics/Latinos. Some of these changes you will see this year. Others phase in over the next several years. By knowing what's in the law and when the different provisions take effect, you can take advantage of the changes for yourself and your family.**

### **Makes Health Insurance More Accessible**

- Those without insurance, small businesses and self-employed people will be able to purchase private health insurance through state-based health insurance exchanges, by 2014. If you are eligible for insurance through an exchange and do not purchase it, you will be subject to a penalty.
- The new law may give you access to insurance coverage before 2014 if you have a pre-existing condition and have been uninsured for six months. This new temporary insurance, called the "Pre-Existing Insurance Plan (PCIP), should be available in your state starting summer 2010. Applications for these insurance plans are on a first come-first served

basis. Coverage under this program will continue until the health insurance exchanges start offering private insurance in 2014. Then, all insurance plans will be required to cover people with pre-existing conditions.

### **Lowers Costs**

- Starting in 2010 for new health plans, you will no longer have to pay some of the out-of-pocket costs for preventive care such as mammograms, immunizations and screenings for cancer or diabetes.
- If you have Medicare, you'll qualify for a new annual wellness visit, mammograms, and other screenings for cancer and diabetes. These new benefits start in 2011 and you will not have to pay for them.
- If you reach the Medicare Part D coverage gap or "doughnut hole" in 2010, you will receive a \$250 rebate check to help pay for prescription drugs. In 2011, if you reach the doughnut hole, you will receive a 50% discount on your brand-name prescription drugs and a 7% discount on your generic prescription drugs while you are in the

coverage gap. The gap will gradually narrow until it disappears in 2020.

- Starting in 2014, if you earn less than about \$58,000 for a couple, or about \$43,000 for an individual, you will get tax credits to help you pay your premiums for health insurance purchased through an exchange. (Higher income levels apply in Alaska and Hawaii.)

### **Eliminates Discriminatory Insurance Practices**

- Effective in 2010, health insurance companies can't drop your health coverage if you become sick. Your health insurance is guaranteed as long as you continue to pay your premiums. There are also new protections in place to limit excessive premiums because of your age or gender.
- Insurance companies can no longer place lifetime or annual limits on your health coverage – giving you peace of mind that your benefits won't run out when you need them the most. The ban on lifetime limits begins in 2010; the ban on annual limits begins in 2014.

### **Helps Pay for Long-Term Care**

- A new voluntary long-term care insurance program – called CLASS – will be available to you if you are working. This program will help you pay for some of your future long-term services and supports. You will receive a cash benefit if you have a qualifying disability, have paid into the program for at least five years, worked at least three of those initial five years, and meet other eligibility requirements. If your employer participates in the program, you will be enrolled automatically unless you choose to not to enroll. You will also be able to buy this

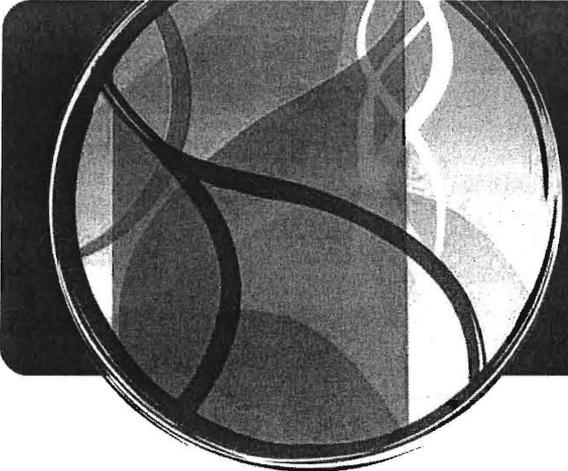
insurance if your employer doesn't participate, if you are self-employed, or have more than one employer. This program is likely to start in 2012 or 2013.

- If you are married to someone on Medicaid who is receiving care services at home, you will have the same protections for your income and other resources as do spouses of those on Medicaid who live in a nursing home. Starts in 2014.
- Your state may receive financial incentives to provide greater access to the services and supports you need to live independently in your own home and community.

### **Increases Efforts to Reduce Disparities in the Health Care System**

- Moves toward eliminating the disparities that Hispanics/Latinos currently face both in their health and in their health care by investing in research about health disparities.
- Expands initiatives to increase the racial and ethnic diversity of health care professionals and strengthen training among health care providers to focus on cultural issues.
- Invests in primary care professionals to ensure that all Americans have access to primary care providers.
- Invests in health care innovations such as community health teams to help you manage chronic conditions such as diabetes, high blood pressure and heart disease.

**Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.**



## HEALTH CARE *and you*

# The New Health Care Law: How it Impacts African Americans

**Congress enacted a new health care law which provides several new benefits to all Americans. Many of the benefits and protections in the new health care law are particularly critical to African Americans. Some of these changes you will see this year. Others phase in over the next several years. By knowing what's in the law and when the different provisions take effect, you can take advantage of the changes for yourself and your family.**

### **Makes Health Insurance More Accessible**

Those without insurance, small businesses and self-employed people will be able to purchase private health insurance through state-based health insurance exchanges, by 2014. If you are eligible for insurance through an exchange and do not purchase it, you will be subject to a penalty.

The new law may give you access to insurance coverage before 2014 if you have a pre-existing condition and have been uninsured for six months. This new temporary insurance, called the "Pre-Existing Insurance Plan (PCIP), should be available in your state starting summer 2010. Applications for these insurance plans are on a first come-first served basis. Coverage under this program will

continue until the health insurance exchanges start offering private insurance in 2014. Then, all insurance plans will be required to cover people with pre-existing conditions.

### **Lowers Costs**

Starting in 2010 for new health plans, you will no longer have to pay some of the out-of-pocket costs for preventive care such as mammograms, immunizations and screenings for cancer or diabetes.

If you have Medicare, you'll qualify for a new annual wellness visit, mammograms, and other screenings for cancer and diabetes. These new benefits start in 2011 and you will not have to pay for them.

If you reach the Medicare Part D coverage gap or "doughnut hole" in 2010, you will receive a \$250 rebate check to help you pay for prescription drugs. In 2011, if you reach the doughnut hole, you will receive a 50% discount on your brand-name prescription drugs and a 7% discount on your generic prescription drugs while you are in the coverage gap. The gap will gradually narrow until it disappears in 2020.

Starting in 2014, if you earn less than about \$58,000 for a couple, or about \$43,000 for an individual, you will get tax credits to help you pay your premiums for health insurance purchased through an exchange. (Higher income levels apply in Alaska and Hawaii.)

### **Eliminates Discriminatory Insurance Practices**

Effective in 2010, health insurance companies can't drop your health coverage if you become sick. Your health insurance is guaranteed as long as you continue to pay your premiums. There are also new protections in place to limit excessive premiums because of your age or gender.

Insurance companies can no longer place lifetime or annual limits on your health coverage – giving you peace of mind that your benefits won't run out when you need them the most. The ban on lifetime limits begins in 2010, while the ban on annual limits begins in 2014.

### **Helps Pay for Long-Term Care**

A new voluntary long-term care insurance program – called CLASS – will be available to you if you are working. This program will help you pay for some of your future long-term care services. You will receive a cash benefit if you have a qualifying disability, have paid into the program for at least five years, worked at least three of those initial five years, and meet other eligibility requirements. If your employer participates in the program, you will be enrolled automatically unless you choose to opt out. You will also be able to buy this insurance if your employer doesn't participate, if you are self-

employed, or have more than one employer. This program is likely to start in 2012 or 2013.

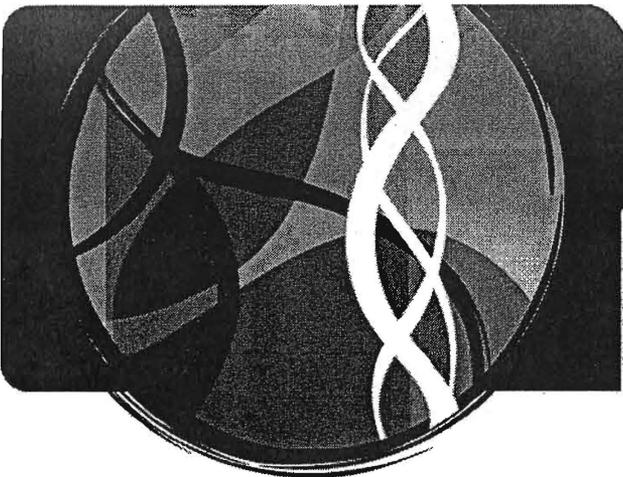
If you are married to someone on Medicaid who is receiving care services at home, you will have the same protections for your income and other resources as do spouses of those on Medicaid who live in a nursing home. Starts in 2014.

Your state may receive financial incentives to provide greater access to the services and supports you need to live independently in your own home and community.

### **Increases Efforts to Reduce Disparities in the Health Care System**

- Moves toward eliminating the disparities that African Americans currently face both in their health and in their health care by investing in research about health disparities.
- Expands initiatives to increase the racial and ethnic diversity of health care professionals and strengthen training among health care providers to focus on cultural issues.
- Invests in primary care professionals to ensure that all Americans have access to primary care providers.
- Invests in health care innovations such as community health teams to help you manage chronic conditions such as diabetes, high blood pressure and heart disease.

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.



## HEALTH CARE *and you*

# The New Health Care Law: What it Means for People with Medicare Advantage Plans

The new health care law makes a number of changes in how Medicare Advantage plans operate. If you have a Medicare Advantage plan, it is important to know how and when these changes might affect you.

If you have a Medicare Advantage plan for 2010, your plan will stay the same through the end of the year. You should use Medicare's open enrollment as an opportunity to review all your Medicare choices for 2011 to select a plan that works best for you. Open enrollment for 2011 coverage begins on November 15, 2010.

When evaluating different plans, remember to consider:

**Cost:** What are the monthly premiums, the annual deductible and co-pays?

**Coverage:** What services are covered?

**Quality:** How does the plan rate on providing quality care?

### Focus on quality and value

The new law rewards Medicare Advantage plans that provide high quality care. The law also sets up new rules to make plans more cost-effective.

- The Centers for Medicare & Medicaid Services (CMS) has a rating system for Medicare Advantage plans. Plans that rate at least four out of five stars will receive bonus payments for providing better quality care. The bonuses begin in 2012. You can review your plan's rating on Medicare's website [www.medicare.gov/mppf](http://www.medicare.gov/mppf).
- Plans must use some of the bonus money they receive for extra benefits and rebates to people participating in the plans. This means that higher quality plans may be able to offer you more services.
- Starting in 2011, Medicare Advantage plans cannot charge more than Original Medicare for certain services. For example, chemotherapy administration, kidney dialysis, and skilled nursing care.
- As of 2014, Medicare Advantage plans must limit how much they spend each year on administrative costs. For each dollar you pay in premiums, Medicare Advantage plans may not spend more than 15 cents on administrative expenses.

## Changes in how Medicare Advantage plans are paid

Currently, Medicare makes extra payments (subsidies) to the private companies that offer Medicare Advantage plans. This means that these plans cost the Medicare program more than Original Medicare – on average about 13% more per person.

In 2011, Medicare Advantage plans will receive the same amount of extra payments as they did in 2010. But beginning in 2012, Medicare will start to reduce these subsidies so that payments will be more in line with Original Medicare. The changes in Medicare Advantage payments will save the Medicare program money. Some of the savings will be used to close the Medicare prescription drug coverage gap or doughnut hole and to provide more preventive care to people with Medicare.

## What this could mean for your Medicare Advantage plan

- Plans will differ in how they respond to the lower subsidies. This will depend partly on the state and county where the plan is located, and on the amount of bonus money the plans receive.
- The lower subsidies could mean that some plans may drop extra services such as eyeglasses and gym memberships. Some plans may raise their premiums and co-payments. Others may even decide to leave the Medicare program.

## How you will know about changes to your Medicare Advantage plan

Every year, even before the new health care law, insurance companies that offered Medicare Advantage plans made decisions about what they would cover and what they would charge. Under the new law, each insurance company will continue to make a business decision whether to change your benefit package and costs.

As in previous years, you will receive a notice from your Medicare Advantage plan in October. It will tell you what changes, if any, will take place in your plan for the upcoming year. This is the time for you to review your options carefully and make the best choice to fit your needs.

- If you have questions about the notice, you can contact your Medicare Advantage plan directly. You can also call **1-800-Medicare (1-800-633-4227)** to speak with a representative about your options.
- You can also compare your options at Medicare Plan Finder: [www.medicare.gov/MPPF](http://www.medicare.gov/MPPF). This site shows which Medicare Advantage plans are offered in your area.
- If your plan is changed or dropped, you can switch to another available Medicare Advantage plan or to Original Medicare during Medicare's open enrollment period (November 15 -December 31).

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.

## HEALTH CARE *and you*

# The New Health Care Law: What it Means for People Living in Rural Areas

**Congress enacted a new health care law which provides several new benefits to all Americans. Many of the provisions in the new health care law are particularly important for those living in rural areas, who pay on average nearly half of their health insurance costs out of their own pockets.**

Some of these changes you will see this year. Others phase in over the next several years. By knowing what's in the law and when the different provisions take effect, you can take advantage of the changes for yourself and your family.

### **Makes Health Insurance More Accessible**

- Those without insurance, small businesses and self-employed people will be able to purchase private health insurance through a health insurance exchange in their state by 2014. In many rural states, one insurance company can dominate the market, meaning that often there is little choice in available health plans. Health insurance exchanges will offer a choice of plans and it will make it easier for people in rural areas to compare plans and prices.
- The new law may give you access to insurance coverage before 2014 if you have a pre-existing condition and have been

uninsured for six months. This coverage – known as the “Pre-Existing Condition Insurance Plan” – should be available in your state in 2010. This program will continue until the health insurance exchanges start in 2014. Then, all insurance plans will be required to cover pre-existing conditions.

### **Lowers Costs**

- Starting in 2010 for new health plans, you will no longer have to pay some of the out-of-pocket costs for preventive care such as mammograms, immunizations and screenings for cancer or diabetes.
- If you have Medicare, you'll qualify for a new annual wellness visit, mammograms, and other screenings for cancer and diabetes. These new benefits start in 2011, and you will not have to pay for them.
- If you reach the Medicare Part D prescription drug coverage gap or “doughnut hole” in 2010, you will receive a \$250 rebate check to help pay for prescription drugs. In 2011, if you reach the doughnut hole, you

will receive a 50% discount on your brand-name prescription drugs and a 7% discount on your generic prescription drugs while you are in the coverage gap. The gap will gradually narrow until it disappears in 2020.

- Starting in 2014, if you earn less than about \$58,000 for a couple, or about \$43,000 for an individual, you will get tax credits to help you pay your premiums for health insurance purchased through an exchange.

#### **Provides Tax Credits for Small Businesses**

- If you operate a small business in a rural area, you may be able to get tax credits to offset part of the cost of offering health insurance to your employees. An estimated 2.8 to 4 million small businesses will be eligible for the credits that start in 2014.

#### **Eliminates Discriminatory Insurance Practices**

- Effective in 2010, health insurance companies can't drop your health coverage if you become sick. Your health insurance is guaranteed as long as you continue to pay your premiums. There are also new protections in place to limit excessive premiums because of your age, gender, or health condition.
- Insurance companies can no longer place lifetime or annual limits on your health coverage – giving you peace of mind that your benefits won't run out when you need them the most. The ban on lifetime limits begins in 2010, while the ban on annual limits begins in 2014.

#### **Increases Access to Health Care in Rural Areas**

- Invests in the health care workforce to ensure that people in rural areas have access to doctors, nurses and other primary care providers.
- Provides more resources to medical and nursing schools to train doctors and nurses to work in rural and underserved areas.
- Invests in health care innovations such as community health teams to help you manage chronic conditions such as diabetes, high blood pressure and heart disease.
- Ensures that hospital and other providers in rural communities receive Medicare funds they need to offer quality care and keep their doors open.
- Provides more funding for community-based health care centers in rural areas, as well as grants for school-based health centers in underserved areas.

Check [www.aarp.org/getthefacts](http://www.aarp.org/getthefacts) frequently for the latest information.

10/7 Ex 2

**LR 467 Interim Study Hearing Materials**  
Prepared by the Nebraska Hospital Association

## Table of Contents

All materials in this booklet can be found at [www.nhanet.org/advocacy/LR\\_467.htm](http://www.nhanet.org/advocacy/LR_467.htm).

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# **LR 467 Interim Study Hearing**

**October 7, 2010  
State Capitol  
Lincoln, Nebraska**

**Bruce Rieker, Vice President, Advocacy**



## **Health Care Reform Coverage Expansion**

- The Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Affordability and Reconciliation Act (HCEARA):
  - Expand Medicaid program to cover non-elderly individuals, including parents; children; and childless adults, up to 133% of the federal poverty level (FPL);
  - Require insurance companies to cover pre-existing conditions;
  - Require employers of 50 or more to provide coverage;
  - Require everyone not covered by an employer-based or governmental plan to purchase health insurance; and
  - Expand coverage to 32 million Americans currently uninsured, for total coverage of 95%. The Congressional Budget Office (CBO) estimates, 21 million will remain uninsured in ten years.



## Medicare and Medicaid Payment Policies

- Medicare Update Factor Reductions
  - Nebraska reduction: \$687.2 million over ten years
  - The update factors for all Medicare Part A and B providers who are subject to a market basket or Consumer Price Index (CPI) update will be reduced to reflect estimated gains in productivity.
  - Further update reductions beyond the productivity adjustment will also be applied.
  - No floor is established to protect provider updates from falling below zero.



## Medicare and Medicaid Payment Policies

- Productivity Offsets:
  - Inpatient and Outpatient Hospitals, Inpatient Rehabilitation Facilities, Inpatient Psychiatric Facilities, Long-term Care Hospitals and Skilled Nursing Facilities
    - Reductions begin in 2012
    - Estimated at 1.3%
  - Hospice: Reductions begin in 2013
  - Home Health Agencies: Reductions begin in 2015



## Medicare and Medicaid Payment Policies

- Additional Reductions
  - Inpatient and Outpatient, Inpatient Rehab, and Inpatient Psychiatric: Market basket updates will be reduced by 0.25 percentage points in 2010 and 2011 increasing to .75 percentage points annually in 2017 through 2019.
  - Long-Term Care Hospitals: Annual updates will be reduced by 0.25 percentage points in 2010 and 0.50 percentage points in 2011 growing to .75 percentage points annually in 2017 through 2019.
  - Home Health Agencies: Reduces annual updates for home health agencies by 1.0 percentage point in 2011, 2012 and 2013.
  - Hospice: In addition to the annual productivity adjustment, updates will be reduced by 0.30 additional percentage points annually in 2013 through 2019.

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## Medicare and Medicaid Payment Policies

- Disproportionate Share Hospital (DSH)  
Reductions
  - Nebraska cuts: \$74.7 million (Medicare only)
  - Medicaid: Approximately 50% reduction compared to FFY 2009.
  - Medicare:
    - 25% of DSH payments are considered to be the “empirically justified” component of DSH and will continue to be paid to each hospital based on the current methodology.
    - 75% of DSH payments will be subject to reductions. For every percentage point reduction in the uninsured rate, DSH funding will be proportionally reduced.

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## Medicare and Medicaid Payment Policies

- Medicare Home Health Agency (HHA) Payments
  - Nebraska reduction: \$71.2 million
  - Payment rebasing: Based on average number and types of visits per episode, intensity of visits, and growth in cost per episode. Reductions are phased-in over four years, beginning in 2014 and cannot exceed 3.5% each year.
  - Cap on outlier payments: In 2011, reduces the HHA outlier pool from 5% of total payments to 2.5% and establishes a 10% cap on the outlier reimbursements.
  - Rural HHA add-on: Provides a 3% add-on payment for home health service provided to Medicare beneficiaries in rural areas from April 1, 2010 through December 31, 2015.



## Medicare and Medicaid Payment Policies

- Health Care Acquired Conditions (HACs)
  - Extends existing Medicare HAC policy to the Medicaid program.
  - 2015: Hospitals in the worst 25th percentile of HAC rates will be subject to a 1% payment penalty under Medicare.
  - Secretary must publicly report hospitals' HAC measures.



## Medicare Payment Policies

- Medicare Readmissions
  - Nebraska reductions: \$21.0 million
  - In 2013, acute care hospitals with higher than expected risk-adjusted readmissions will receive reduced payments for every discharge.
  - In 2013 and 2014, based on readmissions related to three conditions: heart failure, heart attack, and pneumonia.
  - By 2015, Expanded to include chronic obstructive pulmonary disease (COPD), coronary artery bypass graft (CABG), percutaneous transluminal coronary angioplasty (PTCA), and other vascular procedures.
  - Secretary has authority to expand policy to additional conditions in future years, including all-cause readmissions.
  - Maximum reduction: 1.0% in 2013, increasing to 3.0% in 2015.
  - Critical access hospitals (CAHs) exempted.



## Medicare Payment Policies

- Medicare Readmissions
  - Secretary must publicly post (on the CMS Hospital Compare website) all-payer readmission rates for identified conditions.
  - Applies to cancer, children's, rehabilitation, long-term care and psychiatric inpatient facilities.
  - Secretary must establish a quality improvement program by March 2012 for high readmission hospitals.
  - Eligible hospitals would work with patient safety organizations to implement processes to improve readmission rates.
  - In 2011, \$500 million will be available over a five-year period to fund a Community Care Transitions Program for hospitals with high readmission rates.



## Delivery System Reforms

- Medicare Value Based Purchasing (VBP) Program
  - Applies to all hospitals under the inpatient prospective payment system (IPPS) excluding psychiatric, rehabilitation, children's, cancer and long term care hospitals.
  - CAHs and small hospitals with insufficient numbers of measures and/or cases are excluded.
  - Within two years the Secretary shall establish two separate, three-year VBP demonstration programs, one for CAHs and one for the small excluded hospitals.



## Delivery System Reforms

- Value Based Purchasing (VBP) Program
  - Secretary determines scoring and payment methodologies.
    - Must recognize both achievement of standards and improvement.
    - 2013 measures must cover acute myocardial infarction (AMI), heart failure, pneumonia, surgeries from the Surgical Care Improvement project and health care associated infections.
    - Must be related to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.
    - Use of readmissions measures is expressly prohibited.



## **Delivery System Reforms**

- **Demonstration Programs**
  - Bundled payments to evaluate integrated care around a hospitalization, in up to eight states beginning in 2012;
  - Pediatric Accountable Care Organizations (ACOs) beginning in 2012; and
  - Emergency psychiatric projects beginning in 2011.



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## **Medicaid Quality Measures**

- **By 2014, the Secretary must establish a Medicaid Quality Measurement Program for adults.**
  - By 2011, identify and publish priorities for the development of quality measures.
  - By 2012, publish an initial core set of adult health quality measures.
  - By 2013, develop standardized format for reporting and create procedures to encourage states to use those measures to report information regarding quality.



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## Quality Measures

- [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov): Maintained by HHS. Includes information on compliance with best practices in medical care for selected medical/surgical conditions as well as results of the Hospital Consumer Assessment of Hospitals and Providers (HCAHPS) for most hospitals. Also displays average Medicare reimbursements for the selected medical/surgical conditions.
- [www.statesnapshots.ahrq.gov](http://www.statesnapshots.ahrq.gov): Maintained by Agency for Healthcare Research & Quality (AHRQ). Provides an assessment of the state's progress in achieving certain measures for acute care, long term care, ambulatory care and selected conditions such as diabetes; and contains comparison of state to region, United States and top performers.



## Quality Measures

- [www.dartmouthatlas.org](http://www.dartmouthatlas.org): Maintained by Dartmouth College. Provides information on utilization of services by Medicare recipients during the last two years of their life, including: cost, number of services and the number of physicians seen per beneficiary.
- [www.jointcommission.org](http://www.jointcommission.org): The Joint Commission (JC) provides information on the quality of care in hospitals it surveys. Updated annually.
- [www.nhacarecompare.org](http://www.nhacarecompare.org): Maintained by Nebraska Hospital Association. Contains information about average charges by diagnosis related group (DRG) and links to sites about quality. Updated quarterly.



## **Community Hospitals Economic Impact**

- Nebraska's Community Hospitals
  - 86 full-service hospitals
  - 10,000+ patients per day
  - Nearly 45,000 employees
  - \$2.1 billion - earned income
  - \$4.4 billion - revenue



## **Community Hospitals Economic Impact**

- Hospitals are Providers and Consumers
  - Health care
  - Insurance
  - Utilities
  - Construction
  - Equipment
  - Information technology
  - Transportation



## Benefits Provided by Nebraska Community Hospitals

Programs and Services	FY '08 Net Community Benefit
Reimburse for Low-income/Public Programs	\$660,267,514
Traditional charity care	134,337,670
Unpaid Cost of Public Programs:	
Medicare	379,468,368
Medicaid	134,125,368
Other public programs	12,336,068
Community Benefits Services	12,472,482
Community health education and outreach	9,657,501
Community-based clinical services	1,291,355
Health care support services	6,336,625
Health Professions Education	42,124,252
Scholarships/funding for health professions	6,354,986
Residencies and internships	23,474,518
Other	12,645,748
Subsidized Health Services	54,087,793
Emergency and trauma care	7,773,737
Neonatal intensive care	3,445,550
Community clinics	2,074,805
Hospital outpatient services	12,665,003
Women's and children's services	2,503,678
Subsidized continuing care	3,478,198
Behavioral health services	2,128,015
Palliative care	8,379,509
Other subsidized health services	11,429,158

Programs and Services	FY '08 Net Community Benefit
Research	2,665,393
Cash and In-Kind Donations	23,916,351
Community Fundraising Activities	2,072,701
Physical improvements and housing	281,484
Economic development	243,500
Community support	416,152
Environmental improvements	21,697
Leadership development/training	33,428
Coalition building	805,969
Advocacy for community issues	191,078
Workforce development	1,078,576
Community Benefit Operations	871,703
Other	23,552,890
<b>TOTAL COMMUNITY BENEFITS</b>	<b>\$827,931,000</b>
<b>BAD DEBT</b>	<b>175,428,276</b>
<b>TOTAL CONTRIBUTIONS</b>	<b>\$1,003,359,276</b>

Sixty-nine of the 85 NHA member hospitals participated in the 2009 Nebraska Hospitals Community Benefits Survey.

The data represents the aggregate results of the community benefits inventory for each reporting hospital's fiscal year 2008 activities.

Data reported for fiscal year 2008 includes additional categories, aligning with the new IRS Form 990 and its Schedule H.



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## Benefits Provided by Nebraska Community Hospitals

- Current reimbursement from public programs
  - Medicare: 84% of costs
    - Based on analysis of cost report data (HANYS)
  - Medicaid: 76% of costs
    - Based on Databank and should be considered a “sampling”
    - Excludes Disproportionate Share Hospital (DSH) payments
  - Unpaid costs of public programs
    - Medicare: \$379.4 million
    - Medicaid: \$134.1 million
    - Other public programs: \$12.3 million
    - Total: \$526 million



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# Medicaid Services

Federal Medicaid Mandatory and Optional Services Covered in Nebraska  
(Neb. Rev. Stat. § 68-911)

Mandatory Services	Nebraska Optional Services
<ul style="list-style-type: none"> <li>• Inpatient and outpatient hospital services</li> <li>• Laboratory and x-ray services</li> <li>• Nursing facility services</li> <li>• Home health services</li> <li>• Nursing services</li> <li>• Clinic services</li> <li>• Physician services</li> <li>• Medical and surgical services of a dentist</li> <li>• Nurse practitioner services</li> <li>• Nurse midwife services</li> <li>• Pregnancy-related services</li> <li>• Medical supplies</li> <li>• Early and periodic screening and diagnosis treatment (EPSDT) services for children</li> </ul>	<ul style="list-style-type: none"> <li>• Prescribed drugs</li> <li>• Intermediate care facilities for the mentally retarded (ICF/MR)</li> <li>• Home and community-based services for aged persons and persons with disabilities</li> <li>• Dental services</li> <li>• Rehabilitation services</li> <li>• Personal care services</li> <li>• Durable medical equipment</li> <li>• Medical transportation services</li> <li>• Vision-related services</li> <li>• Speech therapy services</li> <li>• Physical therapy services</li> <li>• Chiropractic services</li> <li>• Occupational therapy services</li> <li>• Optometric services</li> <li>• Podiatric services</li> <li>• Hospice services</li> <li>• Mental health and substance abuse services</li> <li>• Hearing screening services for newborn and infant children</li> <li>• School-based administrative services</li> </ul>

Source: Nebraska Medicaid Reform Annual Report, 2010



# Provider Rates

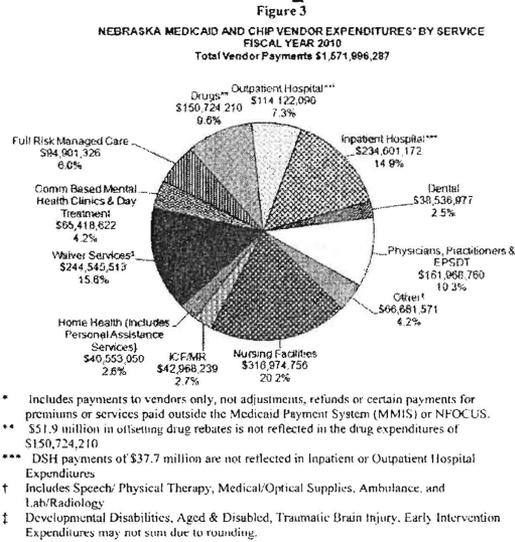
Table 2

Year-to Year Average Medicaid Provider Rate Increases	SFY 2005	SFY 2006	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
Hospitals	3.80%	2.00%	2.00%	1.95%	1.90%	1.50%	0.50%
Practitioners	2.00%	2.00%	2.00%	1.40%	1.40%	1.50%	0.50%
Nursing Facilities	2.00%	6.00%	3.50%	2.50%	2.50%	1.50%	0.50%
Assisted Living	3.00%	2.00%	2.00%	2.00%	2.00%	1.50%	0.50%
Non-public ICF-MRs	3.00%	2.00%	2.00%	2.50%	2.50%	1.50%	0.50%

Source: Nebraska Medicaid Reform Annual Report, 2010



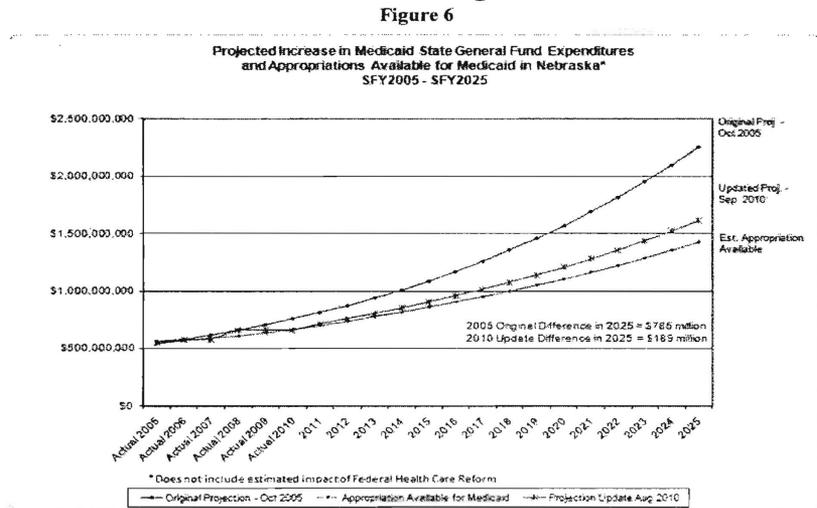
# Medicaid Expenditures



Source: Nebraska Medicaid Reform Annual Report, 2010



# Medicaid Projections



Source: Nebraska Medicaid Reform Annual Report, 2010



## Ten-Year Impact

- Medicare reductions: \$854.5 million
  - Market basket, productivity and re-basing: \$758.4 million
    - Inpatient, outpatient, inpatient rehab, inpatient psychiatric, long-term care, home health rural add-on, home health rebasing and market basket and skilled nursing
  - DSH cuts: \$74.7 million
    - Medicare inpatient acute
  - Readmissions penalties: \$21.4 million
  - Margins expected to decrease from -16% to -39%
- Medicaid reductions
  - DSH: \$47 million



## Ten-Year Impact

- Kaiser Commission
  - Lower participation fiscal impact
    - State: \$106 million
    - Federal: \$2,345 million
    - Total \$2,451 million



## Ten-Year Impact

- Kaiser Commission
  - Enhanced participation fiscal impact
    - State: \$155 million
    - Federal: \$2,732 million
    - Total \$2,886 million



## Ten-Year Impact

- Milliman
  - Mid-range participation fiscal impact
    - State: \$526.3 million
    - Federal: \$3,977.1 million
    - Total \$4,503.4 million



## Ten-Year Impact

- Milliman
  - Full participation fiscal impact
    - State: \$765.9 million
    - Federal: \$5,495.3 million
    - Total \$6,261.2 million



## Ten-Year Impact Summation

- Medicaid expansions will increase the:
  - Number of insured, and
  - Unpaid costs of public programs
    - Current margin from costs: - 24%
    - Potential margin from costs: - 29%
- Medicare reductions exceed \$850 million
  - Current margin from costs: - 16%
  - Estimated margin from costs in ten years: - 39%



## Ten-Year Impact Summation

- Medicaid's Impact on Community Hospitals
  - Increased unpaid costs
    - Hospitals' share of Medicaid expenditures: 30% (estimated)
    - Projected margin from costs: -29%
  - Kaiser Commission: lower participation model
    - Increased state and federal expenditures: \$2.451 billion
    - Additional unpaid costs of Medicaid: \$300 million
  - Milliman: full participation model
    - Increased state and federal expenditures: \$6.261 billion
    - Additional unpaid costs of Medicaid: \$767 million

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## Ten-Year Impact Summation

- PPACA and HCEARA: Added Impact on Community Hospitals
  - Medicare reductions: \$854 million
  - Medicaid unpaid costs: \$300 - \$767 million
  - Combined: \$1.154 - \$1.621 billion

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## **Additional Questions?**

Thank you.

Bruce Rieker  
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### Summary of Provisions Related to:

- Coverage Expansion,
- Medicare and Medicaid Payment Policies,
- Medicare and Medicaid Delivery System Reforms,
- Additional Provider Issues,
- Health Insurance Market Reforms, and
- Administrative Simplification.

## Coverage Expansion

(PPACA Sections 1101, 1323, 1334, 1401, 1421, 1501, 1512, and 2001; HCEARA Sections 1002, 1003, and 1201)

The PPACA and HCEARA increase insurance coverage for American citizens by:

- Expanding the Medicaid program;
- Creating a high risk insurance pool;
- Allowing individuals up to age 26 to be covered under their parents' insurance plans;
- Requiring insurance companies to cover individuals with pre-existing conditions;
- Establishing state-based health insurance market places known as "Exchanges" where individuals not covered by employer-based or governmental health insurance can buy coverage;
- Offering subsidies to low to moderate income Americans who buy insurance through the newly established exchanges;
- Requiring all employers of 50 or more persons to provide health insurance coverage to their employees; and
- Requiring all American citizens not covered by an employer-based or governmental plan to purchase health insurance.

The Acts will eventually expand health insurance coverage to 32 million Americans who are currently uninsured, for total health coverage of 95% of all Americans. Based on Congressional Budget Office estimates, twenty-one million individuals would remain uncovered in ten years.

**Medicaid Program Expansion:** Beginning in 2014, the Medicaid program will be expanded to cover non-elderly individuals, including parents; children; and childless adults, up to 133% of the federal poverty level (FPL).

For most states, a federal matching rate of 100% will be provided for newly eligible individuals. The federal matching rate will decrease to 95% in 2017; 94% in 2018; 93% in 2019; and 90% thereafter. For “expansion” states (those with Medicaid programs that already cover non-pregnant, childless adults up to 133% of the FPL), federal support will be provided to reduce the state’s share by 50% in 2014; 60% in 2015; 70% in 2016; 80% in 2017; and 90% in 2018 for this portion of their Medicaid population. In 2019, expansion states will receive the same federal matching percent, 90%, for the costs of covering non-pregnant, childless adults as non-expansion states.

**Creation of a High Risk Pool:** 90 days after enactment of PPACA, a \$5 billion national high-risk insurance pool will be created to allow individuals with a pre-existing medical condition, who currently are unable to purchase private health insurance, to access insurance. This pool ends when the state-based exchanges become operational.

**Dependent Coverage for Young Adults up to 26 Years Old:** Six months after enactment of PPACA, any group plan or plan purchased on the individual market that provides dependent coverage for children, must continue to offer such coverage until the child turns 26 (if the dependent child is not eligible for employer-sponsored coverage on his/her own).

**Children with Pre-existing Medical Conditions:** Six months after enactment of PPACA, private insurance companies will be prohibited from denying coverage to children due to a pre-existing condition. This requirement applies to all employer plans and new plans in the individual market. (This provision will apply to all individuals in 2014.)

**Establishment of State-Based Health Insurance Exchanges:** No later than January 1, 2014, each state will establish state-based health insurance exchanges open to the individual and small group market. Small employers, with 50 or fewer employees, will be able to shop for coverage in the Small Business Health Options Program (SHOP) exchange. The exchanges will be overseen by state insurance commissioners; the financial integrity of the Exchanges will be overseen by the Secretary of the U.S. Department of Health and Human Services.

- **Plan Requirements:** Several levels of standardized, comprehensive benefit packages will be available at different levels of cost sharing.
- **OPM Plans:** Each Exchange will provide access to multi-state, private plans under the supervision of the federal Office of Personnel Management (OPM). OPM is the agency that regulates and administers the Federal Health Employee Benefit Plan.
- **Co-ops:** Federal funding for start-up loans and grants will be provided to qualified organizations to assist in the establishment of nonprofit, member-run health insurance Consumer Operated and Oriented Plans (Co-Ops). These plans would offer health insurance through the health insurance exchange.
- **Provider Payments:** Providers will negotiate rates with the private plans offered through the exchanges, much the same as is currently done.

- **Insurance Market Reforms:** All plans operating in the exchanges will be subject to new insurance market reforms (see section on Insurance Market Reforms).

**Subsidies for Health Insurance Coverage:** Premium assistance in the form of refundable and advanceable tax credits will be provided on a sliding scale to individuals and families with incomes between 100% and 400% of the FPL. The premium credits will be tied to the second lowest-cost silver plan<sup>1</sup> in the area and will be set on a sliding scale such that the individual's/family's premium contributions are limited to 2.0% of income for those between 100% and 133% of the FPL up to 9.5% of income for those between 300% and 400% of the FPL. (Individuals with incomes less than 133% FPL are intended to get their coverage through Medicaid.) The expected contributions will increase annually based upon premium growth rates.

Small employers (with no more than 25 employees and average annual wages of less than \$50,000) that purchase health insurance for employees are provided with a tax credit.

**Individual Mandate:** Effective January 1, 2014, most individuals who are not covered by employer-based or governmental plans will be required to obtain acceptable health insurance coverage. Failure to purchase such coverage will result in a financial penalty equal to: the greater of \$95 or 1% of income in 2014; \$325 or 2% of income in 2015; \$695 or 2.5% in 2016; and continued indexed amounts after 2016, up to the cap of the national average "bronze" plan premium. Families with children will pay half of the penalty amount for children, up to a cap of \$2,250 for the entire family.

**Employer Mandate:** Effective March 1, 2013, employers will be required to provide notice to employees of their health insurance options, including options available via the exchanges. Employers with 200 or more employees will be required to automatically enroll employees in health insurance plans, allowing individuals to opt-out. Employer penalties will apply for failure to provide affordable coverage as follows:

- Employers with 50 or more full-time workers, that do not offer health insurance coverage will pay an assessment of \$2,000 per full-time worker (not including the first 30 workers) if any of their employees receive a tax credit to purchase insurance through the exchange.
- Employers that offer unaffordable health insurance or a plan that does not cover at least 60 percent of allowable costs will pay \$3,000 for any employee that receives a tax credit in the exchange up to an aggregate cap amount set at \$2,000 multiplied by the number of full-time employees.

**Internet Portal to Affordable Coverage Options:** By July 1, 2010, the Secretary of Health and Human Services (the Secretary) must establish a mechanism, including an internet website, through which a resident of any state may identify affordable health insurance coverage options in that state. The internet website must provide information on private

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<sup>1</sup> The PPACA establishes four levels of plans that can qualify for offering through an exchange: bronze, silver, gold, and platinum (Section 1302). As listed here, the plans increase in the coverage value of benefits with the bronze level covering 60% of the actuarial value of total benefits and platinum covering 90% of the actuarial value of total benefits.

health insurance (including coverage offered through the state exchanges and co-ops, when applicable), the high risk pool, Medicare, and Medicaid.

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## **Medicare and Medicaid Payment Policies**

### **Medicare Update Factor Reductions**

**(PPACA Section 3401; HCEARA Section 1105)**

Savings: U.S.—\$156.6 billion over ten years; Nebraska—\$ 687.2 million (excludes the impact of Home Health market basket reductions which are included in the Home Health Agency section below).

The update factors for all Medicare Part A and B providers who are subject to a market basket or Consumer Price Index (CPI) update will be reduced to reflect estimated gains in productivity. A measure of multifactor productivity gains for the non-farm, general economy will be used (currently estimated at 1.3%) to reduce the update for inpatient and outpatient hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, nursing homes, home health, and hospice care providers.

Further update reductions beyond the productivity adjustment will also be applied.

No floor is established to protect provider updates from falling below zero.

#### **Productivity Offsets:**

**Inpatient and Outpatient Hospitals, Inpatient Rehabilitation Facilities, Inpatient Psychiatric Facilities, Long-term Care Hospitals and Skilled Nursing Facilities:** Beginning in 2012 and every year thereafter, productivity adjustments will be applied to these providers' Medicare update.

*Hospice Providers:* Productivity reductions will begin in 2013.

*Home Health Agencies:* Productivity reductions will begin in 2015.

#### **Update Factor Reductions in Addition to Productivity Offsets:**

**Inpatient and Outpatient Hospitals, Inpatient Rehabilitation Facilities, and Inpatient Psychiatric Facilities:** Market basket updates will be reduced by 0.25 percentage points in 2010 and 2011. The reduction for hospital inpatient and rehabilitation applies to discharges after March 31, 2010. In addition to the annual productivity adjustment, the following market basket reductions will be applied: 0.10 percentage points in 2012 and 2013; 0.30 percentage points in 2014; 0.20 percentage points in 2015 and 2016; and 0.75 percentage points annually in 2017 through 2019.

**Long-Term Care Hospitals:** The annual update factors for long-term care hospitals will be reduced by 0.25 percentage points in 2010 and 0.50 percentage points in 2011. In addition to the annual productivity adjustment, the following market basket reductions will be applied: 0.10 percentage points in 2012 and 2013; 0.30 percentage points in 2014; 0.20 percentage points in 2015 and 2016; and 0.75 percentage points annually in 2017 through 2019.

**Home Health Agencies:** Reduces the annual update factors for home health agencies by 1.0 percentage point in 2011, 2012, and 2013.

**Hospice Providers:** In addition to the annual productivity adjustment, the update factors for hospice providers will be reduced by 0.30 additional percentage points annually in 2013 through 2019.

## **Medicare and Medicaid Disproportionate Share Hospital (DSH) Payment Reductions**

**(PPACA Sections 2551 and 3133; HCEARA Sections 1104 and 1203)**

Savings: U.S.—\$36.1 billion over ten years; Nebraska—\$74.7 million (Medicare Only)

The PPACA and HCEARA reduce Medicare and Medicaid DSH payments to adjust for reductions to the number of uninsured individuals.

**Medicaid DSH Reductions:** Federal Medicaid DSH allotments will be reduced by \$14.1 billion over ten years, beginning with a \$500 million cut in FFY 2014, and increasing to a \$5.6 billion cut in FFY 2019. This represents an approximate 50% reduction compared to the \$11.3 billion federal DSH allotment in FFY 2009.

The Secretary is required to develop a methodology for reducing federal DSH allotments to each state. The largest DSH reductions would be imposed on the states that have the lowest uninsured percentages and on states that do not distribute DSH payments based on Medicaid inpatient volumes and uncompensated care (excluding bad debt).

**Medicare DSH Reductions:** Medicare DSH payments, provided as part of the inpatient PPS, will be reduced by \$22 billion over ten years, beginning in FFY 2014.

25% of DSH payments are considered to be the “empirically justified” component of DSH and will continue to be paid to each hospital based on the current methodology

75% of DSH payments will be subject to reductions to reflect reductions in the uninsured population. For every percentage point reduction in the uninsured rate, DSH funding will be proportionally reduced. The calculation of the reduction in the uninsured population is modified to artificially increase the reduction of uninsured by an additional 0.1 percentage points in 2014 and 0.2 percentage points in 2015 through 2019; thereby increasing the

level of Medicare DSH cuts. After reduction, this portion of DSH funds would be distributed to hospitals based on each hospital's level of uncompensated care compared to total uncompensated care for all hospitals.

## **Medicare Home Health Agency Payment Changes (PPACA Section 3131)**

Savings: U.S.—\$39.7 billion over ten years; Nebraska—\$71.2 million

**Payment Rebasing:** PPACA calls for a rebasing of home health agency (HHA) payment rates, thereby reducing payments. Rebasing would take into account changes in the average number and types of visits per episode, intensity of visits, and growth in cost per episode. Reduced, rebased payments are to be phased-in over four years, beginning in 2014; reductions cannot exceed 3.5% each year.

**Cap on Outlier Payments:** Beginning in 2011, reduces the HHA outlier pool from 5% of total payments to 2.5% and establishes a 10% cap on the reimbursement a home health provider can receive from outlier payments. This mandates the policy that has already been adopted by CMS in its final rate year 2010 rule.

**Rural Home Health Add-on:** Provides a 3% add-on payment for home health service provided to Medicare beneficiaries in rural areas from April 1, 2010 through December 31, 2015.

**Market basket Reductions:** See Medicare Update Factors section above.

## **Medicare Skilled Nursing Facility Payment Changes (PPACA Section 10325)**

**Delay in Implementation of RUGs-IV:** Temporarily delays implementation of Version 4 of the Resource Utilization Groups (RUGs-IV) for one year, from FFY 2011 to FFY 2012. Requires that the Secretary implement a component of RUGs-IV specific to therapy furnished on a concurrent basis. The look-back period is revised to ensure that only those services furnished after admission to a skilled nursing facility are used as factors in determining a case-mix classification under the Skilled Nursing Facility Prospective Payment System.

## **Medicare Rural Provisions (PPACA Sections 3121, 3122, 3123, 3124, 3125, 3126, 3127, 3128, 3129, and 3131)**

Spending: U.S.—\$300 million over ten years; Nebraska—\$1.9 million (excludes the impact of the HHA rural add-on, which is included in the Home Health Agency section above).

**Extension of Outpatient Hold-Harmless Payments:** Extends outpatient PPS hold-harmless payments for one year, through December 31, 2010. These hold-harmless payments are also expanded to apply to all Sole Community Hospitals, not just those with fewer than 100 beds.

**Medicare Dependent Hospitals (MDHs):** Extends the MDH classification, which is set to expire on September 30, 2011, for one additional year, through September 30, 2012.

**Critical Access Hospital Outpatient Payments:** Makes a technical correction clarifying that CAHs which elect an all-inclusive outpatient payment will receive 101% of reasonable costs for facility services, not 100% as interpreted by CMS in the 2010 inpatient rule.

**Clinical Diagnostic Laboratory Services:** Reinstates reasonable cost payment for clinical lab tests performed by hospitals with fewer than 50 beds in qualified rural areas for the period July 1, 2010 through June 30, 2011. A qualified rural area is one with a population density in the lowest quartile of all rural county populations.

**Medicare Payment Adjustment for Low-Volume Hospitals:** Modifies the current low-volume Medicare payment adjustment for FFYs 2011 and 2012. Allows hospitals to qualify for an adjustment if they are more than 15 road miles from another acute hospital and have less than 1,600 discharges during the fiscal year (currently, a low volume hospital must be more than 25 road miles from another acute hospital and have less than 800 discharges). The Secretary is required to determine the low-volume add-on amount using a linear sliding scale ranging from 25% for low-volume hospitals with Medicare discharges below a certain threshold, to no adjustment for hospitals with more than 1,600 Medicare discharges.

**Rural Community Hospital Demonstration Program:** Extends, for five additional years, through December 31, 2014, the rural community hospital demonstration project which provides cost-based inpatient payment for rural hospitals with fewer than 51 beds. The Act also increases the number of participating hospitals from 15 to 30 and expands the eligible sites from the 10 states with the lowest population densities to the 20 lowest density states.

**Rural Home Health Add-on:** See Medicare Home Health Agency Payment Changes section above.

**Expansion of Community Health Integration Models in Rural Areas:** Expands the demonstration which provides cost-based payment for integrated acute and post-acute care service models in certain rural counties within qualifying states. Eligible hospitals must be located in a state in which at least 65 percent of the counties in the state have six or less residents per square mile. The demonstration is restricted to four states selected by the Secretary. The PPACA removes the current limit of six counties per state and extends the demonstration to allow inclusion of physician services.

**MedPAC Review of Medicare Payments for Rural Areas:** Requires MedPAC to review payment adequacy for rural health care providers serving the Medicare program and report to Congress by January 1, 2011.

**Medicare Rural Hospital Flexibility Program:** Extends the "FLEX" program for an additional two years through 2012. Allows Small Rural Hospital Improvement grant program funding to support small rural hospitals' participation in the delivery system reform programs outlined in this legislation (such as VBP, bundling, and accountable care organizations).

## **Medicare Hospital Wage Index (PPACA Sections 3137, 3141 and 10324)**

Spending: U.S.—\$2.3 billion over ten years; Nebraska—Minimal impact

**Wage Index Reform:** PPACA mandates that the Secretary report to Congress by December 31, 2011 with recommendations for comprehensive reform of the Medicare wage index system. The plan is required to take into account the 2007 MedPAC wage index report, including the proposed use of Bureau of Labor Statistics data and the recommended redefinition of wage areas.

**Establishment of a Wage Index Floor for Hospitals and Physicians in Select “Frontier” States:** Establishes a hospital wage index floor of 1.0 for inpatient hospital services (for discharges on or after October 1, 2010) and outpatient services (for services furnished on or after January 1, 2011) in "frontier" states (defined as states where over 50% of the counties have a population density less than 6 persons per square mile). This provision is not subject to budget neutrality. A floor of 1.0 would also apply to the practice expense for physician services provided on or after January 1, 2011 in these frontier states.

**Extension of Section 508 Legislative Medicare Wage Index Reclassifications:** Extends for one year, through September 30, 2010, special Section 508 Medicare hospital wage index reclassifications. By April 1, 2010, CMS must recalculate the reclassified wage indexes to include the data for those hospitals that reclassify under Section 508. If the resulting reclassified wage index value for a Section 508 hospital is higher than the reclassified value paid prior to April 1, the Secretary must retroactively adjust its payments by December 1, 2010.

**Restoration of Medicare Hospital Wage Index Reclassification Thresholds:** Directs the Secretary to restore, for FFY 2011, the lower FFY 2008 Medicare hospital wage index reclassification thresholds used in 2008 to compare hospitals' average hourly wages (AHWs), for the purpose of determining wage index reclassifications (the AHW comparison criterion was made stricter over the past two years).

**Application of Budget Neutrality for the Medicare Hospital Wage Index:** Beginning in FFY 2011, requires that the application of budget neutrality associated with the effect of the Medicare wage index rural floor and imputed rural floor be applied on a national, rather than state-specific basis through a uniform, national adjustment to the area wage index. (The current methodology that applies the wage index floor budget neutrality adjustment at the state level was adopted by CMS in FFY 2009.)

## **Medicare Advantage Payments** (PPACA Section 3201; HCEARA Section 1102)

Savings: U.S.—\$131.9 billion over ten years.

Medicare Advantage (MA) payments are frozen in 2011. Beginning in 2012, phases-in reductions to the Medicare Advantage county-level benchmark rates such that the average MA payment per beneficiary is about 100% of per capita spending for traditional fee-for-service (FFS) Medicare. Adjustments will be made to these benchmarks based measures of spending per capita and on MA plans' performance on quality and patient satisfaction measures. The base benchmarks will range from 95% of FFS spending per capita in the highest cost counties (top quartile) to 115% of FFS in the lowest cost counties (bottom quartile).

## **Independent Payment Advisory Board (IPAB)** (PPACA Section 3403)

Savings: U.S.—\$13.3 billion over ten years.

**Establishment of IPAB:** Establishes an IPAB to submit proposals to Congress beginning in 2014 that would reduce Medicare spending by maximum targeted amounts (0.5 percentage point reduction in 2015 increasing to a 1.5 percentage point reduction in 2018 and beyond) if it is determined that there is excess cost growth in the Medicare program. Congress could modify or pass an alternative to the proposals, but is required to maintain the targeted level of Medicare savings for the year. The Board's original proposal must be implemented if Congress does not consider the Board's proposal.

**Exemption from Board Proposals:** Providers such as hospitals and hospices that are scheduled to receive a reduction to their market basket update in excess of a productivity-based reduction are exempt from any proposed reductions from the Board through 2019. CAHs are not exempt from the Board's proposals.

## **Other Medicare and Medicaid Payment Provisions** (PPACA Sections 10501, 3132, 3138, 3142 and 6411)

**Updating Outpatient Payments for PPS-Exempt Cancer Hospitals:** Requires CMS to conduct a study to determine if the outpatient costs incurred by PPS-exempt cancer hospitals exceed the costs of other hospitals reimbursed under outpatient PPS. If appropriate, CMS will provide an adjustment for services starting January 1, 2011.

**Expansion of the Recovery Audit Contractor (RAC) Program:** The RAC program, which currently audits Medicare Part A and Part B claims, is expanded to include audits of Medicare Parts C and D.

**Expansion of the RAC Program to Medicaid:** By December 31, 2010, each State must establish a similar program for Medicaid under which the State contracts with a recovery audit contractor. Payment to the Medicaid RAC must be made on a contingency basis.

**Medicare Claims Submission:** Beginning January 1, 2010, reduces the maximum period for requests for payment from three years to one year. All requests for payment for services furnished prior to January 1, 2010 must be submitted by December 31, 2010.

**PPS for Federally Qualified Health Centers (FQHCs):** Requires CMS to develop a FQHC PPS system. The PPS will be effective for cost reporting periods beginning on or after October 1, 2014.

**Hospice Payment:** Requires CMS to study possible revisions to the payment rates for hospice care and allows implementation of changes on or after October 1, 2013. The revisions may include adjustments to reflect changes in resource intensity in providing services during the course of the entire episode of hospice care.

**Urban Medicare Dependent Hospital Study:** Requires CMS to study and make recommendations to Congress by November 2010 on whether the Medicare Dependent Hospital (MDH) payment methodology that is currently applied to small rural hospitals should be extended to urban Medicare-dependent hospitals. Urban Medicare-dependent hospitals are defined as facilities with more than 60 percent of inpatient days or discharges covered by Medicare that do not receive any DSH or IME payments.

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## Medicare and Medicaid Delivery System Reforms

### Medicare Readmissions Payment Policy (PPACA Sections 3025 and 3026)

Savings: U.S.—\$7.1 billion over ten years; Nebraska—\$21.0 million

Beginning in FFY 2013, acute care hospitals with higher than expected risk-adjusted readmission rates will receive reduced Medicare payments for every discharge. Payments will be reduced by the lower of a hospital-specific readmissions adjustment factor or a pre-determined floor (see below). In the first two years (FFYs 2013 and 2014), the payment policy will be based on readmissions related to three conditions: heart failure, heart attack, and pneumonia. By the third year (FFY 2015), the payment policy will be expanded to include chronic obstructive pulmonary disease (COPD), coronary artery bypass graft (CABG), percutaneous transluminal coronary angioplasty (PTCA), and other vascular procedures. The Secretary has the authority to expand the policy to additional conditions in future years, including all-cause readmissions.

**Maximum Payment Reduction for Individual Facilities:** 1.0% in FFY 2013, increasing to 3.0% in FFY 2015 and thereafter.

**Sole Community Hospitals and Medicare-Dependent, Small Rural Hospitals:** The payment adjustment for these hospitals will only be applied to the federal portion of the Medicare payment rate (not the hospital-specific amount, if applicable).

**Critical Access Hospitals:** CAHs are not included in the readmissions payment penalty policy.

**Public Reporting of Hospital-Specific Readmissions Rates:** Requires the Secretary to publicly post (on the CMS Hospital Compare website) all-payer readmission rates for identified conditions. This would require hospitals to submit all-payer claims-level data to CMS, either independently or through their state data agency. This provision applies to cancer, children's, rehabilitation, long-term care, and psychiatric inpatient facilities as well.

**Assistance for High Readmission Hospitals:** The Secretary is mandated to establish a quality improvement program by March 2012 for hospitals with high severity-adjusted readmission rates. Eligible hospitals would work with patient safety organizations to implement processes to improve readmission rates. In addition, beginning in January 2011, \$500 million in funding will be available over a five-year period to fund a Community Care Transitions Program for hospitals with high readmission rates and partnership organizations to implement care transitions using evidence-based interventions for targeted high-risk beneficiaries.

**Post-Acute Care Providers:** Requires reporting of all-patient claims data for posting of readmission rates on the Hospital Compare site (see above).

## **Establishment of a Medicare Value-Based Purchasing (VBP) Program (PPACA Sections 3001, 3006, 3007, and 10326)**

Savings: Budget neutral

**Inpatient Hospitals:** The Medicare VBP payment program begins in FFY 2013 (reporting begins in FFY 2012) and will be budget-neutral, with each year's funding pool fully distributed to hospitals in that same year. The VBP program will be funded by Medicare inpatient payment reductions, beginning with a 1.0% reduction in FFY 2013 and increased by 0.25% each year until the reduction reaches 2.0% for FFY 2017 and subsequent years.

The VBP program applies to all "subsection (d)" inpatient hospitals—all hospitals under the Inpatient Prospective Payment System (PPS) excluding psychiatric, rehabilitation, children's, cancer, and long-term care hospitals. Critical Access Hospitals (CAHs) and small hospitals with insufficient numbers of measures and/or cases are excluded from the program. The PPACA mandates that, within two years, the Secretary establish two separate, three-year VBP demonstration programs, one for CAHs and one for the small excluded hospitals. Each of the demonstration programs are to culminate in a report to Congress and recommendations for permanent VBP programs.

The Secretary is responsible for selecting measures, determining the scoring methodology, and determining the payment methodology. Hospitals that meet or exceed a performance standard set by the Secretary will be eligible to earn back the money contributed to the pool. The methodology must recognize both achievement of standards and improvement. Hospital

scores will be determined in advance of the payment year using data from a prior period and hospitals that meet or exceed standards will receive an increase in the payment rate for that year.

In FFY 2013, measures must cover at least the following conditions: acute myocardial infarction (AMI), heart failure, pneumonia, surgeries from the Surgical Care Improvement Project, and healthcare-associated infections. Measures must also be selected related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS). No earlier than FFY 2014, the Secretary is required to include efficiency measures (including adjusted Medicare spending per beneficiary) as part of the VBP program. The use of readmissions measures as part of the VBP program is expressly prohibited.

**Post-Acute Care Providers and Ambulatory Surgical Centers:** The Secretary must submit plans to Congress for VBP programs for home health providers and skilled nursing facilities by October 1, 2011 (FFY 2012). A VBP plan for ambulatory surgical centers must be submitted by January 1, 2011.

**Physicians:** Establishes a value-based payment modifier that allows for differential payments to physicians based upon quality and cost indicators.

**VBP Pilot Programs:** Beginning in 2016, the Secretary is required to implement pilot programs to test VBP payments for inpatient psychiatric facilities, long-term care hospitals, inpatient rehabilitation facilities, cancer hospitals, and hospice programs. The pilots must be budget neutral. The programs may be expanded beginning in 2018.

## **Establishment of Delivery System Reform Programs, Pilots, and Demonstration Projects** (PPACA Sections 2704, 2705, 2706, 2707, 3022, 3023, 10308, and 10504)

Savings: U.S.—\$4.9 billion over ten years.

**Medicaid Demonstration Projects:** The Secretary is authorized to conduct the following Medicaid demonstration projects:

- Medicaid bundled payment demonstrations to evaluate integrated care around a hospitalization, in up to eight states beginning in 2012;
- Medicaid global payment demonstrations for safety net hospitals in up to five states beginning in 2010;
- Pediatric Accountable Care Organization demonstrations beginning in 2012; and
- Medicaid emergency psychiatric demonstration projects beginning in 2011.

**Medicare Payment Bundling Pilot:** The Secretary will implement a national pilot program for bundling payments in 2013.

CMS will select ten conditions to be included in the pilot program. The bundled service would include care delivered three days prior to hospital admission and extend through 30 days following discharge; and would cover:

- acute care inpatient services including readmissions;
- outpatient hospital services including emergency room;
- physician care, including services in and out of the hospital; and
- post-acute care, including home health services, skilled nursing facility, inpatient rehabilitation, and long-term care hospital services.

An entity comprised of providers, including a hospital; a physician group; a skilled nursing facility; and a home health agency, could submit an application to join the pilot program. The Secretary is required to consult with representatives of small rural hospitals and Critical Access Hospitals regarding their participation in the pilot program.

The Secretary will develop bundled payment rates and will test payments based on bids submitted by the entities. Annual payments under the pilot to a single entity may not exceed what would otherwise be paid for the same services under the current Medicare program(s).

The Secretary may expand the duration and scope of the pilot at any time after January 1, 2016, if he/she determines the extension would result in improving the quality of patient care and reducing spending. In 2016, CMS must report to Congress on the results of the pilot program.

**Medicare Accountable Care Organizations (ACOs):** Establishes a program, beginning in 2012, to allow groups of providers to be recognized as ACOs and share in the cost savings they achieve for the Medicare program.

Hospitals can take the lead in formation of an ACO and ACOs may include:

- group practice arrangements;
- networks of individual physician practices;
- partnerships or joint-venture arrangements between hospitals and practitioners; and
- hospitals employing practitioners.

To qualify, the organization must act as the primary care provider for at least 5,000 Medicare fee-for-service beneficiaries. ACO providers must agree to participate for at least three years.

Hospitals and other providers in the ACO would be allowed to share in the Medicare cost savings they achieve if: 1) the ACO meets quality performance standards established by the Secretary; and 2) average per capita Medicare expenditures are below a benchmark based on the claim history and characteristics of the patients assigned to the ACO.

**Demonstration Project to Provide Access to Affordable Care:** Within 6 months after enactment of PPACA, the Secretary (acting through HRSA) must establish a 3-year demonstration in 10 states to provide access to comprehensive health care services to uninsured individuals at reduced fees.

## **Addressing Geographic Variation in Health Spending (PPACA Section 3001; HCEARA Section 1109)**

Spending: U.S.—\$400 million over two years

**Use of Efficiency Measures in VBP:** Requires the Secretary to include efficiency measures in an inpatient hospital VBP program by FFY 2014. Measures of Medicare spending per beneficiary adjusted for age, sex, race, severity of illness, and other factors that the Secretary determines to be appropriate must be included.

**Payments to Qualifying Hospitals:** Beginning in FFY 2011, HCEARA provides new Medicare funding - \$400 million over two years - to be allocated to hospitals located in counties within the lowest quartile of total Medicare Part A and Part B spending per enrollee nationwide. Spending must be adjusted to account for age, sex, and race.

## **Medicare and Medicaid Health Care-Acquired Conditions (HAC) Payment Policies (PPACA Sections 2702 and 3008)**

Savings: U.S.—\$1.4 billion over ten years

The PPACA extends the existing Medicare HAC policy to the Medicaid program. Medicare currently reduces payments to hospitals for cases in which one of a select number of secondary diagnoses was not present on admission and, therefore, considered to be health care-acquired.

**Medicare HAC Payment Policy:** Beginning in FFY 2015, hospitals in the worst 25th percentile of risk-adjusted HAC rates will be subject to a 1.0% payment penalty under Medicare. The reduction will be applied in addition to current CMS payment adjustments for HACs. The Secretary must publicly report on hospitals' HAC measures and is required to study and report to Congress by January 1, 2012 on expanding the HAC policy to inpatient rehabilitation facilities, long-term care hospitals, hospital outpatient departments, skilled nursing facilities, ambulatory surgical centers, health clinics, and other hospitals excluded from the Inpatient PPS.

**Medicaid HAC Payment Policy:** Beginning on July 1, 2011, state Medicaid programs must adopt policies ensuring that higher Medicaid payments are not made for cases with conditions covered by the Medicare HAC policy. The Secretary may exclude certain Medicare HACs determined to be inapplicable to Medicaid populations.

## **Expansion of Medicare and Medicaid Quality Reporting Programs (PPACA Sections 2701, 3002, 3004, 3005, 3011 - 3015, 10322 and 10331)**

The Secretary is required, through a transparent collaborative process, to establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health. The Secretary shall collaborate, coordinate, and consult with the state

agencies responsible for administering the Medicaid program and the Children's Health Insurance Program with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with national priorities.

The PPACA calls for the creation of an Interagency Working Group to coordinate and streamline federal quality activities. The Group's first report must be issued no later than December 31, 2010.

**Pay-for-Reporting:** Implements Medicare pay-for-reporting programs for long-term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, and hospice providers in 2014. Providers that do not report will be subject to a two percentage point reduction in their annual market basket update. Mandatory physician reporting is established beginning in 2015 with comparable penalties for non-compliance (a 2% reduction to payments by 2016).

**Additional Medicare Quality Reporting:** Requires reporting of quality and efficiency measures for cancer hospitals in 2014.

**Quality Compare Websites:** The Secretary is mandated to improve the functionality and ease of use for the various CMS quality comparison websites. The Secretary must make all data reported by providers under the pay-for-reporting program available for public inspection via the quality comparison websites.

**Physician Compare Website:** No later than January 1, 2013, the Secretary shall implement a plan for making publicly available, through a Physician Compare website, information on physician performance that provides comparable information on quality and patient experience measures with respect to physicians enrolled in Medicare. To the extent scientifically sound measures are available, such information, to the extent practicable, shall include measures collected under the Physician Quality Reporting Initiative; an assessment of patient health outcomes and the functional status of patients; an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use; an assessment of efficiency; an assessment of patient experience and patient, caregiver, and family engagement; an assessment of the safety, effectiveness, and timeliness of care; and other information as determined appropriate by the Secretary.

**Medicaid Quality Measurement and Reporting:** No later than January 1, 2011, the Secretary must identify and publish priorities for the development and advancement of quality measures for adults in the Medicaid program. These measures are to be reported and used by providers, state Medicaid programs, and health insurers (including managed care entities) that contract with state entities.

By January 1, 2012, the Secretary must publish an initial core set of adult health quality measures that are applicable to Medicaid eligible adults. By January 1, 2013, the Secretary, in consultation with states, must develop a standardized format for reporting information based on the initial core set of adult health quality measures and create procedures to encourage states to use those measures to voluntarily report information regarding the quality of health care for Medicaid eligible adults.

No later than 12 months after the release of the recommended core set of adult health quality measures (January 1, 2013), the Secretary is to establish a Medicaid Quality Measurement Program. Beginning not later than 24 months after the establishment of the Medicaid Quality Measurement Program, and annually thereafter, the Secretary shall publish recommended changes to the initial core set of adult health quality measures.

A similar program for Medicaid/CHIP eligible children was enacted under the Child Health Insurance Program Reauthorization Act (CHIPRA) of 2009.

### **CMS Center for Medicare and Medicaid Innovation (CMI) (PPACA Section 3021)**

Savings: U.S.—\$1.3 billion over ten years.

By 2011, the Center for Medicare and Medicaid Innovation (CMI) will be established to test innovative payment and service delivery models to improve the coordination, quality, and efficiency of health care services provided to Medicare and Medicaid beneficiaries. Gives preference to models for which there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.

The Secretary may expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested or a demonstration project to the extent determined appropriate, if the Secretary determines that such expansion is expected to reduce spending under the Medicare and/or Medicaid program without reducing the quality of care; or improve the quality of care and reduce spending; and the Chief Actuary of CMS certifies that such expansion would reduce the Medicare and/or Medicaid program.

The Secretary is required to report to Congress every other year beginning in 2012 on the model tested under the CMI and make recommendations for legislative action to facilitate the development and expansion of successful payment models. Funding is set at \$5 million in FFY 2010, \$10 billion for the period FFY 2011 through 2019, and an additional \$10 billion for each subsequent ten-year period.

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## **Additional Provider Issues**

### **Medicare Graduate Medical Education (GME) (PPACA Sections 5503, 5504, and 5506)**

Spending: U.S.—\$1.1 billion over ten years.

GME payments to hospitals are protected, maintaining current levels of funding for Indirect Medical Education and Direct Medical Education in perpetuity.

**Redistribution of Unused Resident Slots:** Effective July 1, 2011, redistributes 65% of the currently unused training slots. Unused slots will be based on each hospital's highest resident level in any of the three most recent cost reporting periods prior to July 1, 2011. Rural hospitals with less than 250 beds and hospitals that participated in voluntary reduction programs are exempt from reductions. Hospitals may apply to receive up to 75 additional residency positions. In return, the hospital will be required to use at least 75% of the increase for primary care or general surgery residency and to maintain its quantity of primary care residents. Priority will be given to hospitals located in states with low resident-to-population ratios; hospitals in one of the top ten states for the ratio of the total population living in a Health Professional Shortage Area (HPSA); and hospitals located in rural areas.

**Preservation of Resident Slots from Closed Hospitals:** Resident slots from closed hospitals will be redistributed using a process to be determined by the Secretary. Priority will be given to other hospitals within the same Core-based Statistical Area (CBSA), followed by hospitals within the same state. This includes hospitals that have closed up to two years prior to enactment.

**Resident Time in Non-Provider Settings:** Allows hospitals to be paid for resident training in non-hospital settings if the hospital incurs the costs of the stipends and fringe benefits for the resident. Further, hospitals are now allowed to count time spent by a resident in non-patient care activities such as didactic conferences and seminars.

### **Hospital Reporting of Charges (PPACA Section 1001)**

Effective for FFY 2011, requires hospitals to publicize a list of standard charges for items and services provided by the hospital, including DRGs.

### **New Requirements Applicable to Tax-Exempt Status (PPACA Section 9007)**

Establishes the following additional criteria for hospitals to maintain their Section 501(c)(3) tax-exempt status:

- implementation of strategies to meet community needs - based on the findings of periodic health needs assessments;
- adoption of a financial assistance policy with criteria to qualify, basis for payment and defined collection policies;
- limitation of charges for those who qualify for financial assistance to no more than the amounts generally billed to those with insurance, and prohibits the use of gross charges; and
- requirement that 501(c)(3) hospitals not engage in extraordinary collection actions.

In addition to meeting all four reporting requirements to maintain tax-exempt status, a \$50,000 excise tax will apply for hospitals that fail to meet the community health plan requirements.

The Internal Revenue Service is required to review information about a hospital's community benefit activities at least once every three years.

The Secretary is required to report to Congress on the levels of charity care, bad debt, unreimbursed costs of non means-tested government programs, and the cost of community benefit activities incurred by tax-exempt, taxable, and government hospitals.

### **340B Drug Discount Program** (PPACA Section 7101; HCEARA Section 2302)

**Extension of 340B Program:** Beginning January 1, 2010, extends access to the 340B program to certain children's and cancer hospitals, CAHs, Sole Community Hospitals (SCHs), and Rural Referral Centers (RRCs). SCHs and RRC must have a DSH adjustment percentage equal to or greater than 8 percent; children's and cancer hospitals must meet the same DSH requirements as other subsection (d) hospitals – a minimum DSH percentage of 11.75%; CAHs are exempted from the DSH requirement. The program is not extended to Medicare Dependent Hospitals.

### **Medical Liability Reform** (PPACA Section 6801)

The Secretary is authorized to award \$50 million in demonstration grants to states over a period of five years, beginning FFY 2011, for the development, implementation, and evaluation of alternatives to the existing civil litigation system. Each state desiring a grant is required to develop an alternative to current tort litigation that allows for the resolution of disputes over injuries allegedly caused by health care providers or health care organizations, and promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes resolved by organizations that engage in efforts to improve patient safety and the quality of health care.

### **Nursing Home Reporting Requirements** (PPACA Sections 6102 through 6107)

Skilled nursing facilities are required to provide information on the ownership and governing body of the facility, staffing, and wages and benefits. CMS is required to publically report data on staffing, number of substantiated complaints, and criminal violations by a facility or its employees. Nursing homes are required to operate a compliance and ethics program.

### **Medically Underserved Populations and Health Professions Shortage Areas** (PPACA Section 5602)

The Secretary is required to initiate a negotiated rulemaking process to establish a methodology and criteria for designation of medically underserved populations and health professions shortage areas.

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## Health Insurance Market Reforms

(PPACA Sections 1001, 1002, 1003, 1005, 1201, 1251 – 1253, and 1301 - 1304)

**No Lifetime or Annual Limits:** Six months after enactment, health plans must eliminate lifetime, annual, or unreasonable limits on coverage. The law, however, does not prevent a plan that does not provide essential health benefits, as defined by the Secretary, from placing per beneficiary limits on specific covered benefits.

**Prohibition of Rescissions:** Six months after enactment, the ban on the practice where insurers retroactively cancel health coverage will be extended to employer-based group policies, except in the case of fraud.

**Medical Loss Ratio (MLR):** Six months after enactment, the minimum required MLR for the group market will be 80%. The minimum MLR required for the individual market will be 75%. State law that requires a higher MLR will preempt this new federal standard, unless the Secretary determines the State's minimum MLR may destabilize the individual market.

Each year, health plans must submit a report detailing the percent of total premium revenue that is spent on provider reimbursement, activities that improve health care quality, and all other non-claim costs, excluding taxes. The report will be made public on the Health and Human Services (HHS) website.

**Appeals Process:** Six months after enactment, health plans must have in place an effective process for appeals of coverage determinations and claims. At a minimum a plan must:

- Have in effect an internal claim appeal process;
- Provide notice to enrollees of available internal and external appeals processes;
- Allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of an appeal; and
- Provide an external review process that includes the consumer protections set forth in the Uniform Review Model Act. The Act, promulgated by National Association of Insurance Commissioners (NAIC), establishes standardized protocols for external review to ensure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination regarding benefits for specific procedures or services.

**Annual Review of Premiums:** Six months after enactment, the Secretary, in cooperation with States, will establish a process for the annual review of unreasonable increases in premiums. The process will require health plans to submit a justification for an unreasonable premium increase prior to the implementation of the increase. The plan must also prominently post the justification on its website.

In 2014, the Secretary and the states will begin monitoring premium increases offered through and outside of an exchange. When determining whether to offer a health plan in the large

group market through an exchange the state must take into account excess premium growth outside of the exchange compared to the rate of premium growth inside the exchange.

**Mandated Coverage for Preventive Health Services:** Six months after enactment, a health plan must provide coverage without cost-sharing requirements for certain preventive care services.

**Extension of Non-discrimination Rules:** Six months after enactment, health plans may not discriminate in favor of highly compensated employees in terms of eligibility to participate and the level of benefits under a plan.

**Uniform Coverage Documents:** Plans must provide a summary explanation that accurately describes benefits and coverage to participants prior to enrollment. The Secretary will provide standards for developing the summary by 2011 and plans will be required to distribute the new summary by 2013.

**Ensuring Quality of Care:** By 2012 the Secretary will develop reporting requirements for use by health plans aimed at improving health outcomes. These reporting requirements may affect provider reimbursement. The Secretary will also promulgate regulations that will provide criteria for determining a reimbursement structure aimed at improving health outcomes.

**Guaranteed Availability and Renewability of Coverage:** Beginning in 2014, health plans that offer coverage must accept every employer and individual that applies for coverage. The plan must also renew or continue to offer coverage for all members.

**Waiting Period Restrictions:** Beginning in 2014, Health plans may not impose any waiting period in excess of 90 days.

**No Discrimination Based on Health Status:** Beginning in 2014, health plans may not establish rules for eligibility to enroll based on the individual's health status.

**Mandated Coverage for Clinical Trials:** Beginning in 2014, health plans cannot deny participation of a qualified individual in a clinical trial, deny coverage of routine costs in connection with the clinical trial, or discriminate on the basis of participation in a clinical trial.

**Fair Health Insurance Premiums:** Beginning in 2014, premium rates may only vary by:

- Whether the plan covers an individual or family;
- Rating area (to be established by the State);
- Age – may not vary more than 3:1 for adults; and/or
- Tobacco use – may not vary more than 15:1

**Mandated Cost-Sharing Limits:** Beginning in 2014, health plans must limit cost-sharing amounts to the limits applicable to high deductible health plans. Group health plans cannot have deductibles that exceed \$2,000 for single coverage or \$4,000 for any other coverage. These amounts are subject to cost-of-living adjustments after 2014.

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## **Administrative Simplification**

### **(PPACA Section 1104)**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has been amended to ensure the establishment of uniform standards and requirements for electronic transmission of health information and to reduce the clerical burden on patients, healthcare providers, and health plans.

All standards and associated operating rules for Health Information Technology (HIT) adopted by the Secretary will:

- Enable determination of individual's eligibility and financial responsibility for services prior to or at the point of care;
- Require minimal augmentation by paper or other communications;
- Provide for timely acknowledgement, response, and status reporting that supports a transparent claims and denial management process, including adjudication and appeals; and
- Describe all data elements, including reason and remark codes, in unambiguous terms and all data elements will be required.

The Secretary will adopt a single set of operating rules for each HIT transaction with the goal of creating as much uniformity in the implementation of the electronic standards as possible.

Eligibility and claim status - may include the use of machine readable ID cards

- Rules will be adopted July 1, 2011
- Rules must be in effect January 1, 2013

# EXECUTIVE SUMMARY

Nebraska hospitals continue to do much more than care for the sick and injured among us. Providers go beyond the delivery of core health care services, providing a safety net 24 hours per day, 7 days per week. Nebraska's hospitals provide compassionate care for all, regardless of a patient's ability to pay. This is evident in the nearly **\$828 million** in community benefits reported in the *2009 Nebraska Hospitals Community Benefits Report*.

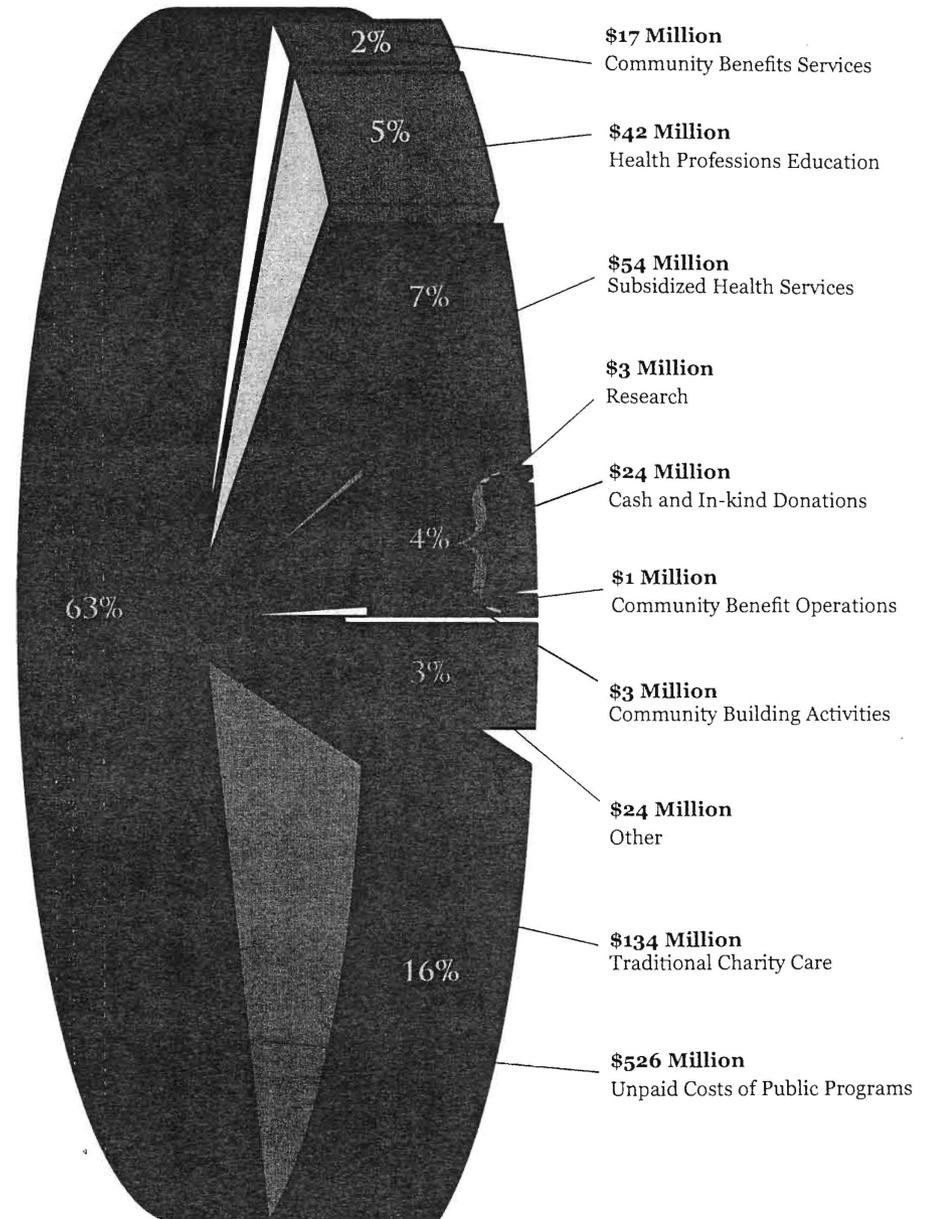
Aside from offering traditional charity care, hospitals provide community benefits in other forms, such as community health education and outreach, health professions education, research, subsidized health services and community activities. These nontraditional community benefits—both on the hospital campus and beyond the hospital walls—improve health status, increase access to care and enhance the quality of their communities' lives.

The impact of hospitals on our communities may be felt in other ways. Nebraska hospitals contribute to the economy by creating jobs and generating business. In fact, Nebraska hospitals employ nearly 42,000 individuals, resulting in over 83,000 jobs in the state created due to hospital jobs. The health care sector is an economic mainstay, providing stability and even growth during times of recession.

The stories and pictures in this publication are examples of how Nebraska hospitals go far beyond the delivery of traditional hospital care to bring health-related services to the people of their communities to make our state a better place to live, work, learn and grow. The value of hospitals is more than you see in any one example of care or in any one set of numbers. It is in all the ways our hospitals are caring for Nebraskans.

Total Value of Community Benefits Provided by Nebraska's Hospitals

**\$828 MILLION**



# COMMUNITY BENEFITS AT-A-GLANCE

Programs and Services	FY '08 Net Community Benefit
Benefits for Low-income/Public Programs	\$660,267,514
Traditional charity care	134,337,670
Unpaid Cost of Public Programs:	
Medicare	379,468,388
Medicaid	134,125,368
Other public programs	12,336,088
Community Benefits Services	17,175,482
Community health education and outreach	9,557,501
Community-based clinical services	1,281,355
Health care support services	6,336,625
Health Professions Education	42,424,252
Scholarships/funding for health professions	6,352,986
Residences and internships	23,425,518
Other	12,645,748
Subsidized Health Services	54,027,763
Emergency and trauma care	7,773,757
Neonatal intensive care	3,445,550
Community clinics	2,074,805
Hospital outpatient services	12,665,093
Women's and children's services	2,653,678
Subsidized continuing care	3,478,198
Behavioral health services	2,128,015
Palliative care	8,379,509
Other subsidized health services	11,429,158

Programs and Services	FY '08 Net Community Benefit
Research	2,625,305
Cash and In-kind Donations	23,903,381
Community Building Activities	3,072,701
Physical improvements and housing	281,404
Economic development	243,500
Community support	416,152
Environmental improvements	21,997
Leadership development/training	33,438
Coalition building	805,962
Advocacy for community issues	191,672
Workforce development	1,078,576
Community Benefit Operations	871,703
Other	23,562,899
<b>TOTAL COMMUNITY BENEFITS</b>	<b>\$827,931,000</b>
<b>BAD DEBT</b>	<b>175,428,276</b>
<b>TOTAL CONTRIBUTIONS</b>	<b>\$1,003,359,276</b>

Sixty-nine of the 85 NHA member hospitals participated in the 2009 Nebraska Hospitals Community Benefits Survey.

- The data represents the aggregate results of the community benefits inventory for each reporting hospital's fiscal year 2008 activities.
- Data reported for fiscal year 2008 includes additional categories, aligning with the new IRS Form 990 and its Schedule H.

# COMMUNITY BENEFITS COMPARISON

Programs and Services	FY '07 Net Community Benefit	FY '08 Net Community Benefit
<b>Benefits for Low-income/Public Programs</b>	<b>\$593,134,000</b>	<b>\$660,267,514</b>
Traditional charity care	116,434,000	134,337,670
<b>Unpaid Cost of Public Programs:</b>		
Medicare	345,878,000	379,468,388
Medicaid	122,104,000	134,125,368
Other public programs	8,718,000	12,336,088
<b>Community Benefits Services</b>	<b>16,633,000</b>	<b>17,175,482</b>
Community health education and outreach	8,290,000	9,557,501
Community-based clinical services	2,207,000	1,281,355
Health care support services	6,136,000	6,336,625
<b>Health Professions Education</b>	<b>43,791,000</b>	<b>42,424,252</b>
Scholarships/funding for health professions	7,170,000	6,352,986
Residences and internships	25,256,000	23,425,518
Other	11,365,000	12,645,748
<b>Subsidized Health Services</b>	<b>49,252,000</b>	<b>54,027,763</b>
Emergency and trauma care	5,564,000	7,773,757
Neonatal intensive care	1,680,000	3,445,550
Community clinics	2,494,000	2,074,805
Hospital outpatient services	12,468,000	12,665,093
Women's and children's services	2,316,000	2,653,678
Subsidized continuing care	2,572,000	3,478,198
Behavioral health services	2,281,000	2,128,015
Palliative care		8,379,509
Other subsidized health services	19,877,000	11,429,158

Programs and Services	FY '07 Net Community Benefit	FY '08 Net Community Benefit
Research	2,547,000	2,625,305
Cash and In-kind Donations	13,507,000	23,903,381
<b>Community Building Activities</b>	<b>2,176,000</b>	<b>3,072,701</b>
Physical improvements and housing	420,000	281,404
Economic development	114,000	243,500
Community support	856,000	416,152
Environmental improvements	31,000	21,997
Leadership development/training	15,000	33,438
Coalition building	337,000	805,962
Advocacy for community issues	195,000	191,672
Workforce development	208,000	1,078,576
Community Benefit Operations	911,000	871,703
Other	19,496,000	23,562,899
<b>TOTAL COMMUNITY BENEFITS</b>	<b>\$741,446,000</b>	<b>\$827,931,000</b>
<b>BAD DEBT</b>	<b>151,792,000</b>	<b>175,428,276</b>
<b>TOTAL CONTRIBUTIONS</b>	<b>\$893,238,000</b>	<b>\$1,003,359,276</b>

The data includes an analysis of community benefits between fiscal year 2007 and fiscal year 2008.

- Over **\$86 million** MORE in community benefits were reported in 2008 than in 2007.
- Sixty-nine hospitals provided fiscal year 2008 data, while 76 hospitals reported data for fiscal year 2007.
- Data reported for fiscal year 2008 includes additional categories, aligning with the new IRS Form 990 and its Schedule H.

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Department of Health & Human Services



*Division of Medicaid and Long-Term Care*

## **Nebraska Medicaid Reform Annual Report**

**September 15, 2010**

**Draft prepared for the Medicaid Reform Council in Accordance  
with Neb. Rev. Stat. § 68-908(4)**

**Prepared by  
Vivianne M. Chaumont, Director  
Division of Medicaid and Long-Term Care  
Department of Health and Human Services**

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**Nebraska Medicaid Reform Annual Report**  
**Neb. Rev. Stat. § 68-908(4)**

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**Nebraska Medicaid Reform Biennial Report**  
**Neb. Rev. Stat. § 68-908(4)**

**I. Introduction**

Medicaid reform was mandated by the Nebraska Legislature in LB 709 (2005), the Medicaid Reform Act (Neb. Rev. Stat. §§ 68-1087 to 68-1094; LB 709, §§ 1-8). The Act mandated "fundamental reform" of the state's Medicaid program and a significant rewriting of Medicaid-related statutes. The Nebraska Medicaid Reform Plan was submitted to the Governor and Legislature on December 1, 2005. Following submission of the Nebraska Medicaid Reform Plan, the Legislature adopted the Medical Assistance Act (Neb. Rev. Stat. §§ 68-901 to 68-949; LB 1248 (2006)). The Medical Assistance Act substantially recodified statutes relating to the Medicaid Program with an emphasis on continuing the reform efforts initiated with LB 709 (2005).

The motivation for Medicaid reform remains the same. The findings the Legislature documented in Neb. Rev. Stat. § 68-904 have not changed: many low-income Nebraskans have health care needs and are unable, without assistance, to meet those needs; Medicaid provides essential coverage for necessary health care for eligible low-income Nebraska children, pregnant women and families, aged persons and persons with disabilities; and Medicaid alone cannot meet all the health care needs of all low-income Nebraskans. Nebraska must continue to address the rate of growth in expenditures of the Medicaid program. The program is unsustainable if expenditures regularly grow at a rate faster than General Fund revenues.

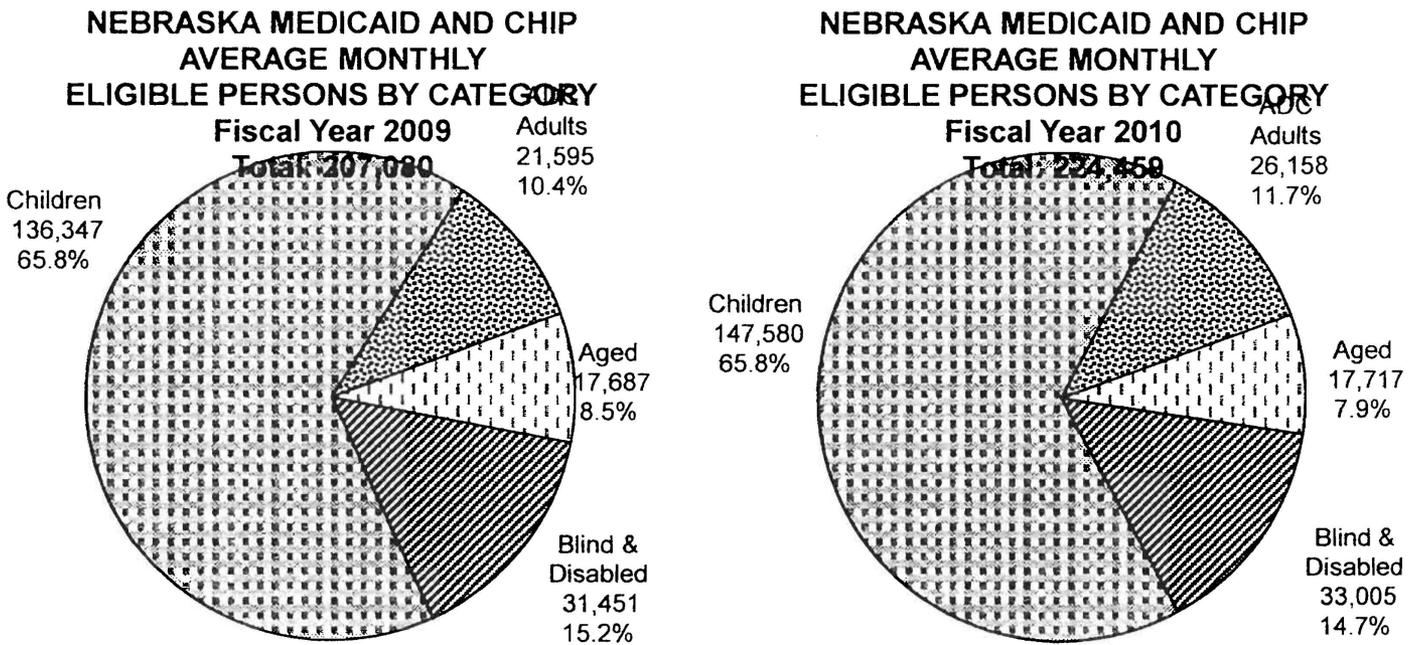
This report meets the reporting requirements of Section 68-908(4) which states that the Department of Health and Human Services (DHHS) shall prepare an annual summary and analysis of the Medicaid Program for legislative and public review, including, but not limited to, a description of eligible recipients, covered services, provider reimbursement, program trends and projections, program budget and expenditures, the status of implementation of the Medicaid Reform Plan, and recommendations for program changes.

**II. Discussion**

**A. Eligible Recipients**

Nebraska Medicaid provides coverage for the following eligibility categories: Children, ADC Adults, Aged, and Blind and Disabled. Figure 1 compares client eligibility by category for State Fiscal Years (SFY) 2009 and 2010.

Figure 1

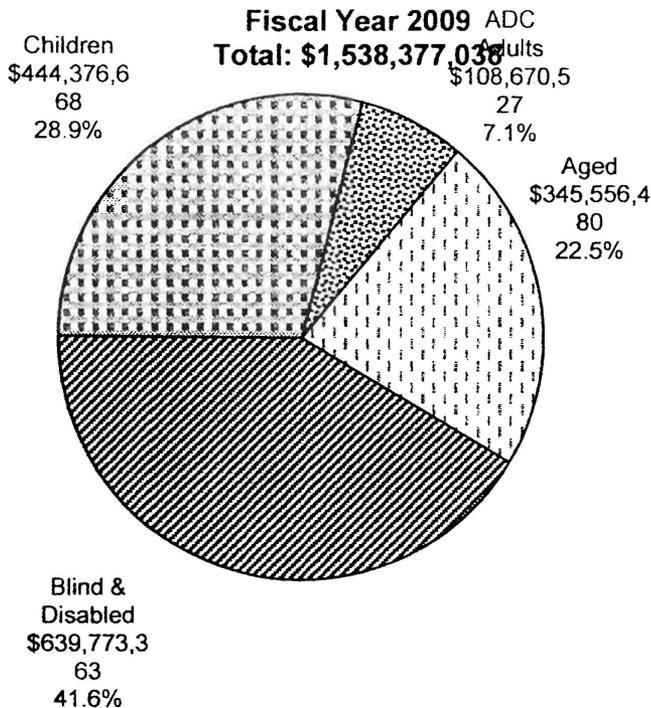


The total increase in average monthly eligibles from SFY 2009 to SFY 2010 was 8.4%. The largest percentage increase was in the Aid to Dependent Children (ADC) Adults category, which grew 21.1%. Average monthly eligibles in the Blind and Disabled category grew by 4.9%, while the Children increased by 8.2%, and eligibles in the Aged category increased by 0.2%. (Figure 1)

Growth in Medicaid eligibility, which had been moderate from SFY 2006 through SFY 2008, experienced a significant increase in the latter half of SFY 2009 that continued until the first half of SFY 2010. This is likely the result of the economic downturn. Historically, Nebraska has been affected late by such downturns and has then lagged in its recovery. Assuming continued pressure on Medicaid caseloads due to weak economic conditions and factoring in the statutory expansion of Children’s Health Insurance Program (CHIP) eligibility to 200% FPL in LB 603, eligibility is projected to increase 6.6% in SFY 2011 and 3.8% in SFY 2012.

Figure 2

**NEBRASKA MEDICAID AND CHIP  
VENDOR EXPENDITURES BY  
ELIGIBILITY**



**NEBRASKA MEDICAID AND CHIP  
VENDOR EXPENDITURES BY ELIGIBILITY**

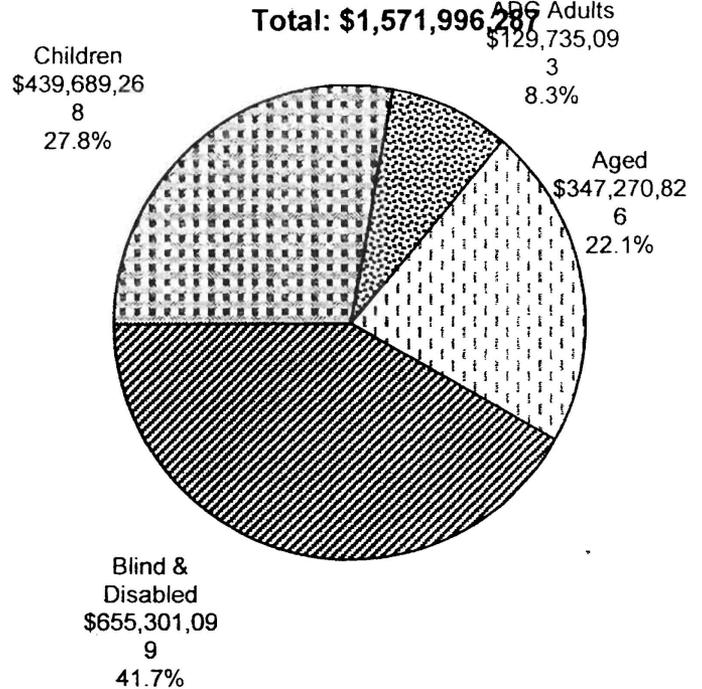


Figure 2 compares vendor expenditures by eligibility category for SFYs 2009 and 2010. The graphic does not account for all Medicaid expenditures, in part because some payments and refunds are not specific to a recipient or eligibility category. Examples of transactions not shown are drug rebates, payments made outside the claims processing systems, and premium payments paid on behalf of persons eligible for Medicare. (See detail on page 7).

Total Medicaid vendor expenditures experienced an increase of 2.2% from SFY 2009 to SFY 2010. The largest increase in expenditures was in the Aid to Dependent (ADC) Adult category, which increased by 19.4% from SFY 2009 to SFY 2010. Blind & Disabled expenditures were the second fastest growing category, increasing by 2.4% from SFY 2009 to SFY 2010, followed by Aged, which increased at 0.5%. Expenditures for Children decreased by 1.1%.

The average monthly cost per eligible decreased 5.7% from SFY 2009 to SFY 2010. The only cost per eligible increase was in the Aged category, which increased by 0.3%, Blind and Disabled decreased by 2.4%. Medicaid expenditures per eligible decreased by 1.4% for ADC Adults and by 8.6% for Children.

**B. Covered Services**

Federal Medicaid statutes mandate states to provide certain services and allow states the option of providing a choice of others. The Nebraska Medical Assistance Act delineates the mandatory and optional services offered in Nebraska.

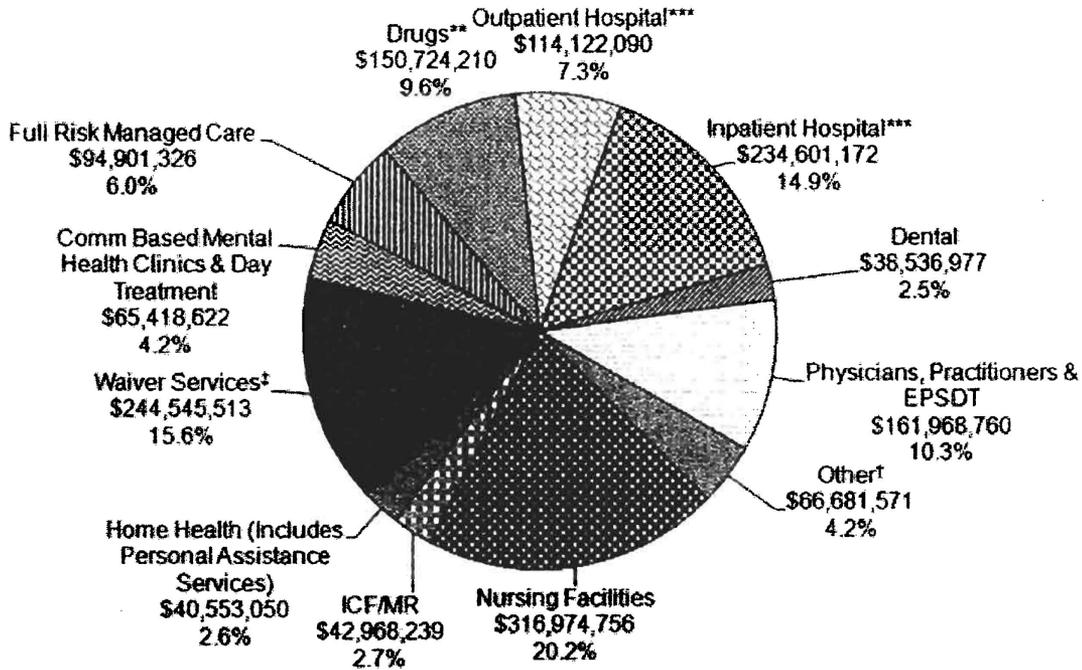
**Federal Medicaid Mandatory and Optional Services Covered in Nebraska**  
**(Neb. Rev. Stat. § 68-911)**

<b>Mandatory Services</b>	<b>Nebraska Optional Services</b>
<ul style="list-style-type: none"> <li>• Inpatient and outpatient hospital services</li> <li>• Laboratory and x-ray services</li> <li>• Nursing facility services</li> <li>• Home health services</li> <li>• Nursing services</li> <li>• Clinic services</li> <li>• Physician services</li> <li>• Medical and surgical services of a dentist</li> <li>• Nurse practitioner services</li> <li>• Nurse midwife services</li> <li>• Pregnancy-related services</li> <li>• Medical supplies</li> <li>• Early and periodic screening and diagnosis treatment (EPSDT) services for children</li> </ul>	<ul style="list-style-type: none"> <li>• Prescribed drugs</li> <li>• Intermediate care facilities for the mentally retarded (ICF/MR)</li> <li>• Home and community-based services for aged persons and persons with disabilities</li> <li>• Dental services</li> <li>• Rehabilitation services</li> <li>• Personal care services</li> <li>• Durable medical equipment</li> <li>• Medical transportation services</li> <li>• Vision-related services</li> <li>• Speech therapy services</li> <li>• Physical therapy services</li> <li>• Chiropractic services</li> <li>• Occupational therapy services</li> <li>• Optometric services</li> <li>• Podiatric services</li> <li>• Hospice services</li> <li>• Mental health and substance abuse services</li> <li>• Hearing screening services for newborn and infant children</li> <li>• School-based administrative services</li> </ul>

**Expenditures**

Medicaid expenditures to vendors in SFY 2010 totaled \$1,571,996,287. Figure 3 shows the services by vendor type. It does not include drug rebates, payments made outside the claims processing systems, or premium payments made on behalf of Medicare eligibles.

**Figure 3**  
**NEBRASKA MEDICAID AND CHIP VENDOR EXPENDITURES\* BY SERVICE**  
**FISCAL YEAR 2010**  
**Total Vendor Payments \$1,571,996,287**



\* Includes payments to vendors only, not adjustments, refunds or certain payments for premiums or services paid outside the Medicaid Payment System (MMIS) or NFOCUS.

\*\* \$51.9 million in offsetting drug rebates is not reflected in the drug expenditures of \$150,724,210

\*\*\* DSH payments of \$37.7 million are not reflected in Inpatient or Outpatient Hospital Expenditures

† Includes Speech/ Physical Therapy, Medical/Optical Supplies, Ambulance, and Lab/Radiology

‡ Developmental Disabilities, Aged & Disabled, Traumatic Brain Injury, Early Intervention Expenditures may not sum due to rounding.

<b>\$1,571,996,287 Vendor Payments</b>
\$46,588,556 Disproportionate Share Hospital/Rate Adjustments
\$39,342,080 Medicare Premiums
\$ 4,455,687 Intergovernmental Transfer (IGT)
\$43,669,288 Other Payments (Managed Care, Transportation, Federal Insurance Contributions Act taxes)
(\$57,225,172) Rebates/Refunds
(\$89,731,513) General Funds Paid in Other Budget Programs
\$33,520,770 Phased Down Contribution
<b>\$1,592,615,982 Net Medicaid Expenditures</b>

Total vendor payments increased \$33,619,249, or 2.2%, from SFY 2009 to SFY 2010. From SFY 2009 to 2010 vendor expenditures for Outpatient Hospital Services, Dental Services, and Waiver Services showed significant increases. (Table 1)

**Table 1**

**Nebraska Medicaid and CHIP Vendor Expenditures**

	FY 2009		FY 2010		FY 2009 to FY 2010	
	Expenditures	% of Total	Expenditures	% of Total	Increase	% Increase
Nursing Facilities	\$309,189,085	20.5%	\$316,974,756	20.2%	\$7,785,671	2.5%
Inpatient Hospital	\$232,884,924	14.9%	\$234,601,172	14.9%	\$1,716,248	0.7%
Waiver Services (DD Waivers, Assisted Living)	\$229,216,010	13.9%	\$244,545,513	15.6%	\$15,329,503	6.7%
Physicians, Practitioners & EPSDT	\$154,973,923	10.3%	\$161,968,760	10.3%	\$6,994,837	4.5%
Drugs	\$154,222,842	10.1%	\$150,724,210	9.6%	-\$3,498,632	-2.3%
Outpatient Hospital	\$98,066,819	5.9%	\$114,122,090	7.3%	\$16,055,271	16.4%
Managed Care Capitation	\$87,230,297	5.9%	\$94,901,326	6.0%	\$7,671,029	8.8%
Other	\$65,919,215	4.6%	\$66,681,571	4.2%	\$762,356	1.2%
Comm Based Mental Health Clinics & Day Treatment	\$65,454,432	4.5%	\$65,418,622	4.2%	-\$35,810	-0.1%
ICF-MR	\$67,710,764	4.5%	\$42,968,239	2.7%	-\$24,742,525	-36.5%*
Home Health	\$38,962,768	2.6%	\$40,553,050	2.6%	\$1,590,282	4.1%
Dental	\$34,545,959	2.3%	\$38,536,977	2.5%	\$3,991,018	11.6%
<b>Total</b>	<b>\$1,538,377,038</b>	<b>100%</b>	<b>\$1,571,996,287</b>	<b>100.0%</b>	<b>\$33,619,249</b>	<b>2.2%</b>

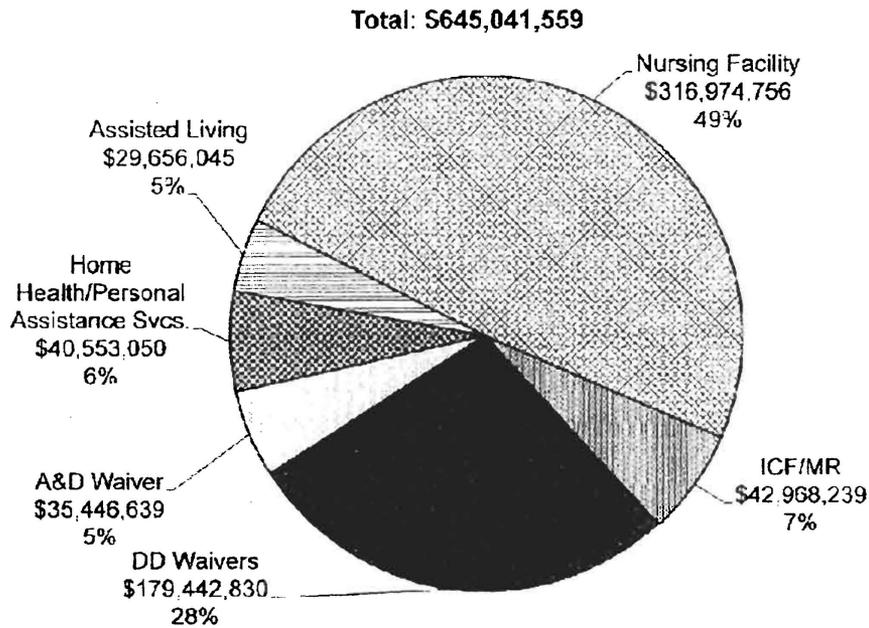
\*Reduction caused by decertification of Beatrice State Developmental Center (BSDC)

**Long-Term Care Services**

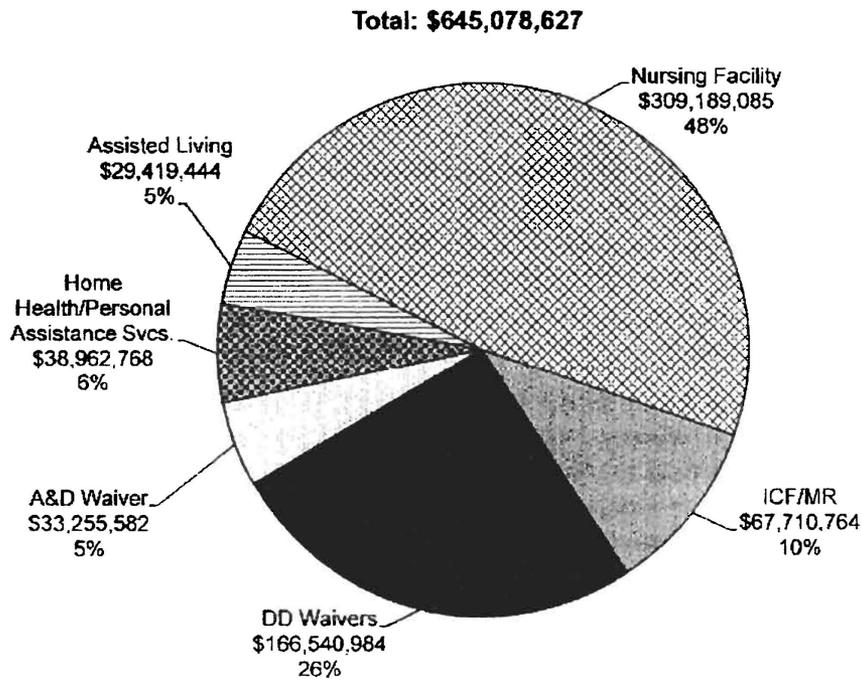
Long-Term Care services support individuals with chronic or ongoing health needs related to age or disability. Services are geared to multiple levels of client need ranging from limited assistance with activities of daily living to complex nursing interventions. Assistance can be offered in a variety of settings from care in an individual's home, to care in small group settings with community supports, to care in a nursing facility or intermediate care facility for persons with mental retardation. In general, home and community-based care is less expensive and offers greater independence for the consumer than facility-based care. For these reasons, state and federal initiatives encourage the development of care options in the community as an alternative to institutional care, as long as a safe plan of care can be established.

Efforts to encourage home and community-based alternatives to facility-based care are resulting in a gradual rebalancing of long-term care expenditures. Comparison of Fiscal Year 2010 spending with Fiscal Year 2009 spending shows a slight decline in the percentage of dollars directed to institutional providers (nursing facilities and ICF/MR) and a corresponding increase in the proportion of spending for services in less restrictive settings. (Figure 4) Institutional payments declined from 58% of total long-term care expenditures in 2009 to 56% in 2010. Home and Community payments increased from 42% of total long-term care expenditures in 2009 to 44% in 2010.

**Figure 4**  
**SFY 2010 Medicaid Expenditures for Long-Term Care Services**



**SFY 2009 Medicaid Expenditures for Long Term-Care Services**



### C. Provider Reimbursement

DHHS uses different methodologies to reimburse Medicaid services. Practitioner, laboratory, and radiology services are reimbursed according to a fee schedule. Prescription drugs are reimbursed according to a discounted product cost calculation plus a pharmacy dispensing fee. Inpatient Hospital services are reimbursed based on a prospective system using either a diagnosis related group or per diem rate. Critical Access Hospitals are reimbursed a per diem based on reasonable cost of providing the service. Federally Qualified Health Centers are reimbursed on a prospective payment system. Rural Health Clinics are reimbursed cost or a prospective rate depending on whether they are independent or provider based. Outpatient Hospital reimbursement is based on a percentage of the submitted charges. Nursing Facilities are reimbursed a daily rate based on facility cost and client level of care. Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are reimbursed a per diem rate based on a cost model. Home and Community-Based Waiver Services, including Assisted Living, are reimbursed at reasonable fees as determined by DHHS.

Table 2 below shows a recent history of provider rate changes by provider type.

**Table 2**

<b>Year-to Year Average Medicaid Provider Rate Increases</b>	<b>SFY 2005</b>	<b>SFY 2006</b>	<b>SFY 2007</b>	<b>SFY 2008</b>	<b>SFY 2009</b>	<b>SFY 2010</b>	<b>SFY 2011</b>
<b>Hospitals</b>	3.80%	2.00%	2.00%	1.95%	1.90%	1.50%	0.50%
<b>Practitioners</b>	2.00%	2.00%	2.00%	1.40%	1.40%	1.50%	0.50%
<b>Nursing Facilities</b>	2.00%	6.00%	3.50%	2.50%	2.50%	1.50%	0.50%
<b>Assisted Living</b>	3.00%	2.00%	2.00%	2.00%	2.00%	1.50%	0.50%
<b>Non-public ICF-MRs</b>	3.00%	2.00%	2.00%	2.50%	2.50%	1.50%	0.50%

For Medicaid recipients participating in at-risk managed care, Medicaid pays a monthly capitation payment to the Managed Care Organization (MCO) based on actuarially determined cost of services and administration per enrollee. Providers are reimbursed by the MCO for services delivered to MCO clients. The MCO independently determines reimbursement methodology and rates for participating providers. As shown in Figure 3, at-risk managed care constitutes approximately \$95 million or 6.0% of vendor expenditures.

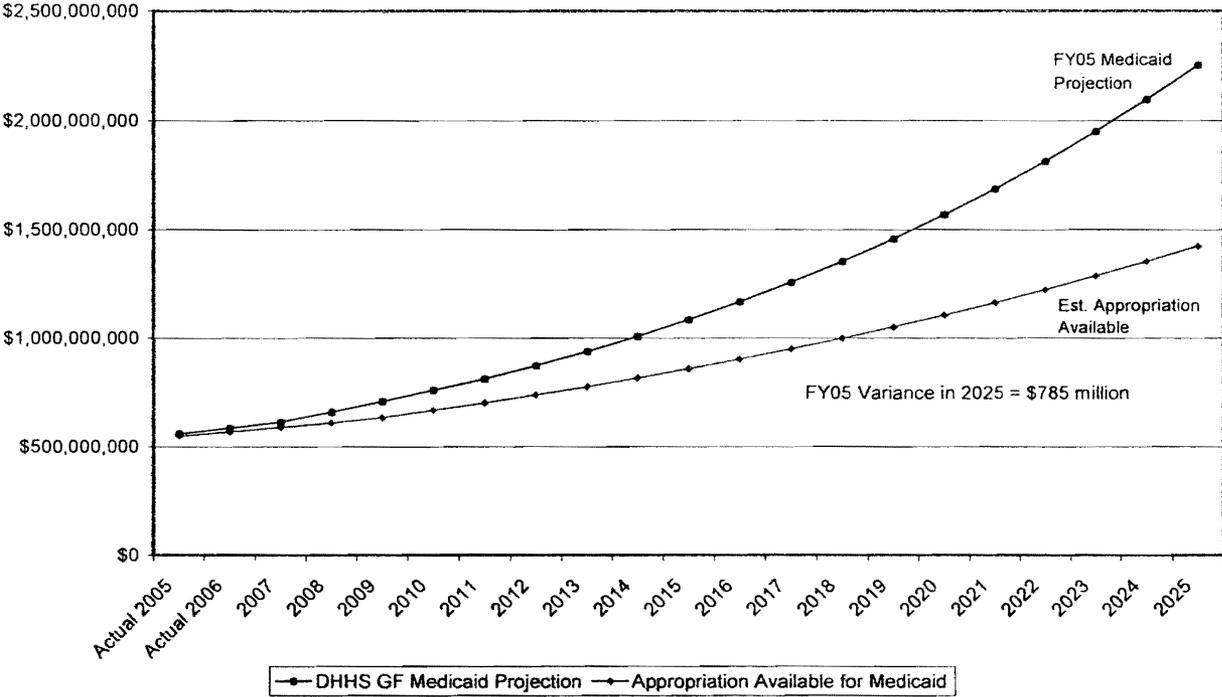
For Medicaid recipients participating in the Primary Care Case Management (PCCM) managed care program, Medicaid paid a monthly payment to the Primary Care Physician (PCP) for care management. Medicaid also paid the PCCM Administrator for administration of the PCCM program. Claims for services provided to recipients were paid directly to providers by the Medicaid program. Nebraska Medicaid paid approximately \$104 million, or approximately 6.6% of vendor expenditures, for PCCM clients for services similar to those covered under the MCO plan. The PCCM program ended July 30, 2010.

### D. Program Trends and Projections

In the Nebraska Medicaid Reform Plan of 2005, DHHS estimated total federal and state Medicaid spending through 2025 by adjusting for demographic changes in the population and projected medical inflation over the next 20 years. Holding the proportion of General Fund

revenues allocated to Medicaid constant, it was projected that, by 2025, there would be a \$785 million gap between projected Medicaid General Fund expenditures and appropriations available for Medicaid. (Figure 5)

**Figure 5**  
**Projected Increase in Medicaid State General Fund Expenditures**  
**and Appropriations Available for Medicaid in Nebraska**  
**SFY2005 - SFY2025**



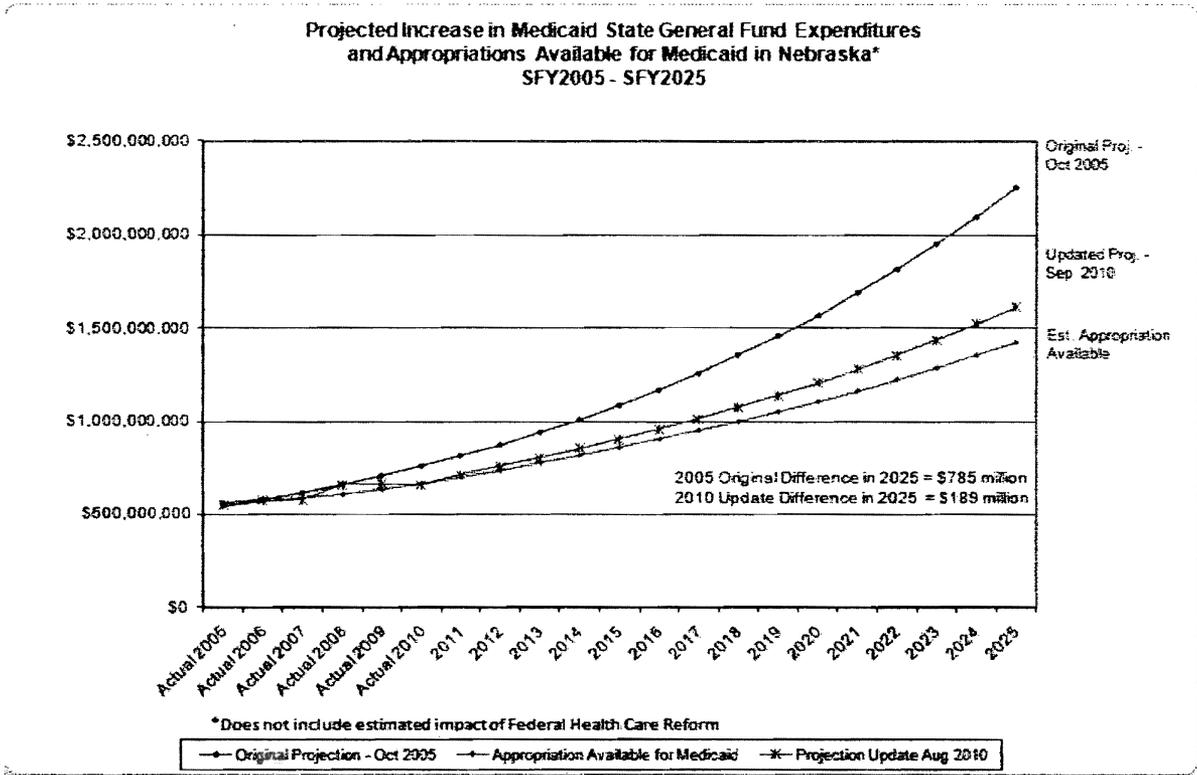
For the 2010 Nebraska Medicaid Reform Annual Report, DHHS forecasts Medicaid eligible persons and costs as follows:

- The average monthly eligible persons by category are updated using final SFY 2010 data.
- Average monthly cost per eligible is the base for forecasting monthly Medicaid costs by eligibility category. Final SFY 2010 averages were used in the calculation. The cost adjustment factor continues to be calculated by blending historical Nebraska Medicaid average cost change rates for the last five years with the national annual medical expenditure per capita projections provided by the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary.

The 2005 base projections previously used were provided by the Center for Public Affairs Research at the University of Nebraska at Omaha. Based on the above revisions, the projected

gap between estimated Medicaid General Fund expenditures and available appropriations in 2025 decreased to \$189 million. (Figure 6)

Figure 6



The estimate was developed as a product of two projections for each fiscal year: average monthly Medicaid eligibles and average monthly Medicaid expenditures per eligible. The resulting average monthly total Medicaid expenditure projection was multiplied by 12 to reach an annual figure. It was then multiplied by 0.4 to estimate the General Fund portion of the projected total Medicaid expenditures.

The projection of average monthly Medicaid eligibles was also based on two sources: average monthly Medicaid eligibles in SFY 2005 and a projection of Nebraska population growth. The Nebraska population forecast was developed by the Center of Public Affairs Research at the University of Nebraska at Omaha. The report projected future Nebraska population by age. The assumption underlying the eligibility projection was that the ratio of average monthly eligibles in each eligibility category to the total population in the age group corresponding to that category would remain constant. For example, in SFY 2007, there were 128,107 average monthly eligibles in the Children category. This represented 24.3% of children less than 21 years of age in Nebraska. It was, therefore, projected that the average monthly children eligible for Medicaid would be 24.3% of whatever the number of children under 21 was for that year in the population forecast. The same projection was done, through 2025, for average monthly Medicaid eligibles in each category: Aged, Blind and Disabled, Adults, and Children.

The other factor in the projection of Medicaid expenditures was a projected average monthly cost per eligible in each of the five categories. This was developed from two factors: actual growth of average monthly cost per eligible in Nebraska Medicaid from SFY 2000 - SFY 2005, and

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projections available at the time from the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) on increases in the cost of health care from 2006 to 2014. In particular, the percentage increase applied to the average monthly cost per eligible for each year in the projection was the average of the average growth in actual Medicaid expenditures per eligible in that category SFY 2000 – 2005 and the projected growth in health care costs from the CMS Office of the Actuary for that time. These average monthly costs per eligible projections were multiplied by the average monthly eligibles projections described above to arrive at the projected Medicaid expenditures used in the charts in question.

While actual Medicaid eligibles grew faster than projected using the population forecast, the distribution of eligibles was different than projected. In particular, the Medicaid Children category has grown at a faster rate than the general population of children in Nebraska. The Aged and Adult categories have grown at a much slower rate than their corresponding age groups in the general population. This is significant because the Aged group tends to have higher costs, on average, and Children tend to have the lowest costs of any Medicaid eligibility group. While there are slightly more people eligible for Medicaid than anticipated, it has also been a significantly less costly mix of eligibles than anticipated.

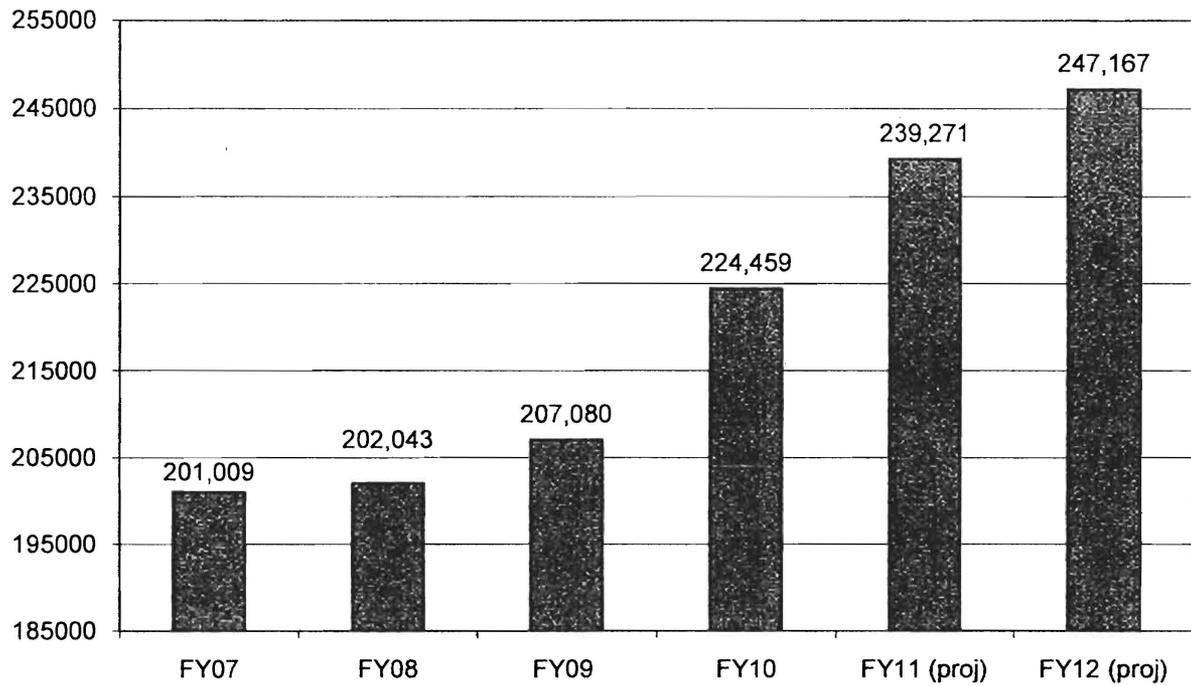
Growth in Medicaid eligibility, which had been moderate from SFY 2006 through SFY 2008, experienced a significant increase in the latter half of SFY 2009 that continued until the first half of SFY 2010. Assuming continued pressure on Medicaid caseloads due to weak economic conditions and factoring in the statutory expansion of Children's Health Insurance Program (CHIP) eligibility to 200% FPL in LB 603, eligibility is projected to increase 6.6% in SFY 2011 and 3.8% in SFY 2012.

As shown in Figure 1, the average monthly number of eligibles in SFY 2010 was 224,459. Figure 7 tracks the annual growth of eligibles. In June 2010, there were 228,482 persons eligible for Medicaid, an increase of 14,737 persons over the same month in 2009.

#### **FIGURE 7**

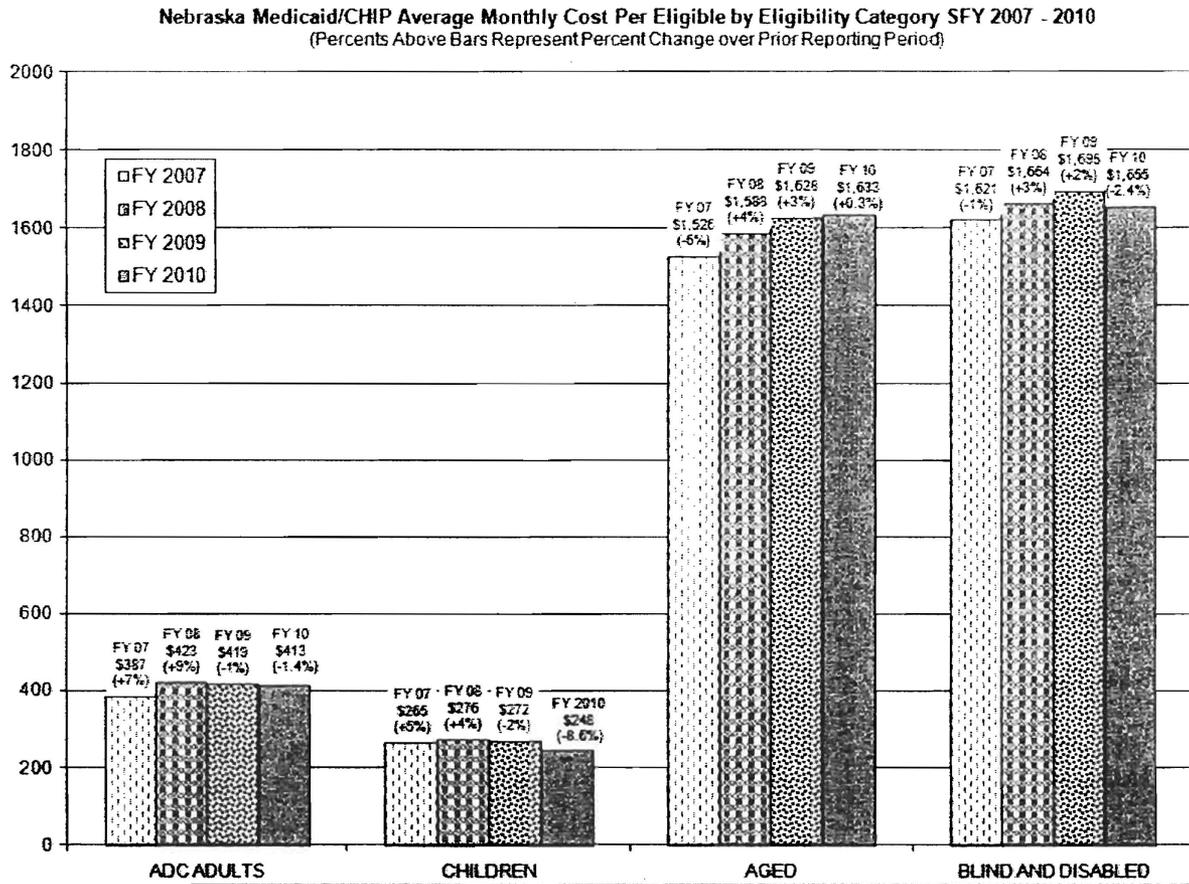
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**Nebraska Medicaid and CHIP Average Monthly Eligibles**  
**SFY 2007-2010 Actual and SFY 2011-2012 Projected**  
**Based on Current Economic Predictions**



Equally important to the fiscal sustainability of Medicaid is the trend in cost per Medicaid eligible person. The trends in average cost per category are shown in Figure 8.

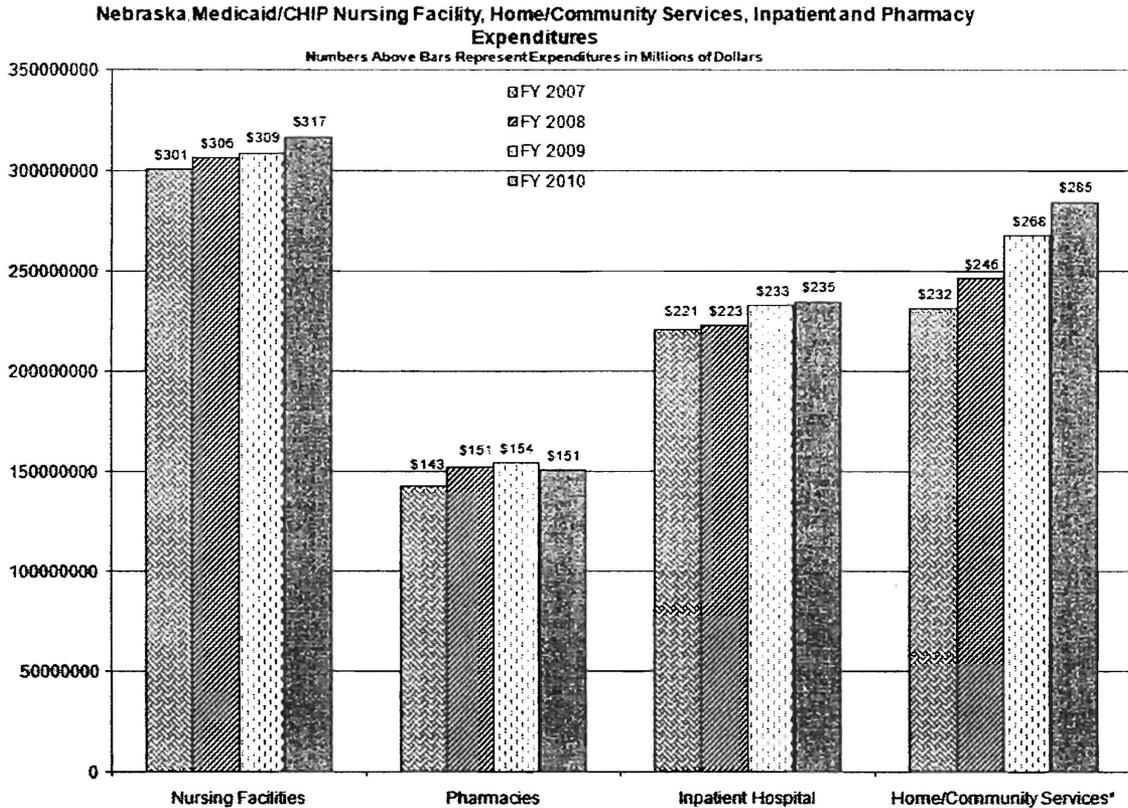
**Figure 8**



These trends are based on vendor payments. The majority of persons in the Aged and the Blind and Disabled categories now have their drug costs paid by Medicare. (Medicare Part D took effect in January 2006, thus Medicare Part D affected only the second half of SFY 2006). The ADC Adult and Children's categories are unaffected by Part D.

The top four vendor expenditure categories in Medicaid are nursing facilities, pharmacies, home and community services, and inpatient hospitals. The home and community service category consists of home health, personal assistance services and waiver services, including assisted living. The trends are shown in Figure 9.

**Figure 9**



\*Includes HCBS Waiver Services, Home Health Services, and Personal Care Aide Services

Spending for nursing facility services is increasing although declining as a percentage of the overall Medicaid program. Home and community services continue to grow both in terms of dollars and as a percentage of the Medicaid program as more care and services are delivered outside of traditional institutional settings. Expenditures for inpatient hospital services continue to increase.

### E. Program Budget and Expenditures

Continuation funding for Medicaid for SFY 2010 and 2011 was enacted in LB 315, the mainline appropriations bill of the 2009 legislative session. The Medicaid appropriation included a rate increase of 1.5% per year for most provider categories as well as an adjustment in the state and federal funding split to reflect enhanced Federal Medical Assistance Percentage (FMAP) funding available to DHHS as a result of the Federal American Recovery and Reinvestment Act (ARRA). Enhanced federal funding is anticipated through June 30, 2011.

Information related to the Medicaid and Long-Term Care budget will be available after September 15, 2010.

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## **F. Medicaid Reform Activities**

### **1. DHHS implemented the Preferred Drug List**

In 2008, the Nebraska Legislature passed the Medicaid Prescription Drug Act, the purpose of which is to provide appropriate pharmaceutical care to Medicaid recipients in a cost-effective manner through the development of a Preferred Drug List (PDL). A committee consisting of physicians, pharmacists and public members determines which medications are to be included on the Preferred Drug List. Comprehensive reviews of the medical literature are conducted to determine which drugs are the most efficacious and safe within therapeutic classes. Medication costs for the State are reduced by 1) supplemental rebate, which are collected from drug manufacturers and 2) increased utilization of less costly medications. The first half of the Preferred Drug List was implemented in the fall of 2009. The second half was implemented in the spring of 2010. Nebraska is now collecting supplemental rebates each quarter.

### **2. DHHS implemented Money Follows the Person Grant**

Nebraska was one of 31 states selected by the Centers for Medicare and Medicaid Services to host a five-year demonstration project called Money Follows the Person. The goal is to help rebalance Medicaid's long-term care spending by decreasing the percentage of funds spent for facility-based care and increasing the percentage spent on home and community-based services. Eligible participants who currently reside in nursing homes or intermediate care facilities for persons with developmental disabilities and who wish to relocate are assisted with their transition from facilities back to their own home or to other suitable community residences, such as houses, apartments, or small group living arrangements. Nebraska's Operational Protocol for Money Follows the Person was approved June 20, 2008. As of June 30, 2010, seventy-two MFP-qualifying individuals have been transitioned into the community.

### **3. DHHS has developed and will implement a Long-Term Care Needs Assessment Tool**

DHHS will implement the Nebraska Home Care Tool for assessing whether clients meet the functional criteria to be eligible for services of the Aged and Disabled Medicaid Waiver or a nursing facility. Programming of the electronic tool and validity is complete. In conjunction, the regulations that address level of care criteria have been revised. Proposed implementation is January 1, 2011.

### **4. DHHS conducted a study for rate setting methodology for Long-Term Care Services**

DHHS contracted with Myers & Stauffer for a study to review and provide recommendations for nursing facility reimbursement structure. The contractor submitted its final report to DHHS in April 2009. The report and its recommendations were presented by the contractors to Nebraska's nursing facility providers in May 2009. A provider workgroup was established for the purpose of discussing potential improvements to Nebraska's nursing facility reimbursement methodology. Effective July 1, 2010, DHHS updated the algorithm used for determining the nursing facility residents' levels of care and corresponding Medicaid reimbursement rates, as Nebraska's prior algorithm would no longer be supported by the Center for Medicare and Medicaid Services after September 30, 2010. The contractor and the provider workgroup recommended this change. Also effective July 1, 2010, Medicaid will only pay the co-insurance amounts for Medicare Part

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A nursing facility claims when the amount already paid on the claim by Medicare is less than the Medicaid rate. This change was also a contractor recommendation.

**5. DHHS implemented enhanced care coordination for high-cost recipient with multiple medical conditions**

DHHS contracted with US Care Management to provide a voluntary Enhanced Care Coordination for high-cost Medicaid recipients who have multiple medical conditions. The program started on July 1, 2008. The contract with US Care Management ended August 31, 2010.

**6. DHHS expanded at-risk managed care for physical health**

Effective November 1, 2009, managed care was expanded from Douglas, Sarpy and Lancaster counties to include the counties of Otoe, Cass, Washington, Saunders, Dodge, Gage, and Seward. DHHS initiated a procurement process for the purpose of selecting two Managed Care Organizations (MCOs) for the ten county area. Two bids were accepted and contracts were awarded to United Health Care of the Midlands, Inc. (Share Advantage) and to Coventry Health Care of Nebraska, Inc. The two MCO contracts began August 1, 2010. The Primary Care Case Management (PCCM) program ended July 31, 2010. The Physical Health managed care program will cover 95,201 clients.

**7. DHHS is implementing electronic billing by providers**

Electronic claim submission assists DHHS to operate a more efficient payment system. DHHS currently receives over 90% of claims electronically. DHHS' current MMIS is able to accept and process all incoming claim types for services provided to eligible clients. Providers benefit when they submit electronic claims with shorter turnaround time for payments resulting in improved cash flow, improved tracking and monitoring capabilities, and reduced postage and paper handling costs. DHHS has begun an awareness campaign to remind providers of the benefits of electronic claim submission. Other options for reducing paper claims and enhancing electronic options are being reviewed, such as direct data entry of claims data by providers through the creation of a DHHS web portal.

**8. DHHS implemented a new Medicaid card**

In August 2009, DHHS discontinued the monthly mailing to clients of the 8 ½" x 11" document containing person-specific Medicaid eligibility information. All clients now have a permanent wallet-sized plastic identification card issued once, similar to private health insurance. The initiative for doing this was to make it easier for the client to carry as well as reduce significantly the printing and mailing costs. To date, feedback from the clients has been positive. In the first year, a savings of over \$450,000 has been realized. If the volume remains stable, it is anticipated that savings in the second year will be more than \$550,000.

**9. DHHS will utilize a transportation broker for non-emergency medical transportation**

DHHS has determined that centralized management of transportation services would result in program efficiencies. DHHS is in the process of awarding a contract for statewide non-emergency transportation brokerage services.

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#### **10. DHHS implemented radiology management services**

DHHS contracted with MedSolutions to provide radiology management services which require prior authorization of high tech outpatient radiology procedures. A State Plan Amendment was submitted to and approved by CMS. The Program was implemented on September 1, 2009. During the first 6 months of 2010, 13.68% of the requested prior authorizations were denied. A 6 month utilization review indicates a distinct reduction in the Medicaid claims paid for advanced radiology procedures from a prior use rate of 125-160 per 1000 to 60-80 per 1000. Claims paid data from three years prior to initiation of this contract was used in this analysis.

#### **11. DHHS has begun development of a Program of All-Inclusive Care for the Elderly (PACE)**

The PACE Program provides comprehensive health care services within a defined geographic area for voluntarily enrolled individuals age fifty-five and older. DHHS will make capitated payments to a PACE organization which will utilize Medicare, Medicaid, and private pay revenues to provide coordinated care. The organization will be at-risk for all covered services offered by Medicare and Medicaid.

A minimum period of 18-24 months is required to launch an operational PACE program. DHHS issued a Request for Information (RFI) in late December, 2009, to ascertain interest in and capacity to successfully develop a PACE program. One provider responded with a proposal for two sites: one in Omaha and one to follow in Lincoln approximately 18 months later. The respondent has been invited to submit a PACE application to CMS. In the meantime, DHHS is developing a proposed Medicaid payment rate. The final step in this process will be the execution of a program agreement between CMS, DHHS, and the PACE provider organization.

#### **12. DHHS implemented the Behavioral Pharmacy Management Program**

The Behavioral Pharmacy Management program (BPM) evaluates behavioral health pharmacy claims and identifies prescribing patterns that are inconsistent with national, evidence-based guidelines. This program is operated by DHHS with assistance from the Nebraska Medical Association (NMA) and Care Management Technologies (CMT), an independent vendor, who contracts directly with state Medicaid agencies or other third party payers. The Nebraska Medicaid BPM Committee is comprised of Medicaid employees and local Mental Health Professionals (2 Doctors, 3 Pharmacists, an APRN, a Medicaid Manager, and a Medicaid Project Coordinator). The committee is responsible for selecting the Quality Indicators that will be targeted in Nebraska. Educational materials are mailed to doctors who deviate from national prescribing guidelines, and also inform doctors when their patients fail to fill prescriptions in a timely fashion. If physician's prescribing practices do not become more consistent with national evidence based guidelines over time, they are offered a peer consultation to discuss prescribing practices with a NMA physician. The goal of the BPM is to share the latest prescribing best practices for mental health drugs with Nebraska prescribers and, in turn, shape the prescribing practices in Nebraska to more closely align with these national evidence-based guidelines. The first mailing that has a focus on the adult population was sent out July 1, 2010 and the second mailing that focuses on the child population was mailed on August 3, 2010.

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## **G. Program Changes**

### **1. DHHS submitted a State Plan Amendment to receive federal funding to cover LPR children and pregnant women**

In June 2010, DHHS submitted an amendment to the State Plan as required by LB 1106 to obtain federal funds without the current five-year delay to allow for payment for medical services to children who are lawfully residing in the United States and who are otherwise eligible for Medicaid and CHIP. This change also applies to eligible pregnant women who are lawfully residing in the US and who are otherwise eligible for Medicaid.

### **2. DHHS implemented a Site of Service Differential reimbursement system for physician services**

The Medicare Physician Fee Schedule contains two rates for selected procedures. One rate is paid when the procedure is performed in a facility setting (usually a hospital), and a higher rate is paid when the procedure is performed in any other setting (usually the physician's office). This compensation scheme is more equitable with respect to costs than a single-rate scheme; the procedures selected for site of service differential rates are those that would require a physician performing them in an office setting to have purchased equipment that would normally be owned by a facility, thus the physician performing the procedure in a facility is able to do so at a lower cost. Nebraska Medicaid implemented a similar site of service differential reimbursement system for physician services effective July 1, 2010.

### **3. DHHS provision of autism services on hold**

DHHS was approved in April 2010 by CMS to operate a Medicaid Home and Community Based Waiver to implement an intensive early intervention service based on behavioral principles for children with Autism Spectrum Disorder who receive such services prior to the age of nine. The legislation regarding the waiver required the receipt of private matching donations to finance the program. DHHS was notified in July 2010 that the primary donor decided not to proceed with its planned financial donation. DHHS remains ready to implement the waiver upon receipt of the private funds required in the statute.

### **4. DHHS continues work on a Medical Home Project (LB 396)**

By January 1, 2011, DHHS will have developed and implemented a two-year medical home pilot program in consultation with the Medical Home Advisory Council in one or more geographic regions of the state. The purpose of the pilot is to improve health care access and health outcomes for patient and to contain costs of the medical assistance program. A Request for Interest process will determine the selection of the participating practices. The payment methodology includes a per-member-per-month (PMPM) with an option to meet advanced medical home to receive an additional reimbursement incentive. To support the practices in transforming into a patient-centered medical home, they will receive comprehensive technical assistance, a patient registry, and funding for care coordination staff. The pilot will be evaluated for improved health care access and improved health outcomes for patients, Medicaid cost containment, patient satisfaction, and provider satisfaction.

### **5. DHHS will maximize federal funding with University of Nebraska Medical Center**

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## Physicians

Current Medicaid reimbursement for physician services in Nebraska is based upon a set fee schedule. Similar to what has been done in other states, the University of Nebraska Medical Center (UNMC) worked with DHHS to develop a physician upper payment limit (UPL) program to provide higher reimbursement to designated physician groups. The development, implementation, and ongoing operation of the concept as well as the non-federal share of the enhanced payments will be funded by UNMC. A state plan was submitted to CMS on February 23, 2010 and approved on August 26, 2010.

### **6. DHHS will establish reimbursement for Pediatric Feeding Disorder services (LB 342)**

A State Plan Amendment to provide for Medicaid payments for the comprehensive treatment of pediatric feeding disorders through interdisciplinary treatment was submitted to CMS on May 27, 2010.

### **7. DHHS has added Secure Residential mental health services (LB 603)**

DHHS submitted a State Plan Amendment (SPA) to provide Medicaid payments for Secure Residential Services. Secure Residential is a 24-hour residential program that provides intensive mental health services for adults as an alternative to long-term psychiatric hospitalization or upon discharge from the Regional Center. The SPA was approved by CMS March 19, 2010. Corresponding regulations have been promulgated and providers are being enrolled.

### **8. DHHS will implement Health Information Technology provisions of Federal law**

DHHS will implement the Medicaid EHR Incentive Program in order to provide federal payments to eligible Medicaid professionals and hospitals for efforts to adopt, implement, upgrade, or meaningfully use certified electronic health record (EHR) technology.

### **9. DHHS reviews the Coordination of Benefits, Third Party Liability and Health Insurance Premium Payment (HIPP) programs for efficiencies**

DHHS is reviewing options on how to make the Coordination of Benefits (COB) and Third Party Liability (TPL) activities for the Department's COB/TPL unit and Nebraska's Health Insurance Premium (HIPP) program more efficient through practices such as automated data matching to identify commercial coverage; medical support enforcement; casualty recovery; and efficiencies in the administration of the HIPP program.

### **10. DHHS contracted for statewide utilization management and quality control of Medicaid home health and private-duty nursing services**

Effective April 1, 2010, DHHS contracted with Qualis Health to perform prior authorization reviews of all home health and private-duty nursing services, in order to improve the efficiency and consistency of this process and gather accurate and complete utilization data. Initial data indicated areas of misuse of Medicaid reimbursement, which have been addressed through provider education, policy clarification and process changes.

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**11. DHHS implemented a higher resource allowance for Medicare Savings Programs (MSP) as required by federal law**

The Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI) programs are federal Medicare Savings Programs (MSPs) which help low-income elders and younger Medicare beneficiaries access Medicare benefits. On January 1, 2010, DHHS implemented a higher resource allowance for QMBs, SLMBs and QIs, raising the resource allowance to \$6,600 for an individual and \$9,910 for a couple, as required by the Medicare Improvements for Patients and Providers Act (MIPPA). MSP/QMB individuals have income of less than 100% of the federal poverty level (FPL) and are eligible for Medicaid payment of co-insurance and deductibles on Medicare claims, as well as payment of Medicare Part B premiums. SLMB and QI individuals have income between 100% and 135% of FPL and are eligible for Medicaid payment of Medicare Part B premium only.

**III. Conclusion**

In the years since the publication of the Medicaid Reform Plan, DHHS has undertaken significant steps to implement the recommendations it contains. Many of the recommendations have become a part of the Medicaid Program. To slow the growth of the Medicaid Program and ensure fiscal sustainability the strategies discussed in this report have been developed to make Medicaid more efficient and cost effective through better management of services, better delivery of care, more appropriate services, and improved administration of the program. Due to current economic conditions, Medicaid eligibility has been increasing steadily. This growth is anticipated to continue in the coming year. However, the Medicaid Reform initiatives that are being undertaken will help to mitigate this growth.

The Department of Health and Human Services, Division of Medicaid and Long-Term Care looks forward to continuing to work with the Governor, the Legislature, and the Medicaid Reform Council to improve Medicaid for current and future generations.



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August 16, 2010

Ms. Vivianne Chaumont, Director  
Division of Medicaid & Long-Term Care  
Department of Health and Human Services  
State of Nebraska  
P.O. Box 95026  
Lincoln, NE 68509-5026

**RE: PATIENT PROTECTION AND AFFORDABLE CARE ACT WITH HOUSE  
RECONCILIATION – FINANCIAL ANALYSIS**

Dear Vivianne:

Milliman, Inc. (Milliman) has been retained by the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care (DHHS) to provide consulting services related to the financial review of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (Affordable Care Act) as they relate to the provisions impacting the State's Medicaid program and budget. This correspondence documents the results of our analysis.

**SUMMARY OF RESULTS**

Milliman has developed two estimates of the enrollment and fiscal impact associated with the Medicaid expansion and other related provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act. We have developed (1) a mid-range participation scenario and (2) a full participation scenario. We have prepared our fiscal analysis to reflect the state impact for state fiscal years 2011 through 2020. We have adjusted all data to reflect the three month offset between the federal fiscal year and the state fiscal year as appropriate.

Enclosures 1 and 2 provide the fiscal impact results of the Affordable Care Act under a mid-range participation scenario (Enclosure 1) and a full participation scenario (Enclosure 2). The total fiscal impact to the Nebraska Medicaid budget during the next 10 years would be estimated to be in the range of approximately \$526.3 million to \$765.9 million based upon the assumptions outlined in this document. Table 1 illustrates the anticipated expenditure impacts to the Nebraska Medicaid budget for the period of SFY 2011 through SFY 2020 under each scenario.

**Table 1**

**Nebraska Department of Health and Human Services**  
**Division of Medicaid and Long-Term Care**  
  
**Patient Protection and Affordable Care Act**  
**as Amended by the Health Care and Education Reconciliation Act**  
  
**State Budget Fiscal Impact – SFY 2011 through SFY 2020**  
**(Values Illustrated in Millions)**

Component	Estimated Fiscal Impact – State Only	
	Mid-Range Participation Scenario	Full Participation Scenario
Adults/Parents/Children Expansion to 138% FPL	\$465.1	\$617.3
Administration	82.4	106.8
Pharmacy Rebate Loss for Nebraska	68.1	74.4
Physician Fee Schedule Increase to Medicare Rates	0.0	56.8
Foster Children Coverage to Age 26	15.1	15.1
Medically Needy Expansion to 138% FPL	5.6	5.6
DSH Reduction	(18.8)	(18.8)
CHIP Enrollment Shift and FMAP Increase	(30.9)	(30.9)
State Disability Shift to Medicaid and Expansion to 138% FPL	(60.5)	(60.5)
<b>Total</b>	<b>\$526.3</b>	<b>\$765.9</b>

Note: Values have rounded

**Estimated Medicaid Enrollment Impact**

Table 2 illustrates the projected increase in Medicaid enrollment reflecting a 138% Federal Poverty Level (FPL) limit. The 138% FPL limit reflects the 133% FPL indicated in the Affordable Care Act with the 5% income disregard allowance. The values in Table 2 were derived from the 2009 Current Population Survey (2009 CPS) data from the U.S. Census Bureau collected in 2009 (representing 2008 insurance and income data) as well as Medicaid enrollment data provided by DHHS. Children were defined as ages 0 through 19. The Adult and Parent populations were defined as ages 20 through 64.

Table 2

**Nebraska Department of Health and Human Services**  
**Division of Medicaid and Long-Term Care**  
  
**Patient Protection and Affordable Care Act**  
**as Amended by the Health Care and Education Reconciliation Act**  
  
**State Budget Enrollment Impact – 2009 CPS Census Data**

Population	FPL Range	Enrollment Full Participation Scenario	Mid-Range Participation Assumption	Enrollment Mid-Range Participation Scenario
Uninsured Adults	0% - 138%	36,779	80%	29,423
Newly Eligible Parents	50% - 138%	20,510	85%	17,433
Woodwork Parents	< 50%	4,623	70%	3,236
Woodwork Children	<138%	23,119	80%	18,496
Insured Switchers – Adults	0% - 138%	23,916	50%	11,958
Insured Switchers – Parents	0% - 138%	21,429	75%	16,071
Insured Switchers – Children	0% - 138%	14,538	75%	10,903
State Disability <sup>(1)</sup>	0% - 138%	154	DHHS 133% FPL Assumption+ 5%	154
Medically Needy <sup>(2)</sup>	43% - 138%	229	DHHS 133% FPL Assumption +5%	229
<b>Sub-total</b>		<b>145,297</b>		<b>107,903</b>

Notes: (1) State Disability currently covered with state funds to 100% FPL. Enrollment reflects shift to Medicaid and FPL expansion estimated as of 2014.  
 (2) Enrollment reflects FPL expansion estimated as of 2014.

The mid-range participation rates in Table 2 were reviewed for consistency with participation in the Medicare program which exceeds 95% and the Medicaid/CHIP programs for children which exceeds 85%. Actual participation in the Medicaid program after the expansion may exceed the participation rates noted in these other programs, since there will be an individual mandate for health insurance coverage under federal health care reform legislation.

**Percentage increase in Medicaid in relation to the total number of Nebraskans**

- Calendar Year 2008 Nebraska Census Estimate 1,783,000
- Increase would be approximately 6.1% to 8.2% more Nebraska residents on Medicaid
- Increase from 11.6% to range of 17.7% - 19.8% - or nearly 1 in 5 Nebraskans

The remainder of this letter discusses each of the Medicaid components of health care reform as listed in Table 1.

**a. Adults/Parents/Children Expansion to 138% FPL**

The fiscal impact associated with the Adults, Parents, and Children expansion to 138% FPL includes both currently insured and uninsured individuals below the 138% FPL amount and children not currently covered under Medicaid, who are also below the 138% FPL limit. The 138% FPL limit reflects the 133% FPL indicated in the Affordable Care Act with the 5% income disregard allowance. The analysis presented in this report reflects full participation (full participation scenario) as well as an alternate participation assumption (mid-range participation scenario). The participation assumptions by population are presented in Table 2. The assumed average annual cost per enrollee by population as of State fiscal year 2009 is provided in Table 3.

**Table 3**

**Nebraska Department of Health and Human Services  
 Division of Medicaid and Long-Term Care**

**Patient Protection and Affordable Care Act  
 as Amended by the Health Care and Education Reconciliation Act**

**Average Cost per Enrollee as of SFY 2009**

Population	Average Annual Cost
Uninsured Adults	\$5,467
Newly Eligible Parents	\$4,881
Woodwork Parents	\$4,881
Woodwork Children	\$2,654
Insured Switchers – Adults	\$5,900
Insured Switchers – Parents	\$5,268
Insured Switchers – Children	\$2,950
State Disability <sup>(1)</sup>	\$78,107
Medically Needy – Disabled <sup>(1)</sup>	\$85,390
Medically Needy – Long-Term <sup>(1)</sup>	\$109,932

Notes: (1) State Disability and Medically Needy costs provided by DHHS for FFY 2014.

The cost estimates for the State Disability and Medically Needy populations were obtained from the health care reform projection provided by DHHS. All other annual cost estimates were developed from SFY 2009 enrollment and expenditures provided in the *Nebraska Medicaid Reform Annual Report* dated December 1, 2009 with appropriate adjustments. The values in Table 3 reflect the age/gender mix of each population based upon the 2009 CPS census data. For example, the insured switcher adult population does not have the same age distribution as the uninsured adult population which impacts expected average cost. Milliman additionally used internally available data from other Medicaid expansion analyses to develop the cost relationship between adults and parents. Milliman assumed a composite annual trend of 3.0% to project the claim cost for the expansion population into future years. The 3.0% trend reflects the impact of enrollment growth as well as projected trend for utilization and intensity of services.

The Affordable Care Act reflects the following Federal Medical Assistance Percentages (FMAP) for the expansion populations.

- 100% FMAP in CY 2014, 2015, and 2016
- 95% FMAP in CY 2017
- 94% FMAP in CY 2018
- 93% FMAP in CY 2019
- 90% FMAP in CY 2020+

Milliman assumed that the projected FFY 2012 FMAP rate of 57.64% for Medicaid and 70.35% for CHIP would continue through 2020 for non-expansion populations.

**b. Administration**

In addition to the expenditures associated with providing medical services, Nebraska will incur additional administrative expenditures. The expenditures for the initial modifications to the current administrative systems, as well as establishment of an Exchange, are estimated to be \$25 million (State and Federal) or \$12.5 million (State only). On-going costs for the coverage of the additional 108,000 to 145,000 Medicaid enrollees are estimated to be \$21.5 to \$29.0 million per year (State and Federal) or \$10.8 to \$14.5 million per year (State only). The on-going costs were developed assuming approximately \$200 per recipient per year or approximately 3.75% of total expected medical expenditures. Based on my experience with Medicaid programs, the state Medicaid administrative costs range from 3.5% to 6.0% of the total medical costs. The administrative expenses would be anticipated to be incurred in calendar years 2012 and 2013 for the initial administrative expenditures and in calendar year 2014 forward for the on-going expenditures.

**c. Pharmacy Rebate Loss for Nebraska**

The Affordable Care Act includes increased rebate percentages for covered outpatient drugs provided to Medicaid patients. The minimum rebate percentage is increased from 15.1% to 23.1% for most brand name drugs and from 11% to 13% for generic drugs effective January 1, 2010. However, the Affordable Care Act indicates that the impact will be accrued 100% to the Federal government. Milliman has modeled that this could reduce Nebraska's rebates by 20.7% to 22.6% or more beginning on January 1, 2010. The 20.7% assumption used for the mid-range participation scenario corresponds to a 75%/25% distribution of brand-name/generic pharmacy expenditures. An 8% reduction for brand-name drugs and a 2% reduction for generic drugs equates to an average 6.5% reduction under the 75%/25% assumption. The 6.5% reduction is approximately 20.7% of the current 31.5% assumed rebate level. The 22.6% assumption used for the full participation scenario corresponds to an 85%/15% distribution of brand-name/generic pharmacy expenditures.

**d. Physician Fee Schedule Increase to Medicare Rates**

According to an April 2009 report by the Urban Institute's Health Policy Center, the current Nebraska Medicaid fee schedule reimburses at approximately 82% of the Medicare fee schedule for primary care services. The Affordable Care Act requires an increase in the Medicaid physician fee schedule for a

limited set of primary and preventive care services to 100% of the Medicare physician fee schedule. 100% Federal funding is available for calendar years 2013 and 2014. No additional funding is available for other physician services.

*Full Participation Scenario –*

The full participation scenario assumes that DHHS will increase the fee schedule for the required services for both primary care and specialty care providers and will continue the increased fee schedule after calendar year 2014 to assure continued access to physician care. In addition to increasing the expected cost of corresponding existing expenditures by approximately 22%, the analysis reflects an additional \$120 per year for the dual eligible population since Medicare only pays 80% of the fee schedule for Part B services.

Under the full participation scenario, the increased cost would be an estimated \$27 million (State and Federal) per year for the current Medicaid program and expansion populations. During calendar years 2013 and 2014, the state would have to pay the standard state portion of the increase for specialty providers for the existing Medicaid population. Therefore, the state share in these two calendar years would be approximately \$2.8 million (State only) per year. In 2015, the State only cost for the fee schedule expansion would grow to an estimated \$9 million (State only).

*Mid-Range Participation Scenario –*

The mid-range participation scenario assumes that DHHS will only increase the fee schedule for primary care providers, not specialty care providers. The mid-range participation scenario further assumes that the fee schedule increase will only continue through calendar year 2014 and will terminate when the Federal funding level decreases. The annual cost would be approximately \$18 million and reflects 100% Federal funding for the calendar year 2013 and 2014 period.

**e. Foster Children Coverage to Age 26**

It is Milliman's understanding that Nebraska currently provides Medicaid eligibility coverage to Foster Children to age 19. The Affordable Care Act includes mandatory coverage for Foster Children to age 26 beginning on January 1, 2014. Milliman has estimated the annual cost at \$5.5 million per year (State and Federal) or approximately \$2.3 million per year (State only).

**f. Medically Needy Expansion to 138% FPL**

The Medically Needy population is currently covered to 43% FPL. The population is limited to non-Dual eligibles under age 65. Effective January 1, 2014, the population will be covered to 138% FPL including the 5% income disregard allowance. Milliman has utilized the DHHS expenditure estimate for the Medically Needy population for fiscal year 2014 assuming expansion to 133% FPL under the Medicaid enhanced FMAP rate. Our projection adjusts the DHHS estimate by a factor of 1.05 to reflect expansion to the 138% FPL level. We have additionally adjusted the estimate provided by DHHS from a Federal fiscal year basis to a State fiscal year basis. Although these individuals would theoretically be included in the 2009 CPS data, the cost intensity needs to be additionally reflected.

**g. DSH Reduction**

Based upon the aggregate Disproportionate Share Hospital (DSH) payment reductions indicated in the Affordable Care Act, Milliman developed average Federal fiscal year DSH reduction percentages. Milliman adjusted the Federal fiscal year percentages to a State fiscal year basis. The baseline DSH expenditures of \$44.0 million provided by DHHS were ultimately reduced to two-thirds of the National reduction percentage. The reduction was reduced to two-thirds of the National percentage to reflect that Nebraska is a low DSH state.

Federal Fiscal Year	DSH Percentage Reduction	
	National Percentage	Nebraska Percentage
2014	4.4%	2.9%
2015	5.3%	3.5%
2016	5.3%	3.5%
2017	15.9%	10.6%
2018	44.1%	29.4%
2019	49.4%	32.9%
2020	35.3%	23.5%

Note: Nebraska percentage reduction was estimated at 2/3 of National percentage reduction since Nebraska is a low DSH state.

**h. CHIP Enrollment Shift and FMAP Increase**

Under the Affordable Care Act, the CHIP program is required to continue to 2019. However, the legislation provides an additional Federal matching rate of 23% beginning on October 1, 2015 and ending September 30, 2019. The additional 23% FMAP will increase the total FMAP for the CHIP program to approximately 93.35%. The enhanced FMAP will decrease expenditures for Nebraska and increase expenditures for the Federal share.

The projection additionally reflects that approximately 30% of current CHIP program enrollees will shift to Medicaid eligibility effective January 1, 2014. The 30% reflects CHIP enrollees <138% FPL.

**i. State Disability Shift to Medicaid and Expansion to 138% FPL**

Nebraska currently covers the State Disability population to 100% FPL with 100% state funds. Milliman has utilized the DHHS expenditure estimate for the State Disability population for Federal fiscal year 2014 assuming expansion to 133% FPL under the Medicaid enhanced FMAP rate. Our projection adjusts the DHHS estimate by a factor of 1.05 to reflect expansion to the 138% FPL level. We have additionally adjusted the estimate provided by DHHS from a Federal fiscal year basis to a State fiscal year basis. Although these individuals would theoretically be included in the 2009 CPS data, the cost intensity needs to be additionally reflected.

## OTHER CHANGES TO CURRENT PROGRAMS

Milliman anticipates potential savings from the following populations even if the programs are not discontinued. However, savings estimates have not been included in the total impact projection for either the full participation scenario or mid-range participation scenario.

### *Pregnant Women above 138% FPL*

The State of Nebraska currently provides eligibility for pregnant women up to 185% FPL. It would be anticipated that the majority of pregnant women between 138% FPL and 185% FPL will receive care through the insurance exchange. We have estimated that approximately 10% of the current expenditures for the pregnant women population will no longer be incurred by the Nebraska Medicaid program. We have estimated the annual savings to be approximately \$3.4 million (State and Federal) per year or \$1.4 million (State only) per year beginning on January 1, 2014.

### *Breast and Cervical Cancer Program*

The State of Nebraska currently provides eligibility under the Breast and Cervical Cancer program. The total annual expenditures under the program are approximately \$5.0 million (State and Federal) or \$1.5 million (State only). It is not anticipated that this program will be required to be continued with the expansion requirements below 138% FPL and insurance reforms for individuals above 138% FPL. Therefore, we have estimated that this program could be terminated beginning on January 1, 2014; although, some of these individuals will become eligible under the new Medicaid eligibility requirements.

## LIMITATIONS

The information contained in this correspondence, including any enclosures, has been prepared for the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care and their advisors. These results may not be distributed to any other party without the prior consent of Milliman. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling that will allow appropriate use of the data presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for DHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.



Ms. Vivianne Chaumont  
August 16, 2010  
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Milliman has relied upon certain data and information provided by DHHS as well as enrollment and expenditure data obtained from the Medicaid Statistical Information System (MSIS) State Summary Datamart and the *Nebraska Medicaid Reform Annual Report* dated December 1, 2009 as retrieved from the DHHS website. The values presented in this correspondence are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented will need to be reviewed for consistency and revised to meet any revised data. The data and information included in the report has been developed to assist in the analysis of the financial impact of Nebraska Medicaid Assistance expenditures. The data and information presented may not be appropriate for any other purpose. It should be emphasized that the results presented in this correspondence are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this letter.



If you have any questions or comments regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

A handwritten signature in cursive script that reads "Robert M. Damler".

Robert M. Damler, FSA, MAAA  
Principal and Consulting Actuary

RMD/lrb  
Enclosures



**ENCLOSURE 1**

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Division of Medicaid and Long-Term Care  
 Health Care Reform Projection - Mid-Range Participation Scenario  
 (Values in Millions)

8/17/2010  
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EXPENDITURES	<u>SFY 2011</u>	<u>SFY 2012</u>	<u>SFY 2013</u>	<u>SFY 2014</u>	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	SFY 2011 - <u>SFY 2020</u>
<b>Current Programs</b>											
<b>Medicaid</b>											
Total (State and Federal)	\$1,745.1	\$1,792.5	\$1,841.2	\$1,891.3	\$1,942.7	\$1,995.5	\$2,049.7	\$2,105.4	\$2,162.6	\$2,221.4	\$19,747.6
Federal Funds	\$1,029.1	\$1,036.8	\$1,061.3	\$1,090.1	\$1,119.8	\$1,150.2	\$1,181.5	\$1,213.6	\$1,246.5	\$1,280.4	\$11,409.3
State Funds	\$716.0	\$755.7	\$780.0	\$801.2	\$822.9	\$845.3	\$868.3	\$891.9	\$916.1	\$941.0	\$8,338.3
<b>CHIP</b>											
Total (State and Federal)	\$63.2	\$65.1	\$67.0	\$69.0	\$71.1	\$73.3	\$75.4	\$77.7	\$80.0	\$82.4	\$724.4
Federal Funds	\$45.0	\$45.9	\$47.2	\$48.6	\$50.0	\$51.5	\$53.1	\$54.7	\$56.3	\$58.0	\$510.3
State Funds	\$18.1	\$19.2	\$19.9	\$20.5	\$21.1	\$21.7	\$22.4	\$23.0	\$23.7	\$24.4	\$214.1
<b>State Disability</b>											
Total (State and Federal)	\$8.1	\$8.4	\$8.6	\$8.9	\$9.2	\$9.4	\$9.7	\$10.0	\$10.3	\$10.6	\$93.3
Federal Funds	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
State Funds	\$8.1	\$8.4	\$8.6	\$8.9	\$9.2	\$9.4	\$9.7	\$10.0	\$10.3	\$10.6	\$93.3
<b>All Programs</b>											
Total (State and Federal)	\$1,816.4	\$1,866.0	\$1,916.9	\$1,969.2	\$2,023.0	\$2,078.2	\$2,134.9	\$2,193.2	\$2,253.0	\$2,314.4	\$20,565.3
Federal Funds	\$1,074.1	\$1,082.7	\$1,108.5	\$1,138.7	\$1,169.8	\$1,201.7	\$1,234.6	\$1,268.2	\$1,302.9	\$1,338.4	\$11,919.6
State Funds	\$742.3	\$783.3	\$808.5	\$830.5	\$853.2	\$876.5	\$900.4	\$924.9	\$950.1	\$976.0	\$8,645.7

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Division of Medicaid and Long-Term Care  
 Health Care Reform Projection - Mid-Range Participation Scenario  
 (Values in Millions)

8/17/2010  
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EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
<b>Health Care Reform</b>											
<b>Adults/Parents/Children - Expansion to 138% FPL</b>											
Total (State and Federal) - Newly Eligible				\$142.6	\$293.7	\$302.5	\$311.6	\$320.9	\$330.5	\$340.5	\$2,042.2
Total (State and Federal) - Woodwork				\$37.6	\$77.5	\$79.8	\$82.2	\$84.7	\$87.2	\$89.8	\$538.7
Total (State and Federal) - Insured Switchers				\$108.6	\$223.8	\$230.5	\$237.4	\$244.5	\$251.8	\$259.4	\$1,556.0
Federal Funds				\$265.0	\$545.8	\$562.2	\$566.4	\$567.6	\$579.3	\$585.6	\$3,671.8
State Funds				\$23.8	\$49.1	\$50.6	\$64.8	\$82.4	\$90.3	\$104.1	\$465.1
<b>Administrative Expenses</b>											
Total (State and Federal)		\$6.3	\$12.5	\$17.0	\$21.5	\$21.5	\$21.5	\$21.5	\$21.5	\$21.5	\$164.8
Federal Funds		\$3.1	\$6.3	\$8.5	\$10.8	\$10.8	\$10.8	\$10.8	\$10.8	\$10.8	\$82.4
State Funds		\$3.1	\$6.3	\$8.5	\$10.8	\$10.8	\$10.8	\$10.8	\$10.8	\$10.8	\$82.4
<b>Pharmacy Rebate Loss for Nebraska</b>											
Total (State and Federal)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Federal Funds	(\$5.0)	(\$5.5)	(\$5.8)	(\$6.2)	(\$6.5)	(\$6.9)	(\$7.4)	(\$7.8)	(\$8.3)	(\$8.8)	(\$68.1)
State Funds	\$5.0	\$5.5	\$5.8	\$6.2	\$6.5	\$6.9	\$7.4	\$7.8	\$8.3	\$8.8	\$68.1
<b>Physician Fee Schedule Increase to Medicare Rates</b>											
Total (State and Federal)			\$7.2	\$18.3	\$9.4	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$34.9
Federal Funds			\$7.2	\$18.3	\$9.4	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$34.9
State Funds			\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
<b>Foster Children Coverage to Age 26</b>											
Total (State and Federal)				\$2.8	\$5.5	\$5.5	\$5.5	\$5.5	\$5.5	\$5.5	\$35.8
Federal Funds				\$1.6	\$3.2	\$3.2	\$3.2	\$3.2	\$3.2	\$3.2	\$20.6
State Funds				\$1.2	\$2.3	\$2.3	\$2.3	\$2.3	\$2.3	\$2.3	\$15.1
<b>Medically Needy Expansion to 138% FPL</b>											
Total (State and Federal)				\$10.6	\$21.8	\$22.5	\$23.2	\$23.9	\$24.6	\$25.3	\$151.9
Federal Funds				\$10.6	\$21.8	\$22.5	\$22.6	\$22.6	\$23.0	\$23.2	\$146.2
State Funds				\$0.0	\$0.0	\$0.0	\$0.6	\$1.3	\$1.6	\$2.2	\$5.6
<b>DSH Reduction</b>											
Total (State and Federal)				(\$1.0)	(\$1.5)	(\$1.6)	(\$3.9)	(\$10.9)	(\$14.1)	(\$11.4)	(\$44.3)
Federal Funds				(\$0.6)	(\$0.9)	(\$0.9)	(\$2.2)	(\$6.3)	(\$8.1)	(\$6.6)	(\$25.5)
State Funds				(\$0.4)	(\$0.6)	(\$0.7)	(\$1.7)	(\$4.6)	(\$6.0)	(\$4.8)	(\$18.8)

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Division of Medicaid and Long-Term Care  
 Health Care Reform Projection - Mid-Range Participation Scenario  
 (Values in Millions)

8/17/2010  
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EXPENDITURES	<u>SFY 2011</u>	<u>SFY 2012</u>	<u>SFY 2013</u>	<u>SFY 2014</u>	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	SFY 2011 - <u>SFY 2020</u>
<b>CHIP Enrollment Shift and FMAP Increase</b>											
Total (State and Federal)				\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Federal Funds				(\$1.3)	(\$2.7)	\$6.1	\$9.3	\$9.5	\$9.8	\$0.2	\$30.9
State Funds				\$1.3	\$2.7	(\$6.1)	(\$9.3)	(\$9.5)	(\$9.8)	(\$0.2)	(\$30.9)
<b>State Disability Shift to Medicaid and Expansion to 138% FPL</b>											
Total (State and Federal)				\$1.6	\$3.4	\$3.5	\$3.6	\$3.7	\$3.8	\$3.9	\$23.6
Federal Funds				\$6.1	\$12.6	\$12.9	\$13.0	\$13.0	\$13.2	\$13.3	\$84.0
State Funds				(\$4.4)	(\$9.2)	(\$9.4)	(\$9.4)	(\$9.3)	(\$9.4)	(\$9.4)	(\$60.5)
<b>All Programs - After Expansion</b>											
Total (State and Federal)	\$1,816.4	\$1,872.2	\$1,936.6	\$2,307.3	\$2,678.0	\$2,742.4	\$2,815.9	\$2,886.9	\$2,963.9	\$3,049.0	\$25,068.7
Federal Funds	\$1,069.1	\$1,080.3	\$1,116.1	\$1,440.7	\$1,763.2	\$1,811.5	\$1,850.1	\$1,880.8	\$1,925.7	\$1,959.2	\$15,896.7
State Funds	\$747.3	\$791.9	\$820.5	\$866.6	\$914.8	\$930.9	\$965.8	\$1,006.1	\$1,038.2	\$1,089.8	\$9,172.0
<b>All Programs - Fiscal Impact</b>											
Total (State and Federal)	\$0.0	\$6.3	\$19.7	\$338.1	\$655.0	\$664.2	\$681.0	\$693.8	\$710.9	\$734.5	\$4,503.4
Federal Funds	(\$5.0)	(\$2.3)	\$7.6	\$302.0	\$593.4	\$609.8	\$615.5	\$612.6	\$622.8	\$620.8	\$3,977.1
State Funds	\$5.0	\$8.6	\$12.1	\$36.1	\$61.6	\$54.4	\$65.5	\$81.2	\$88.0	\$113.7	\$526.3
<b>Optional Changes to Current Programs</b>											
<b>Pregnant Women (133% - 185%)</b>											
Total (State and Federal)				(\$1.6)	(\$3.3)	(\$3.4)	(\$3.5)	(\$3.6)	(\$3.7)	(\$3.8)	(\$22.8)
Federal Funds				(\$0.9)	(\$1.9)	(\$2.0)	(\$2.0)	(\$2.1)	(\$2.1)	(\$2.2)	(\$13.2)
State Funds				(\$0.7)	(\$1.4)	(\$1.4)	(\$1.5)	(\$1.5)	(\$1.6)	(\$1.6)	(\$9.7)
<b>Breast &amp; Cervical Cancer</b>											
Total (State and Federal)				(\$2.4)	(\$5.0)	(\$5.2)	(\$5.3)	(\$5.5)	(\$5.6)	(\$5.8)	(\$34.8)
Federal Funds				(\$1.7)	(\$3.5)	(\$3.6)	(\$3.7)	(\$3.8)	(\$3.9)	(\$4.0)	(\$24.4)
State Funds				(\$0.7)	(\$1.5)	(\$1.5)	(\$1.6)	(\$1.6)	(\$1.7)	(\$1.7)	(\$10.3)

ATTACHMENT 1



**ENCLOSURE 2**

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Division of Medicaid and Long-Term Care  
 Health Care Reform Projection - Full Participation Scenario  
 (Values in Millions)

8/17/2010  
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EXPENDITURES	<u>SFY 2011</u>	<u>SFY 2012</u>	<u>SFY 2013</u>	<u>SFY 2014</u>	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	SFY 2011 - <u>SFY 2020</u>
<b>Current Programs</b>											
<b>Medicaid</b>											
Total (State and Federal)	\$1,745.1	\$1,792.5	\$1,841.2	\$1,891.3	\$1,942.7	\$1,995.5	\$2,049.7	\$2,105.4	\$2,162.6	\$2,221.4	\$19,747.6
Federal Funds	\$1,029.1	\$1,036.8	\$1,061.3	\$1,090.1	\$1,119.8	\$1,150.2	\$1,181.5	\$1,213.6	\$1,246.5	\$1,280.4	\$11,409.3
State Funds	\$716.0	\$755.7	\$780.0	\$801.2	\$822.9	\$845.3	\$868.3	\$891.9	\$916.1	\$941.0	\$8,338.3
<b>CHIP</b>											
Total (State and Federal)	\$63.2	\$65.1	\$67.0	\$69.0	\$71.1	\$73.3	\$75.4	\$77.7	\$80.0	\$82.4	\$724.4
Federal Funds	\$45.0	\$45.9	\$47.2	\$48.6	\$50.0	\$51.5	\$53.1	\$54.7	\$56.3	\$58.0	\$510.3
State Funds	\$18.1	\$19.2	\$19.9	\$20.5	\$21.1	\$21.7	\$22.4	\$23.0	\$23.7	\$24.4	\$214.1
<b>State Disability</b>											
Total (State and Federal)	\$8.1	\$8.4	\$8.6	\$8.9	\$9.2	\$9.4	\$9.7	\$10.0	\$10.3	\$10.6	\$93.3
Federal Funds	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
State Funds	\$8.1	\$8.4	\$8.6	\$8.9	\$9.2	\$9.4	\$9.7	\$10.0	\$10.3	\$10.6	\$93.3
<b>All Programs</b>											
Total (State and Federal)	\$1,816.4	\$1,866.0	\$1,916.9	\$1,969.2	\$2,023.0	\$2,078.2	\$2,134.9	\$2,193.2	\$2,253.0	\$2,314.4	\$20,565.3
Federal Funds	\$1,074.1	\$1,082.7	\$1,108.5	\$1,138.7	\$1,169.8	\$1,201.7	\$1,234.6	\$1,268.2	\$1,302.9	\$1,338.4	\$11,919.6
State Funds	\$742.3	\$783.3	\$808.5	\$830.5	\$853.2	\$876.5	\$900.4	\$924.9	\$950.1	\$976.0	\$8,645.7

*Attachment 2*

**NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**Division of Medicaid and Long-Term Care**  
**Health Care Reform Projection - Full Participation Scenario**  
(Values in Millions)

8/17/2010  
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EXPENDITURES	<u>SFY 2011</u>	<u>SFY 2012</u>	<u>SFY 2013</u>	<u>SFY 2014</u>	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	SFY 2011 - <u>SFY 2020</u>
<b>Health Care Reform</b>											
<b>Adults/Parents/Children - Expansion to 138% FPL</b>											
Total (State and Federal) - Newly Eligible				\$174.6	\$359.6	\$370.4	\$381.5	\$393.0	\$404.8	\$416.9	\$2,500.8
Total (State and Federal) - Woodwork				\$48.6	\$100.2	\$103.2	\$106.3	\$109.5	\$112.8	\$116.2	\$696.8
Total (State and Federal) - Insured Switchers				\$172.1	\$354.5	\$365.1	\$376.1	\$387.4	\$399.0	\$411.0	\$2,465.2
Federal Funds				\$364.2	\$750.2	\$772.7	\$778.3	\$779.9	\$795.9	\$804.4	\$5,045.5
State Funds				\$31.1	\$64.1	\$66.1	\$85.6	\$109.9	\$120.7	\$139.7	\$617.3
<b>Administrative Expenses</b>											
Total (State and Federal)		\$6.3	\$12.5	\$20.8	\$29.0	\$29.0	\$29.0	\$29.0	\$29.0	\$29.0	\$213.5
Federal Funds		\$3.1	\$6.3	\$10.4	\$14.5	\$14.5	\$14.5	\$14.5	\$14.5	\$14.5	\$106.8
State Funds		\$3.1	\$6.3	\$10.4	\$14.5	\$14.5	\$14.5	\$14.5	\$14.5	\$14.5	\$106.8
<b>Pharmacy Rebate Loss for Nebraska</b>											
Total (State and Federal)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Federal Funds	(\$5.5)	(\$6.0)	(\$6.4)	(\$6.7)	(\$7.1)	(\$7.6)	(\$8.0)	(\$8.5)	(\$9.0)	(\$9.6)	(\$74.4)
State Funds	\$5.5	\$6.0	\$6.4	\$6.7	\$7.1	\$7.6	\$8.0	\$8.5	\$9.0	\$9.6	\$74.4
<b>Physician Fee Schedule Increase to Medicare Rates</b>											
Total (State and Federal)			\$10.1	\$27.3	\$28.1	\$28.9	\$29.7	\$30.5	\$31.3	\$32.2	\$218.0
Federal Funds			\$8.9	\$24.5	\$22.7	\$20.3	\$20.6	\$20.9	\$21.4	\$21.8	\$161.3
State Funds			\$1.2	\$2.8	\$5.4	\$8.6	\$9.0	\$9.5	\$9.9	\$10.4	\$56.8
<b>Foster Children Coverage to Age 26</b>											
Total (State and Federal)				\$2.8	\$5.5	\$5.5	\$5.5	\$5.5	\$5.5	\$5.5	\$35.8
Federal Funds				\$1.6	\$3.2	\$3.2	\$3.2	\$3.2	\$3.2	\$3.2	\$20.6
State Funds				\$1.2	\$2.3	\$2.3	\$2.3	\$2.3	\$2.3	\$2.3	\$15.1
<b>Medically Needy Expansion to 138% FPL</b>											
Total (State and Federal)				\$10.6	\$21.8	\$22.5	\$23.2	\$23.9	\$24.6	\$25.3	\$151.9
Federal Funds				\$10.6	\$21.8	\$22.5	\$22.6	\$22.6	\$23.0	\$23.2	\$146.2
State Funds				\$0.0	\$0.0	\$0.0	\$0.6	\$1.3	\$1.6	\$2.2	\$5.6
<b>DSH Reduction</b>											
Total (State and Federal)				(\$1.0)	(\$1.5)	(\$1.6)	(\$3.9)	(\$10.9)	(\$14.1)	(\$11.4)	(\$44.3)
Federal Funds				(\$0.6)	(\$0.9)	(\$0.9)	(\$2.2)	(\$6.3)	(\$8.1)	(\$6.6)	(\$25.5)
State Funds				(\$0.4)	(\$0.6)	(\$0.7)	(\$1.7)	(\$4.6)	(\$6.0)	(\$4.8)	(\$18.8)

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Division of Medicaid and Long-Term Care  
 Health Care Reform Projection - Full Participation Scenario  
 (Values in Millions)

8/17/2010  
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EXPENDITURES	<u>SFY 2011</u>	<u>SFY 2012</u>	<u>SFY 2013</u>	<u>SFY 2014</u>	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	SFY 2011 - <u>SFY 2020</u>
<b>CHIP Enrollment Shift and FMAP Increase</b>											
Total (State and Federal)				\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Federal Funds				(\$1.3)	(\$2.7)	\$6.1	\$9.3	\$9.5	\$9.8	\$0.2	\$30.9
State Funds				\$1.3	\$2.7	(\$6.1)	(\$9.3)	(\$9.5)	(\$9.8)	(\$0.2)	(\$30.9)
<b>State Disability Shift to Medicaid and Expansion to 138% FPL</b>											
Total (State and Federal)				\$1.6	\$3.4	\$3.5	\$3.6	\$3.7	\$3.8	\$3.9	\$23.6
Federal Funds				\$6.1	\$12.6	\$12.9	\$13.0	\$13.0	\$13.2	\$13.3	\$84.0
State Funds				(\$4.4)	(\$9.2)	(\$9.4)	(\$9.4)	(\$9.3)	(\$9.4)	(\$9.4)	(\$60.5)
<b>All Programs - After Expansion</b>											
Total (State and Federal)	\$1,816.4	\$1,872.2	\$1,939.5	\$2,426.7	\$2,923.6	\$3,004.8	\$3,085.9	\$3,164.7	\$3,249.7	\$3,343.0	\$26,826.5
Federal Funds	\$1,068.6	\$1,079.8	\$1,117.2	\$1,547.4	\$1,984.1	\$2,045.4	\$2,085.7	\$2,117.1	\$2,166.7	\$2,202.8	\$17,414.9
State Funds	\$747.8	\$792.4	\$822.3	\$879.2	\$939.6	\$959.3	\$1,000.1	\$1,047.6	\$1,083.0	\$1,140.3	\$9,411.6
<b>All Programs - Fiscal Impact</b>											
Total (State and Federal)	\$0.0	\$6.3	\$22.6	\$457.4	\$900.7	\$926.6	\$951.0	\$971.5	\$996.7	\$1,028.6	\$6,261.2
Federal Funds	(\$5.5)	(\$2.8)	\$8.8	\$408.7	\$814.3	\$843.7	\$851.2	\$848.8	\$863.8	\$864.4	\$5,495.3
State Funds	\$5.5	\$9.1	\$13.8	\$48.7	\$86.4	\$82.9	\$99.8	\$122.7	\$132.8	\$164.2	\$765.9
<b>Optional Changes to Current Programs</b>											
<b>Pregnant Women (133% - 185%)</b>											
Total (State and Federal)				(\$1.6)	(\$3.3)	(\$3.4)	(\$3.5)	(\$3.6)	(\$3.7)	(\$3.8)	(\$22.8)
Federal Funds				(\$0.9)	(\$1.9)	(\$2.0)	(\$2.0)	(\$2.1)	(\$2.1)	(\$2.2)	(\$13.2)
State Funds				(\$0.7)	(\$1.4)	(\$1.4)	(\$1.5)	(\$1.5)	(\$1.6)	(\$1.6)	(\$9.7)
<b>Breast &amp; Cervical Cancer</b>											
Total (State and Federal)				(\$2.4)	(\$5.0)	(\$5.2)	(\$5.3)	(\$5.5)	(\$5.6)	(\$5.8)	(\$34.8)
Federal Funds				(\$1.7)	(\$3.5)	(\$3.6)	(\$3.7)	(\$3.8)	(\$3.9)	(\$4.0)	(\$24.4)
State Funds				(\$0.7)	(\$1.5)	(\$1.5)	(\$1.6)	(\$1.6)	(\$1.7)	(\$1.7)	(\$10.3)

ATTACHMENT 2

**medicaid**  
and the **uninsured**

**Medicaid Coverage and Spending in Health Reform:  
National and State-by-State Results for Adults at or Below 133% FPL**

*Prepared by:*

John Holahan and Irene Headen  
Urban Institute

**May 2010**



# kaiser commission medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

James H. Farkon

Chairman

Diane Rowland, M.D.

Executive Director

## Executive Summary

The Patient Protection and Affordable Care Act (PPACA) expands Medicaid to nearly all individuals under age 65 with incomes up to 133 percent of the federal poverty line (FPL) which will extend coverage to large numbers of the nation's uninsured population, especially adults. However, the ultimate reach of the program will depend heavily on both federal and state actions to implement the new law. The Congressional Budget Office (CBO) has provided national estimates of the impacts of health reform, but does not provide state-by-state estimates. We know that the impact of health reform will vary across states based on coverage levels in states today. This analysis provides national and state-by-state estimates of the increases in coverage and the associated costs compared to a baseline scenario without the Medicaid expansions in health reform. Nationally and across states, this analysis shows that:

- ***Medicaid expansions will significantly increase coverage and reduce the number of uninsured***
- ***The federal government will pay a very high share of new Medicaid costs in all states***
- ***Increases in state spending are small compared to increases in coverage and federal revenues and relative to what states would have spent if reform had not been enacted***

Today there is a great deal of variation across states in terms of Medicaid coverage, the uninsured, state fiscal capacity, leadership and priorities. These variations make it impossible to know how each state individually will respond to the new health reform law. There are a range of implementation scenarios that will impact the number of people who participate or sign up for coverage and these participation rates are directly related to the estimates of coverage and cost for health reform. Since it is impossible to predict the behavior of each state, this analysis examines two participation rate scenarios that are applied uniformly across states; however, we recognize that some states may implement reform to achieve coverage levels above expectations and others may be slower to implement reform or face implementation barriers that result in lower coverage levels. The two modeled scenarios are:

1. ***Standard Participation Scenario.*** This scenario attempts to approximate participation rates used by the CBO to estimate the national impact of the Medicaid expansion and then examines the results by state. These results assume moderate levels of participation similar to current experience among those made newly eligible for coverage and little additional participation among those currently eligible. This scenario assumes 57 percent participation among the newly eligible uninsured and lower participation across other coverage groups.
2. ***Enhanced Outreach Scenario.*** This scenario examines the impact and reach of Medicaid assuming a more aggressive outreach and enrollment campaign by federal and state governments as well as key stakeholders including community based organizations and providers that would promote more robust participation among those newly eligible (75 percent participation among the newly eligible that are currently uninsured and lower participation across other coverage groups) and higher participation among those currently eligible for coverage than in the standard scenario.

Even in a scenario with higher participation, we did not assume that there will be full or 100 percent participation. We did not model a participation rate lower than the standard, but this scenario might result in coverage levels that are not a substantial improvement over what would have occurred in the absence of reform (or baseline levels).

This analysis estimates the impact of the coverage provisions for adults in health reform between 2014 and 2019 but does not account for other Medicaid changes in the law. For a more detailed description of the methods used in the analysis for this brief and a description of how the changes in the Medicaid match rates are applied to different populations, see the full text of the report and boxes 1 and 2 at the end of the executive summary.

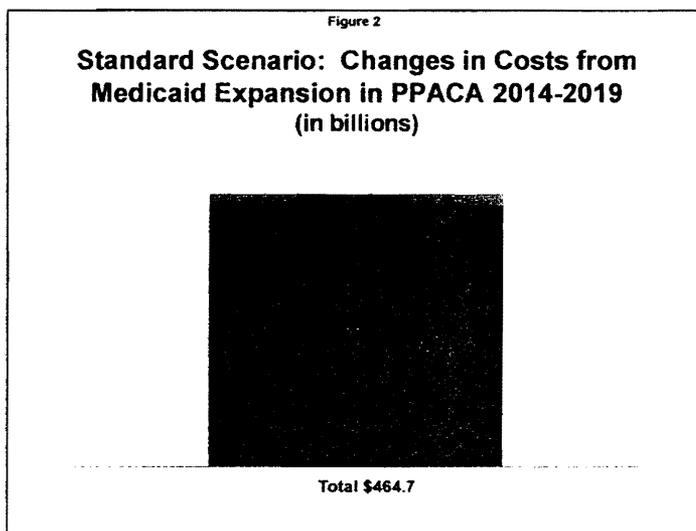
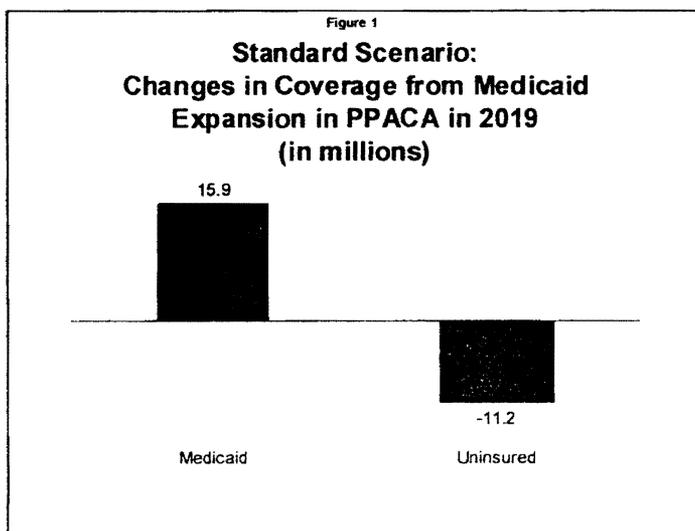
### Standard Participation Scenario

This scenario assumes that states will implement health reform and achieve levels of participation similar to current enrollment in Medicaid among those made newly eligible for coverage; however, this scenario assumes little additional participation among those currently eligible. These results attempt to approximate participation rates used by the CBO.

#### National Results

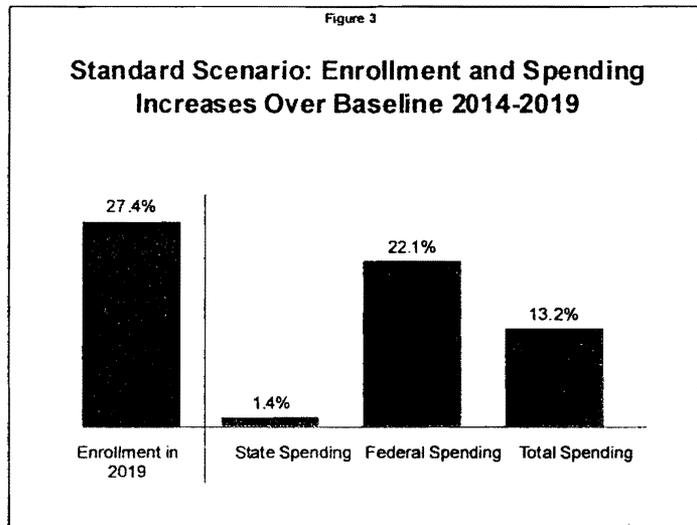
**Medicaid expansions will significantly increase coverage and reduce the number of uninsured.** Medicaid enrollment is projected to increase by 15.9 million by 2019. This new coverage would result in a reduction of uninsured adults under 133 percent of poverty of 11.2 million, a 45 percent reduction in 2019 (Figure 1). States with more limited coverage and higher uninsured rates pre-reform (like Texas) will see larger decreases in the uninsured compared to states with broader coverage and fewer uninsured pre-reform (like Massachusetts).

**The federal government will pay a very high share of new Medicaid costs in all states.** In this scenario, federal spending would increase by \$443.5 billion and state spending would increase by \$21.1 billion between 2014-2019 (Figure 2). Thus about 95 percent of all new spending would be by the federal government. Spending in 2014 is expected to be relatively small, particularly for states because enrollment is being phased-in and the federal matching rate for new eligibles is 100 percent. Overall and state spending increases by 2019 as coverage is phased in to full implementation levels and federal matching rates for new eligibles fall to 93 percent from 100 percent.



*Increases in state spending are small compared to increases in coverage and federal revenues and relative to what states would have spent if reform had not been enacted (baseline).* Nationally, enrollment is expected to increase by 27.4 percent compared to baseline. This increase in enrollment far exceeds increases in state spending relative to baseline of 1.4 percent. Due to the large increase in federal matching rates, the federal increases in Medicaid spending compared to baseline are expected to be 22.1 percent with overall spending increases of 13.2 percent.

(Figure 3) The federal matching rates pre-reform and pre-ARRA average 57.1 percent. The federal matching rate after reform is the combination of current matching rates on current eligibles, expansion state match rate for certain childless adults, and the higher federal matching rates on new eligibles. The aggregate match rates for Medicaid or the share of total Medicaid spending financed by the federal government is expected to increase from 57.1 percent (under current law) to 61.6 percent; however, states that have had large increases in the number of new eligibles will see the greatest increases in matching rates.



### **State-by-State Results**

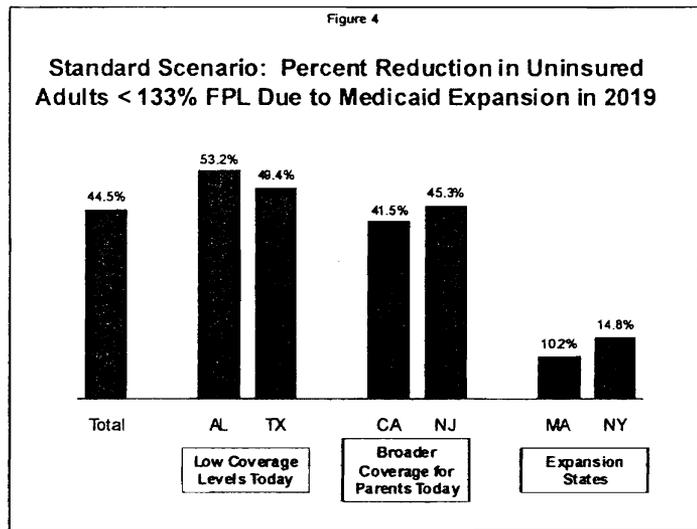
The impact of the Medicaid expansions under health reform will vary across states based on current levels of coverage and current match rates for states. The next section reviews the variation in the impact of costs and coverage across states. For state-by-state results of the standard scenario see Table 1. For purposes of this discussion we group the results into the experience in three types of states. For each group we will use the results from two states as illustrative of the experience for other states in that group:

- States with low Medicaid eligibility for adults today (Alabama and Texas)
- States that have broader coverage today for parents but have no Medicaid coverage for childless adults (California and New Jersey), and
- Expansion states that cover both parents and childless adults in Medicaid today (Massachusetts and New York).<sup>1</sup>

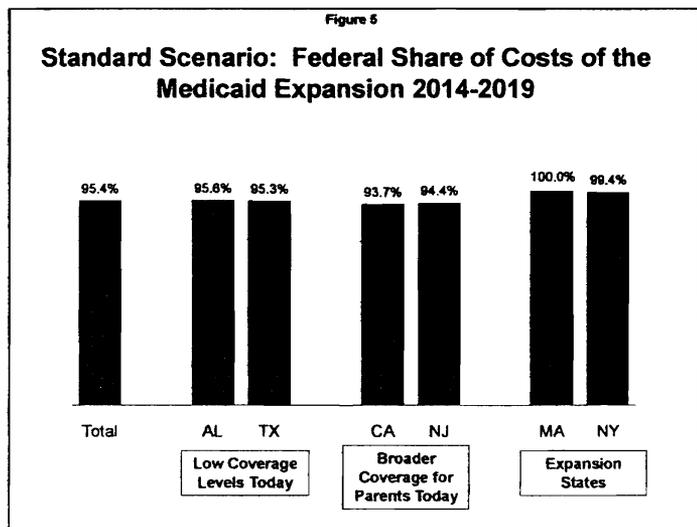
<sup>1</sup> For this analysis we assume that there are seven “expansion states” which include: Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, and Vermont.

**The Medicaid expansion will result in large reductions in the uninsured across states, but especially in states that have higher levels of uninsured today.** Overall, the Medicaid expansion is expected to result in a decrease in the number of uninsured of 11.2 million people, or 45 percent of the uninsured adults below 133 percent of poverty. States with low coverage levels and higher uninsured rates today will see larger reductions (Alabama 53.2 percent and Texas 49.4). States with broader coverage levels for parents today, no coverage for childless adults and high uninsured rates will also see large reductions in the uninsured (California 41.5 percent and New Jersey 45.3 percent). States with lower uninsured rates today will see smaller reductions (Massachusetts 10.2 percent and New York 14.8 percent). (Figure 4)

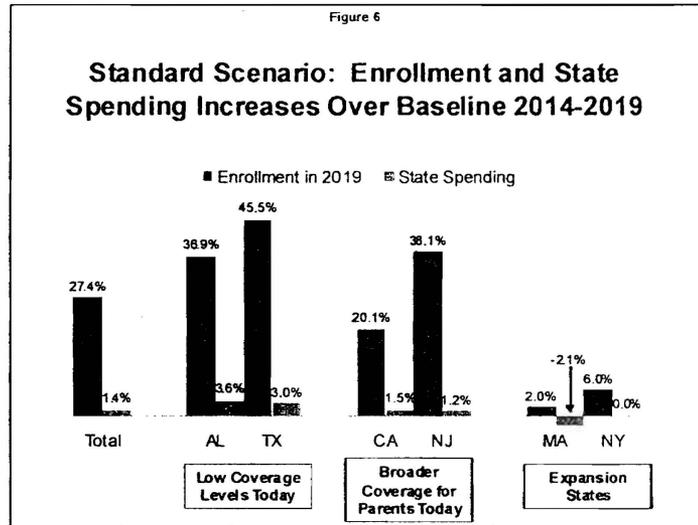
Overall, Texas and California could each see a reduction in the uninsured of about 1.4 million compared to baseline in 2019.



**The actual federal share of the costs of the Medicaid expansion varies based on state coverage levels today, but it is always very high.** States with low coverage levels today will see the vast majority of the costs of new enrollment financed by the federal government over the 2014 to 2019 period because most of their increased enrollment is from individuals made eligible by health reform who qualify for the high newly eligible match rate (for Alabama, 96 percent and Texas, 95 percent). States with broader coverage of parents today have the majority of costs financed by the federal government, but at slightly lower levels because they experience a higher participation of those currently eligible whose coverage is reimbursed at the states' regular match rates (California, 94 percent and New Jersey 94 percent). For expansion states, the level of federal financing varies with the proportion of current eligibles to newly eligible or those eligible for the expansion match rate. Massachusetts, a state with no new eligibles, will actually achieve some savings because the benefit of the expansion match rate for current and new coverage of childless adults outweighs any new state costs related to increases in participation for parents at the regular Medicaid match rate. States with state funded coverage programs for adults benefit because these adults will be considered newly eligible for Medicaid and qualify for the newly eligible match rate. Generally, states will benefit from a large influx of federal dollars and new coverage is likely to reduce the need for state payments for uncompensated care. (Figure 5)



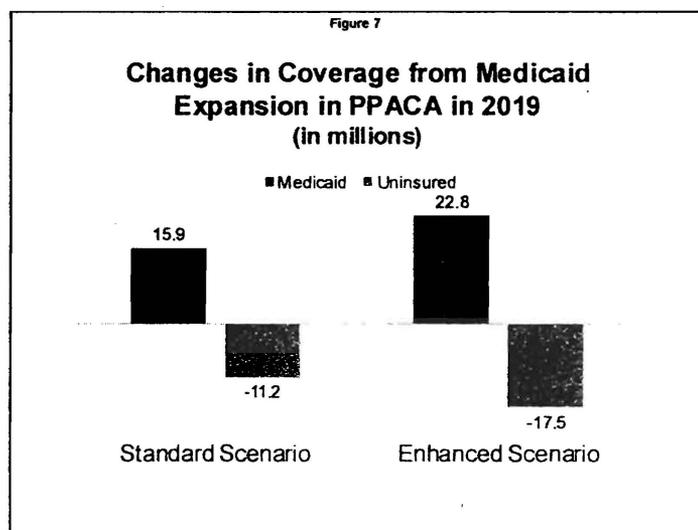
*Compared to projected enrollment without health reform, increases in new enrollment and coverage will far exceed new state costs, but these increases vary based on current levels of coverage across states.* States with more modest coverage today are expected to see large increases in enrollment compared to projections without health reform. Increases in enrollment will be lower in states that have already covered a large share of these populations. Increases in enrollment far exceed increases in state spending relative to baseline estimates and this differential is biggest in states with low coverage today. For example, Texas could see an increase in enrollment of 46 percent but an increase in state spending of about 3 percent. Federal spending in Texas is expected to increase by 39 percent compared to baseline. States with low coverage today are expected to see large increases in federal spending relative to baseline both because of the very favorable matching rate on new eligibles and because these states also have a high regular Medicaid match rate for current eligibles. Increases in coverage and spending will be lower in states that have already covered a large share of these populations. (Figure 6)



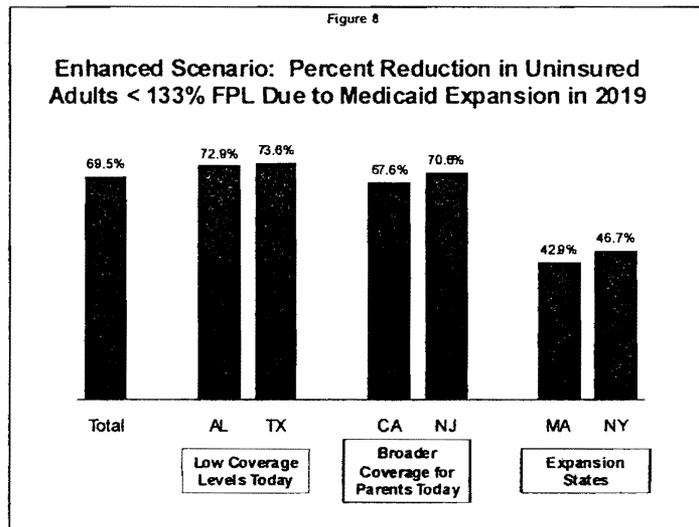
### Enhanced Outreach Scenario

This scenario examines the impact on Medicaid and the uninsured assuming a more aggressive outreach and enrollment campaign at both the federal and state levels that would promote more robust participation in Medicaid and further reduce the number of uninsured in this low-income population compared to the standard scenario. The enhanced scenario also assumes that individuals respond favorably to the new mandate for coverage. Even though the large majority of those eligible for Medicaid will be exempt from the penalties for failure to comply with the mandate, a new culture of coverage along with outreach efforts are likely to yield more participation. These factors would increase participation of both those made newly eligible for coverage under health reform and eligible for coverage prior to changes in reform.

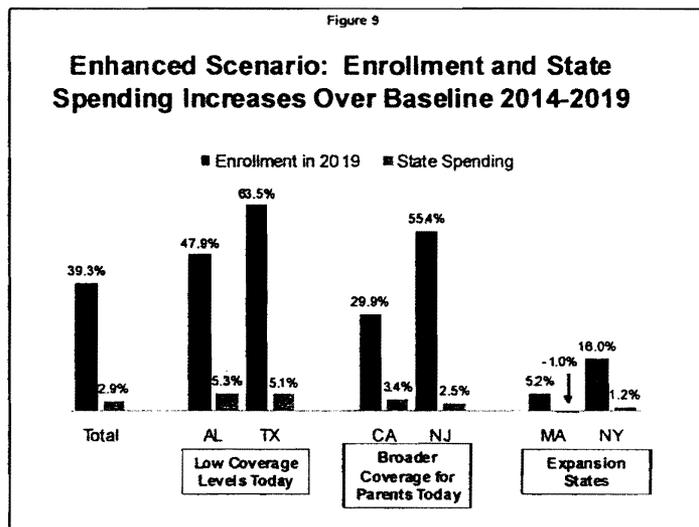
Under the enhanced outreach scenario applied uniformly across states, Medicaid enrollment could increase by 22.8 million by 2019 resulting in a 17.5 million reduction in uninsured adults under 133 percent of poverty (a 70 percent reduction). (Figure 7)



Compared to the standard scenario, states will see larger reductions in the uninsured. Similar to the standard scenario, states with low coverage levels today will see larger reductions (Alabama 73 percent and Texas 74 percent). States with broader coverage levels for parents but no coverage for childless adults and high uninsured rates will also see large reductions in the uninsured (California 68 percent and New Jersey 71 percent). States with lower uninsured rates today will see smaller reductions (Massachusetts 43 percent reduction and New York 47 percent). (Figure 8) In this scenario, California could see a reduction in the uninsured of 2.3 million and Texas could see a 2.1 million reduction compared to baseline projections in 2019. See Table 2 for the state-by-state results of the enhanced participation scenario.



Under these higher participation assumptions, new spending for Medicaid would continue to be mostly federal (92.5 percent) over the 2014 to 2019 period. State spending could increase by \$43 billion while federal spending could increase by \$532 billion. The share of spending borne by the federal government will be somewhat lower under the higher participation assumptions, primarily due to higher take-up among those who are eligible under pre-PPACA rules. Since the states will receive lower federal matching rates for those previously eligible, states will be responsible for a higher share of their costs. Relative to baseline spending, Medicaid enrollment could increase by 39 percent, significantly higher than state spending increases of 2.9 percent. Federal spending nationally in this scenario could be about 27 percent higher than baseline projections. (Figure 9) . In this scenario, the aggregate match rates for Medicaid or the share of total Medicaid spending financed by the federal government is expected to increase from 57.1 percent (under current law) to 62.1 percent; however, states with large increases in the number of new eligibles will see the greatest increases in matching rates.



### Limited Outreach Scenario

Right now, states are still in the midst of a major economic downturn facing historic declines in revenues and increased demand for public programs. The impact of the downturn varies across states and the economic recovery will vary across states as well. Heading into health reform, some states will move quickly to promote coverage with efforts that may begin in 2010, while others may move more slowly. Some are challenging and opposing health reform through amendments to their state statutes and constitutions, ballot initiatives and court challenges. Continuing an approach to Medicaid that dates back to its enactment in 1965, health reform revises the standards with which states that choose to participate in the program must comply. Because

Medicaid is voluntary, states may choose to not to participate and thereby forego the federal Medicaid funding to which participating states are entitled. States that elect not to implement these new requirements in effect would be making the choice not to participate.

The outcome of state actions will affect the extent to which implementation of health reform reaches its fullest potential. If states fall short of implementation expectations, fewer individuals will be covered and more individuals will remain uninsured. Under this scenario, states would also forgo large sums of federal funding tied to the coverage of those made newly eligible under reform. Even though states would have higher numbers of uninsured in this scenario, they will also face a reduction in the federal dollars to support uncompensated care since the new law calls for reductions in disproportionate share hospital payments (DSH) of \$14 billion over the 2014 to 2019 period.

## **Conclusion**

The changes to the Medicaid program under the Patient Protection and Affordability Care Act (PPACA) significantly expand Medicaid coverage for adults. There will be large increases in coverage and federal funding in exchange for a small increase in state spending. States with low coverage levels and high uninsured rates will see the largest increases in coverage and federal funding. Higher levels of coverage will allow states to reduce payments they make to support uncompensated care costs.

The impact of health reform will vary across states based on coverage levels in states today, state decisions about implementation and ultimately the number of individuals who sign up for coverage. It is impossible to know how individual states will respond, so this analysis looked at a range of participation assumptions that are applied uniformly across states, but in reality this will vary. Some states may not aggressively implement health reform and therefore not see significant reductions in the uninsured while other states will have higher levels of participation because of effective outreach and enrollment strategies and see greater reductions in the number of uninsured.

## Box 1: Methods Summary

**The Model Database.** We use the 2007 and 2008 Current Population Survey (CPS) as our baseline data set (which provides data for 2006 and 2007). It is generally accepted that the CPS has an undercount of the Medicaid population. We adjust for the undercount with a partial adjustment to state administrative data. We then generate a 2009 dataset by growing the population to 2009. We account for the impact of unemployment on coverage which has the effect of reducing employer coverage, increasing Medicaid enrollment, and increasing the number of uninsured. We also benchmark to 2009 CPS total population estimates by state and estimate population growth to 2019 using growth rates based on Census population projections.

**Eligibility Simulation.** To estimate the impact of health reform on states, we use a model developed at the Urban Institute's Health Policy Center (Health Insurance Policy Simulation Model or HIPSM). The model takes into account state-level eligibility requirements for Medicaid and CHIP eligibility pathways and applies them to person- and family-level data from the Annual Social and Economic Supplement to the CPS to simulate the eligibility determination process. The model identifies eligibility for Section 1115 waiver programs which is critical for determining match rates for coverage in seven states: Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, and Vermont.

**Participation Rates.** Once we have identified individuals who are newly eligible for Medicaid, we then assess the likelihood that they will participate in Medicaid under reform. The uninsured are likely to participate at relatively higher rates post-reform because they currently lack coverage but not all new participation will come from the ranks of the uninsured. Participation rates are also likely to increase for those who are currently eligible but not participating in Medicaid. Under the standard scenario, we use a set of participation rates that attempt to approximate those used by CBO (57% participation from the uninsured and lower rates for other coverage groups). The actual participation rates assumed in the CBO estimates are not publicly available. We also look at the impact of a scenario with aggressive broader outreach and enrollment efforts and stronger response to the individual mandate (even though the Medicaid population is largely exempt from these requirements). In this scenario we assume 75% participation of the uninsured and lower rates for other coverage groups.

Baseline Coverage	Standard Scenario	Enhanced Scenario
<b>Current Eligibles</b>		
ESI	3%	5%
Non-group	7%	10%
Uninsured	10%	40%
<b>New Eligibles</b>		
ESI	25%	25%
Non-group	54%	60%
Uninsured	57%	75%

**Cost per Person.** We make estimates on the costs per enrollee using data from HIPSM. These estimates are based on the Medical Expenditure Panel Survey (MEPS) but calibrated to reflect differences in health status of Medicaid eligibles who are currently uninsured, have non-group coverage, or employer-sponsored insurance. Estimates from MEPS are adjusted to be consistent with targets from the Medicaid Statistical Information System (MSIS). Cost per enrollee is then grown to 2019 using growth rates taken from the CBO March 2009 baseline.

**The Baseline.** We use estimates of state and federal Medicaid spending in the baseline, i.e. what would have happened without reform if current law continued, to assess the impact of reform. Baseline enrollment and national spending totals for the years 2009-2019 were calculated using published CBO estimates from March 2009 to grow data from the 2007 Medicaid Statistical Information Statistics (MSIS) and CMS Form-64 Medicaid Financial Report (CMS-64). Using published Federal Medical Assistance Percentages (FMAP) from the Department of Health and Human Services, we calculated the federal and state share of spending for each state. These 2007 federal spending counts were grown to match 2009 spending from the CBO by enrollment group at the national level. Then these same growth rates were applied to each state. Published 2009 FMAP rates were then used to calculate the state and total spending amounts in 2009. This process was repeated for each year, 2010 through 2019, using CBO estimates and the most recent FMAP rates for each year, without the adjustments made by the American Recovery and Reinvestment Act (ARRA).

**Other Assumptions.** These estimates do not account for: increased participation for states with current Medicaid coverage levels above 133% FPL because after 2014 states are unlikely to continue to cover these individuals on Medicaid; costs associated with the increase in physician payment rates for primary care; the effects of reform for children; or the fiscal implications of the reductions of disproportionate share hospital payments. Finally, the analysis also does not account for any changes in Medicaid between 2010 and 2014. States are permitted to extend coverage to childless adults and receive their regular federal medical assistance percentages (FMAP) until 2014.

## Box 2: Medicaid Match Rates for Coverage in Health Reform Summary

The health reform law establishes a new, minimum standard for Medicaid coverage that is uniform across the country and fills the biggest gaps in coverage for low-income people. Specifically, the PPACA requires states by January 1, 2014, to extend Medicaid eligibility to all groups of people under age 65 with income up to 133 percent of the FPL who are not otherwise eligible for Medicaid.<sup>2</sup> For most states, this will mean providing Medicaid to adults without children for the first time, as well as increasing their income eligibility threshold for parents to 133 percent of the federal poverty line. The law specifies different match rates for individuals eligible for coverage as of December 1, 2009; those made newly eligible for coverage under health reform and for certain expansion states.

- Regular Medicaid Matching Rate:** The regular Medicaid matching rate is determined by a formula that has been in place since the program was enacted in 1965. It ranges from 50 percent to 76 percent, and is designed to provide more federal support to states with lower per capita incomes. In 2014, it will continue to be used for “already-eligible” individuals (people who qualify for Medicaid under the rules in effect on December 1, 2009).
- Newly-Eligible Matching Rate:** The newly-eligible matching rate assures that the federal government finances much of the cost of the Medicaid expansion to 133 percent of the FPL included in the health reform legislation. It is set at 100 percent in FY2014 through FY2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond. Beginning in 2014, it is available for non-elderly adults with income up to 133 percent of the FPL who are not eligible for Medicaid under the rules that a state had in place on December 1, 2009.
- “Expansion” States Matching Rate:** The transition-matching rate is designed to provide some additional federal help to “expansion” states (states that expanded coverage for adults to at least 100 percent of the FPL prior to enactment of health reform). These states can receive a phased-in increase in their federal matching rate for adults without children under age 65 beginning on January 1, 2014 so that by 2019 it will equal the enhanced matching rate available for newly-eligible adults. This analysis assumes that there are seven states that fall into this category: Arizona, Delaware, Hawaii, Massachusetts, Maine, New York, and Vermont.

### Enhanced Matching Rates for Parents and Childless Adults, 2014 and Beyond

Year	Newly-Eligible Parents & Childless Adults (up to 133% FPL)	Medicaid-Eligible Childless Adults in “Expansion” States Only		
		Transition Percentage used to Calculate Enhanced Match	Example: State with 50% Original FMAP <i>Regular FMAP + [(Newly-Eligible Enhanced Match Rate – Regular FMAP) x Transition Percentage]</i>	Example: State with 60% Original FMAP <i>Regular FMAP + [(Newly-Eligible Enhanced Match Rate – Regular FMAP) x Transition Percentage]</i>
2014	100%	50%	75%	80%
2015	100%	60%	80%	84%
2016	100%	70%	85%	88%
2017	95%	80%	86%	88%
2018	94%	90%	89.6%	90.6%
2019	93%	100%	93%	93%
2020 on	90%	100%	90%	90%

<sup>2</sup>To promote coordination, the gross income standard that will be used for the premium tax credits available in the Exchanges also will apply to most existing Medicaid eligibility groups. A standard five percent of income disregard will be built into the gross income test for Medicaid to compensate for the loss of other, existing Medicaid disregards. In addition, states will no longer be able to impose asset tests on most Medicaid populations.

**Table 1: Standard Participation Scenario**

	Coverage in 2019			Spending in 2014-2019 (in millions)				Change From Baseline 2014-2019			
	Total New Medicaid Enrollees*	Previously Uninsured Newly Enrolled	% Reduction in Uninsured Adults < 133% FPL	State Spending	Federal Spending	Total Spending	% Federal Spending	Enrollment in 2019	State Spending	Federal Spending	Total Spending
<b>Northeast</b>											
Connecticut	114,083	75,864	48.0%	\$263	\$4,686	\$4,949	94.7%	20.1%	1.2%	21.0%	11.1%
Maine	43,468	27,877	47.4%	-\$118	\$1,857	\$1,738	100%*	11.8%	-1.5%	12.9%	7.7%
Massachusetts**	29,921	10,401	10.2%	-\$1,274	\$2,137	\$864	100%*	2.0%	-2.1%	3.5%	0.7%
New Hampshire	55,918	34,625	48.7%	\$63	\$1,204	\$1,267	95.0%	38.8%	1.1%	21.3%	11.2%
New Jersey	390,490	292,489	45.3%	\$533	\$9,030	\$9,563	94.4%	38.1%	1.2%	20.9%	11.1%
New York	305,945	223,175	14.8%	\$50	\$8,049	\$8,099	99.4%	6.0%	0.0%	3.3%	1.7%
Pennsylvania	482,366	282,014	41.4%	\$1,054	\$17,086	\$18,140	94.2%	21.7%	1.4%	17.7%	10.5%
Rhode Island	41,185	29,147	50.6%	\$70	\$1,559	\$1,629	95.7%	20.0%	0.7%	14.6%	8.1%
Vermont	4,484	3,214	10.2%	-\$26	\$112	\$86	100%*	2.8%	-0.6%	1.9%	0.9%
<b>Midwest</b>											
Illinois	631,024	429,258	42.5%	\$1,202	\$19,259	\$20,461	94.1%	25.8%	1.6%	25.9%	13.8%
Indiana	297,737	215,803	44.2%	\$478	\$8,535	\$9,013	94.7%	29.4%	2.5%	22.9%	16.1%
Iowa	114,691	74,498	44.1%	\$147	\$2,800	\$2,947	95.0%	25.3%	1.4%	15.7%	10.3%
Kansas	143,445	89,265	50.9%	\$166	\$3,477	\$3,643	95.4%	42.0%	1.7%	24.0%	14.8%
Michigan	589,965	430,744	50.6%	\$686	\$14,252	\$14,938	95.4%	30.2%	2.0%	21.5%	14.8%
Minnesota	251,783	132,511	44.2%	\$421	\$7,836	\$8,257	94.9%	32.9%	1.2%	22.0%	11.6%
Missouri	307,872	207,678	45.5%	\$431	\$8,395	\$8,826	95.1%	29.8%	1.7%	19.5%	13.0%
Nebraska	83,898	50,364	53.9%	\$106	\$2,345	\$2,451	95.7%	36.2%	1.5%	23.5%	14.4%
North Dakota	28,864	17,198	45.1%	\$32	\$595	\$627	94.9%	44.0%	1.4%	16.9%	10.8%
Ohio	667,376	462,024	50.0%	\$830	\$17,130	\$17,960	95.4%	31.9%	1.6%	19.2%	12.8%
South Dakota	31,317	18,594	51.9%	\$32	\$717	\$748	95.8%	25.9%	1.1%	16.4%	10.5%
Wisconsin	205,987	127,862	50.6%	\$205	\$4,252	\$4,457	95.4%	20.8%	0.9%	12.7%	8.0%
<b>South</b>											
Alabama	351,567	244,804	53.2%	\$470	\$10,305	\$10,776	95.6%	36.9%	3.6%	35.9%	25.7%
Arkansas	200,690	154,836	47.6%	\$455	\$9,401	\$9,856	95.4%	27.9%	4.7%	38.9%	29.1%
Delaware	12,081	7,916	15.9%	\$3	\$387	\$390	99.2%	6.7%	0.1%	6.2%	3.3%
District of Columbia	28,900	15,308	49.1%	\$42	\$902	\$944	95.6%	16.1%	0.9%	8.3%	6.1%
Florida	951,622	683,477	44.4%	\$1,233	\$20,050	\$21,283	94.2%	34.7%	1.9%	24.3%	14.3%
Georgia	646,557	479,138	49.4%	\$714	\$14,551	\$15,265	95.3%	40.4%	2.7%	28.9%	19.8%
Kentucky	329,000	250,704	57.1%	\$515	\$11,878	\$12,393	95.8%	37.3%	3.5%	32.2%	24.0%
Louisiana	366,318	277,746	50.7%	\$337	\$7,273	\$7,610	95.6%	32.4%	1.7%	21.6%	14.4%
Maryland	245,996	174,484	46.2%	\$533	\$9,112	\$9,645	94.5%	32.4%	1.7%	29.6%	15.6%
Mississippi	320,748	256,920	54.9%	\$429	\$9,865	\$10,294	95.8%	41.2%	4.8%	37.0%	28.9%
North Carolina	633,485	429,272	46.6%	\$1,029	\$20,712	\$21,741	95.3%	38.2%	2.6%	29.0%	19.7%
Oklahoma	357,150	261,157	53.1%	\$549	\$12,179	\$12,728	95.7%	51.2%	4.0%	48.2%	32.7%
South Carolina	344,109	247,478	56.4%	\$470	\$10,919	\$11,389	95.9%	38.4%	3.6%	36.0%	26.3%
Tennessee	330,932	245,691	43.3%	\$716	\$11,072	\$11,788	93.9%	20.9%	2.5%	20.4%	14.3%
Texas	1,798,314	1,379,713	49.4%	\$2,619	\$52,537	\$55,156	95.3%	45.5%	3.0%	38.9%	24.7%
Virginia	372,470	245,840	50.6%	\$498	\$9,629	\$10,127	95.1%	41.8%	1.8%	35.1%	18.4%
West Virginia	121,635	95,675	56.7%	\$164	\$3,781	\$3,945	95.9%	29.5%	2.4%	20.4%	15.6%
<b>West</b>											
Alaska	42,794	33,106	48.4%	\$117	\$2,046	\$2,163	94.6%	38.5%	2.1%	36.9%	19.5%
Arizona	105,428	81,095	13.6%	\$56	\$2,091	\$2,147	97.4%	7.7%	0.2%	4.2%	2.9%
California	2,008,796	1,406,101	41.5%	\$2,982	\$44,694	\$47,676	93.7%	20.1%	1.5%	23.0%	12.3%
Colorado	245,730	166,471	50.0%	\$286	\$5,917	\$6,203	95.4%	47.7%	1.8%	37.1%	19.4%
Hawaii	84,130	42,381	50.0%	-\$28	\$2,999	\$2,971	100%*	38.0%	-0.5%	46.8%	24.0%
Idaho	85,883	59,078	53.9%	\$101	\$2,402	\$2,502	96.0%	39.4%	2.5%	27.1%	19.4%
Montana	57,356	37,978	49.6%	\$100	\$2,178	\$2,278	95.6%	54.5%	3.7%	40.0%	27.9%
Nevada	136,563	100,813	47.0%	\$188	\$3,445	\$3,633	94.8%	61.7%	2.9%	49.8%	27.1%
New Mexico	145,024	111,279	52.6%	\$194	\$4,510	\$4,704	95.9%	28.3%	2.1%	21.3%	15.5%
Oregon	294,600	211,542	56.7%	\$438	\$10,302	\$10,739	95.9%	60.6%	3.6%	50.6%	33.1%
Utah	138,918	78,284	52.5%	\$174	\$4,129	\$4,304	96.0%	56.1%	3.7%	35.3%	26.2%
Washington	295,662	189,463	52.2%	\$380	\$8,271	\$8,651	95.6%	25.2%	1.2%	26.0%	13.6%
Wyoming	29,899	19,099	53.0%	\$32	\$683	\$715	95.6%	40.0%	1.2%	26.8%	14.0%
<b>Total</b>	<b>15,904,173</b>	<b>11,221,455</b>	<b>44.5%</b>	<b>\$21,148</b>	<b>\$443,530</b>	<b>\$464,678</b>	<b>95.4%</b>	<b>27.4%</b>	<b>1.4%</b>	<b>22.1%</b>	<b>13.2%</b>

\*Includes newly enrolled 1115 waiver eligible population.

\*\*Massachusetts has a low share of uninsured within the newly enrolled due to low levels of uninsurance in the baseline.

Note: These estimates relate solely to the Medicaid expansion and do not account for other changes in health reform such as access to subsidized coverage in the exchanges or state or federal savings from reduced uncompensated care or the transition of individuals from state-funded programs to Medicaid in 2014.

**Table 2: Enhanced Outreach Scenario**

	Coverage in 2019			Spending in 2014-2019 (in millions)				Change From Baseline 2014-2019			
	Total New Medicaid Enrollees*	Previously Uninsured Newly Enrolled	% Reduction in Uninsured Adults < 133% FPL	State Spending	Federal Spending	Total Spending	% Federal	Enrollment in 2019	State Spending	Federal Spending	Total Spending
<b>Northeast</b>											
Connecticut	154,664	113,876	72.1%	\$440	\$5,048	\$5,488	92.0%	27.3%	2.0%	22.6%	12.3%
Maine	59,502	41,858	71.1%	-\$65	\$2,105	\$2,040	100%*	16.2%	-0.8%	14.7%	9.1%
Massachusetts**	75,569	43,508	42.9%	-\$628	\$2,783	\$2,155	100%*	5.2%	-1.0%	4.5%	1.8%
New Hampshire	76,744	52,146	73.4%	\$117	\$1,470	\$1,586	92.6%	53.3%	2.1%	26.0%	14.0%
New Jersey	567,852	455,627	70.6%	\$1,078	\$11,129	\$12,207	91.2%	55.4%	2.5%	25.7%	14.1%
New York	820,623	706,575	46.7%	\$2,859	\$17,170	\$20,030	85.7%	16.0%	1.2%	7.1%	4.1%
Pennsylvania	682,880	458,200	67.2%	\$2,041	\$19,489	\$21,530	90.5%	30.8%	2.7%	20.2%	12.4%
Rhode Island	53,841	40,850	70.9%	\$100	\$1,768	\$1,868	94.6%	26.2%	1.1%	16.5%	9.2%
Vermont	15,509	13,443	42.9%	\$8	\$283	\$291	97.4%	9.7%	0.2%	4.9%	2.9%
<b>Midwest</b>											
Illinois	911,830	694,012	68.8%	\$2,468	\$22,109	\$24,577	90.0%	37.2%	3.3%	29.7%	16.6%
Indiana	427,311	337,987	69.1%	\$899	\$10,112	\$11,010	91.8%	42.2%	4.8%	27.1%	19.6%
Iowa	163,264	117,621	69.6%	\$257	\$3,298	\$3,555	92.8%	36.1%	2.4%	18.4%	12.4%
Kansas	192,006	131,528	75.1%	\$260	\$4,033	\$4,293	93.9%	56.2%	2.6%	27.8%	17.5%
Michigan	812,818	635,231	74.6%	\$1,096	\$16,944	\$18,040	93.9%	41.6%	3.2%	25.6%	17.9%
Minnesota	348,684	211,781	70.7%	\$745	\$9,116	\$9,861	92.4%	45.6%	2.1%	25.6%	13.9%
Missouri	437,735	324,276	71.0%	\$773	\$10,228	\$11,001	93.0%	42.4%	3.1%	23.8%	16.2%
Nebraska	110,820	71,053	76.0%	\$155	\$2,732	\$2,886	94.6%	47.8%	2.2%	27.4%	16.9%
North Dakota	40,017	26,457	69.4%	\$57	\$709	\$766	92.5%	61.0%	2.5%	20.2%	13.2%
Ohio	901,023	670,992	72.6%	\$1,335	\$19,578	\$20,913	93.6%	43.1%	2.6%	22.0%	14.9%
South Dakota	41,847	27,160	75.8%	\$46	\$844	\$890	94.9%	34.6%	1.6%	19.3%	12.5%
Wisconsin	277,116	188,043	74.3%	\$314	\$4,912	\$5,226	94.0%	28.0%	1.4%	14.7%	9.4%
<b>South</b>											
Alabama	455,952	335,547	72.9%	\$693	\$11,404	\$12,097	94.3%	47.9%	5.3%	39.7%	28.9%
Arkansas	286,347	234,695	72.1%	\$761	\$11,523	\$12,284	93.8%	39.9%	7.9%	47.7%	36.3%
Delaware	28,839	23,317	46.9%	\$90	\$686	\$776	88.4%	15.9%	1.6%	11.0%	6.6%
District of Columbia	38,763	22,891	73.4%	\$62	\$1,068	\$1,129	94.5%	21.5%	1.3%	9.9%	7.3%
Florida	1,376,753	1,073,391	69.7%	\$2,537	\$24,260	\$26,797	90.5%	50.2%	3.8%	29.4%	18.0%
Georgia	907,203	721,558	74.4%	\$1,233	\$17,916	\$19,149	93.6%	56.7%	4.6%	35.6%	24.9%
Kentucky	423,757	337,987	77.0%	\$695	\$13,220	\$13,915	95.0%	48.1%	4.7%	35.8%	26.9%
Louisiana	507,952	409,869	74.8%	\$536	\$8,937	\$9,472	94.3%	44.9%	2.8%	26.5%	17.9%
Maryland	348,140	267,555	70.8%	\$1,060	\$10,881	\$11,941	91.1%	45.9%	3.4%	35.3%	19.4%
Mississippi	419,571	350,091	74.8%	\$581	\$10,959	\$11,539	95.0%	53.9%	6.4%	41.1%	32.4%
North Carolina	887,560	661,292	71.8%	\$1,791	\$24,720	\$26,511	93.2%	53.5%	4.6%	34.6%	24.0%
Oklahoma	470,358	367,541	74.8%	\$789	\$13,436	\$14,225	94.5%	67.4%	5.8%	53.2%	36.6%
South Carolina	443,020	334,296	76.2%	\$615	\$12,109	\$12,724	95.2%	49.4%	4.7%	39.9%	29.4%
Tennessee	474,240	372,894	65.7%	\$1,523	\$13,128	\$14,651	89.6%	29.9%	5.4%	24.2%	17.8%
Texas	2,513,355	2,055,888	73.6%	\$4,514	\$62,056	\$66,570	93.2%	63.5%	5.1%	45.9%	29.8%
Virginia	504,466	365,514	75.2%	\$863	\$11,129	\$11,992	92.8%	56.7%	3.1%	40.5%	21.8%
West Virginia	156,582	129,185	76.5%	\$217	\$4,182	\$4,399	95.1%	37.9%	3.2%	22.6%	17.4%
<b>West</b>											
Alaska	59,914	49,061	71.7%	\$219	\$2,379	\$2,598	91.6%	53.9%	3.9%	42.9%	23.4%
Arizona	305,634	273,008	45.6%	\$739	\$4,861	\$5,600	86.8%	22.4%	2.9%	9.9%	7.5%
California	2,986,362	2,291,221	67.6%	\$6,544	\$54,936	\$61,481	89.4%	29.9%	3.4%	28.3%	15.8%
Colorado	337,706	249,208	74.8%	\$470	\$6,925	\$7,395	93.6%	65.6%	2.9%	43.4%	23.2%
Hawaii	110,203	64,167	75.7%	\$30	\$3,414	\$3,444	99.1%	49.7%	0.5%	53.3%	27.8%
Idaho	115,730	85,523	78.1%	\$133	\$2,896	\$3,028	95.6%	53.1%	3.3%	32.7%	23.5%
Montana	78,840	56,889	74.3%	\$155	\$2,558	\$2,713	94.3%	75.0%	5.7%	47.0%	33.3%
Nevada	196,168	156,025	72.7%	\$338	\$4,100	\$4,438	92.4%	88.6%	5.2%	59.3%	33.1%
New Mexico	201,855	163,105	77.1%	\$278	\$5,608	\$5,885	95.3%	39.4%	3.0%	26.5%	19.4%
Oregon	386,845	292,651	78.4%	\$555	\$11,723	\$12,279	95.5%	79.6%	4.6%	57.6%	37.9%
Utah	180,478	113,872	76.3%	\$227	\$4,695	\$4,921	95.4%	72.8%	4.8%	40.2%	30.0%
Washington	395,577	276,096	76.1%	\$567	\$9,573	\$10,139	94.4%	33.6%	1.8%	30.1%	15.9%
Wyoming	40,041	27,488	76.2%	\$49	\$818	\$867	94.3%	53.6%	1.9%	32.0%	17.0%
<b>Total</b>	<b>22,809,862</b>	<b>17,524,046</b>	<b>69.5%</b>	<b>\$43,218</b>	<b>\$531,958</b>	<b>\$575,176</b>	<b>92.5%</b>	<b>39.3%</b>	<b>2.9%</b>	<b>26.5%</b>	<b>16.4%</b>

\*Includes newly enrolled 1115 waiver eligible population.

\*\*Massachusetts has a low share of uninsured within the newly enrolled due to low levels of uninsurance in the baseline.

Note: These estimates relate solely to the Medicaid expansion and do not account for other changes in health reform such as access to subsidized coverage in the exchanges or state or federal savings from reduced uncompensated care or the transition of individuals from state-funded programs to Medicaid in 2014.



## Introduction

This paper examines the impacts of the Patient Protection and Affordable Care Act (PPACA) on state and federal Medicaid coverage and associated costs. The PPACA will expand Medicaid coverage to large numbers of the nation's uninsured population. Currently, Medicaid provides fairly broad coverage of children, but there is less extensive coverage of parents and coverage of non-disabled childless adults is generally prohibited unless a state has a waiver. The law would expand Medicaid to nearly all individuals under age 65 with incomes up to 133 percent of the federal poverty line (FPL). As has been true in the past, undocumented immigrants are not eligible for Medicaid.

There is a great deal of variation today across states in terms of Medicaid coverage, uninsured rate and fiscal capacity so it is no surprise that the Medicaid expansion in health reform will affect states differently. While the new coverage requirements do not take effect until 2014, several states have raised concerns about the fiscal implications of expanded eligibility for Medicaid particularly because states are currently dealing with the severe economic downturn and the resulting sharp decline in their revenues. This analysis shows that while there will be significant increases in coverage and new federal revenues, there will be only small increases in how much more money states will be expected to spend on Medicaid from their own funds.

## Federal Matching Rates Under PPACA

Under the PPACA, the federal government will finance the vast majority of spending for those made newly eligible for Medicaid. The PPACA will provide states, for all new eligibles, with 100 percent federal funding in 2014-2016, 95 percent federal financing in 2017, 94 percent federal financing in 2018, 93 percent federal financing in 2019 and 90 percent federal financing for 2020 and subsequent years.

However, some states, prior to passage of the PPACA had already made childless adults eligible for Medicaid up to 100 percent FPL at lower federal matching rates than those described above under the new law. Policymakers did not want those states that had gone further than others to be financially worse off under the PPACA. Consequently, the new law phases in an increase in the federal match rates so that by 2019, federal matching rates for childless adults who have been eligible for Medicaid through Section 1115 waivers will equal the rate for newly eligible populations at 93 percent

As Medicaid eligibility expands under the PPACA, new efforts are made at the state and federal level for program outreach, enrollment procedures are simplified, and the requirement to obtain coverage shifts perceptions of individual responsibility, we also anticipate significant increases in the enrollment of uninsured individuals currently eligible for Medicaid. With the exception of the childless adults in the waiver states described above, the federal government will pay current matching rates for any new enrollees who are eligible under pre-PPACA Medicaid rules. Under PPACA, states are now required to maintain eligibility standards in place on March 23, 2010. The different matching rates are shown in Table 1.

In general, one could think of states as falling into one of three categories:

- States who will have very large numbers of new eligibles starting in 2014 like Alabama and Texas. These tend to be states in the south and some in the west that have low levels of current eligibility and coverage. Most of their new enrollees will be newly eligible under PPACA and they will receive the high federal matching rates for them.

- States that have already covered large numbers of adults, mostly parents, through their Medicaid programs, using poverty related provisions of Medicaid law (these states do not cover childless adults through waiver programs). These include many states such as California and New Jersey. Because of higher participation rates among current eligibles, a smaller share of their new enrollees under PPACA will be from those made newly eligible.
- States that currently cover parents and childless adults in Medicaid today like Massachusetts and New York, or “expansion states”.
  - Massachusetts and Vermont that already cover childless adults with incomes above 133 percent of the FPL through Section 1115 waiver programs. These states will have no new eligibles; they will, however, receive the higher “waiver” matching rates on those currently eligible childless adults, including prior and new enrollees.
  - States that have extended coverage through Section 1115 waiver programs to childless adults but did not do so for those all the way up to 133 percent of the FPL. These states, Arizona, Hawaii, Delaware, Maine, and New York will receive the waiver matching rate for the childless adults that are currently eligible under these rules. Because PPACA expands eligibility for those up to 133 percent of the FPL, these states will receive the law’s higher matching rates for their new eligibles.

A major determinant of the financial impact on states of the Medicaid reforms in the PPACA will be the numbers of eligible people in each of the eligibility categories (current eligibles, new eligibles, parents, childless adults) who actually enroll in the program, i.e. the group specific participation rates. The Congressional Budget Office (CBO) seems to have assumed relatively modest participation rates in Medicaid, primarily because the law imposes no financial penalties for the lowest income people who do not obtain health insurance coverage, and this would include much if not all of those eligible for Medicaid (CBO, 2009). However, there are likely to be strong outreach efforts on the part of state and

federal governments, community based organizations as well as on the part of health care providers. Moreover, there will be some new generalized societal pressure to obtain insurance coverage since most people will be required to do so. For example, the insurance coverage rate for low-income people in Massachusetts is very high, even though this population is not penalized for being uninsured. While we do not expect all states to achieve the coverage rates observed in Massachusetts, participation could be higher than assumed by CBO. Thus we present results that approximate CBO participation rate assumptions as well as a set of assumptions with somewhat higher participation rates.

The key results below can be summarized as follows. Medicaid enrollment will clearly increase under health reform, by about 16.0 million and possibly more. The federal government will pay a very high share of new Medicaid spending under reform in all states. States with very low coverage rates today are perhaps the greatest beneficiaries because most of their new enrollment is from new eligibles for whom there is the extremely high federal matching rate. States with broader current coverage today, particularly of parents, have somewhat lower share of new spending borne by the federal government but the federal share still approximates 90 percent. The seven states with Section 1115 waiver programs that have provided extensive coverage to non-parents benefit from the phase-in of the higher expansion rate as well as the higher match on any new eligibles. States with state-funded programs that cover adults benefit from the fact that these adults are all considered new Medicaid eligibles. Other states that do not have state funded programs but make substantial contributions to uncompensated care can thus reduce the spending and will benefit from a large influx of federal dollars. While most states will experience some increase in spending, this is quite small relative to the federal matching payments and low relative to the costs of uncompensated care that they would bear if they were no health reform.

We do not address a number of topics that would affect state revenues. We did not assume changes in state Medicaid eligibility levels above 133% FPL (after 2014), although the availability of federal subsidies for the purchase of coverage through the new health insurance exchanges mean that states are likely to stop covering these somewhat higher income people through Medicaid. This change will affect a sizable share of the medically needy population and will provide significant savings to states that have, in the past, extended coverage in this way. These individuals will then obtain subsidized coverage through the new insurance exchanges. If states do continue to cover those with incomes above 133 percent FPL, there could be higher participation because of reform – we do not account for this either.

Second, we did not include estimates of increased costs resulting from higher physician payment rates under Medicaid. The effects of these rate increases will be fully borne by the federal government in 2013 and 2014, but not thereafter.

Third, we did not examine the eligibility provisions that affect children, but these provisions generally seem to benefit states financially. Under the new law, states are required to maintain coverage levels for children in Medicaid and CHIP through 2019 and funding for CHIP is extended from 2013 through 2015. If CHIP is reauthorized by 2015, the new law provides states with a 23 percentage point increase in the CHIP match rate (up to 100 percent) and if CHIP is not reauthorized, we assume that these children (i.e., those above 133% FPL) would likely be enrolled in exchanges with all subsidies financed by the federal government.

Fourth, we did not examine the fiscal implications of the reductions of disproportionate share hospital payments. Most states will be affected by these provisions, but the payment reductions will be small in comparison to estimates of the spending changes presented in this paper.

Finally, we did not examine any changes in Medicaid between 2010 and 2014. States are permitted to extend coverage to childless adults and receive their regular federal medical assistance percentages (FMAP) until 2014. States with state funded programs for childless adults may well take advantage of the opportunity to enroll these populations in Medicaid and will achieve significant savings by doing so.

## Methods

**The Model Database.** We use the 2007 and 2008 Current Population Survey (CPS) as our baseline data set (which provides data from 2006 and 2007). Two years of data are used to increase sample size, but estimates can still be imprecise, particularly in smaller states.<sup>1</sup> As described below, we attached eligibility indicators to identify those eligible for Medicaid under PPACA rules. The CPS has excellent income information and allows us to identify, with a fair degree of accuracy, those who would become eligible under the law's Medicaid eligibility expansion to individuals with incomes up to 133 percent of the FPL. The CPS also provides information on health insurance coverage (or lack of coverage) during the past year. However, it is generally accepted that the CPS undercounts the number of people enrolled in Medicaid, as evidenced by a substantial discrepancy between state Medicaid administrative data and CPS estimates (cites). We make a partial adjustment of the CPS data to state administrative data totals (see Dubay, Holahan, and Cook, 2007, for a complete description of this adjustment). We then reweight the total population to hit 2009 population estimates. We account for the impact of unemployment on coverage using estimates made by Holahan and Garrett (2009). This analysis estimated the impact of unemployment on changes in employer and public coverage and the uninsured. Assuming a nine percent unemployment rate, we used these results to reduce employer coverage, increase Medicaid enrollment, and increase the number of uninsured. We also benchmark to 2009 CPS total population estimates by state in addition to taking into account coverage and income distributions in the reweighting process. We estimate population growth to 2019 using growth rates based on Census population projections.

**Eligibility Simulation.** To estimate the impact of health reform on states, we need to simulate current eligibility. Once we identify whether individuals are currently eligible, we can then estimate the impact of expanding coverage to 133 percent of the FPL.<sup>2</sup> Individuals eligible for Medicaid, the Children's Health

Insurance Program (CHIP), and state-only financed programs are identified using a detailed Medicaid and CHIP eligibility model developed at the Urban Institute's Health Policy Center (Dubay and Cook, 2009). The model takes into account state-level eligibility requirements for Medicaid and CHIP eligibility and applies them to person- and family-level data from the Annual Social and Economic Supplement to the CPS, simulating the eligibility determination process. The model also accounts for the pathways by which individuals can gain eligibility. Most important for our purposes, it identifies eligibility for Section 1115 waiver programs. Because Section 1115 waiver eligibles are treated differently under reform in seven states, it is important to identify those who are eligible for and currently enrolled through 1115 waiver programs. The states that we identified as meeting section 1115 program benchmark standards include Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, and Vermont.

Family-level characteristics used in determining eligibility, such as income, are based on the health insurance unit (HIU). The model takes into account childcare expenses, work expenses, and earnings disregards in determining eligibility in the baseline. However, because the CPS does not collect information on monthly income, it is not possible to determine how eligibility status changes as a result of income fluctuations throughout the year. For non-citizens, the eligibility simulation also takes into account length of residency in the United States in states where this is a factor in eligibility. To account for the possibility that some foreign born individuals are unauthorized immigrants and therefore not eligible for public health insurance coverage, the model imputes legal immigrant status. Legal immigrant status is imputed based on a model that identified immigration status on the March 2004 CPS and then was used to predict immigration status on the March 2007 and 2008 CPS file used here. Estimates derived from the model are consistent with those produced using the March 2008 CPS (Passel and Cohen, 2009).

**Participation Rates.** Once we have identified individuals who are newly eligible for Medicaid under PPACA rules, we then assess the likelihood that they will participate in Medicaid under reform. The uninsured are likely to participate at relatively high rates post-reform, but not all new participation will come from the ranks of the uninsured. Some who now have employer-sponsored or non-group coverage will see Medicaid as a preferred alternative, due to low or no premiums, better benefits, and lower or no cost sharing. Some are likely to drop private coverage and take up Medicaid once eligible. Participation rates are also likely to increase for those who are currently eligible but not participating in Medicaid, regardless of whether they currently have employer-sponsored coverage, non-group coverage, or are uninsured, due to expanded outreach and simplified enrollment processes expected under the PPACA. Thus we make assumptions about increased take-up rates among those populations as well.

In our first scenario, we make Medicaid participation assumptions that approximate those used by CBO. We adjust take-up rates so that our expenditure estimates are in line with CBO's estimates. This includes lower take-up rates for the early years of the reform plan when CBO assumes lower expenditures due to a phasing up of new Medicaid enrollment. In the early years, CBO assumes little increase in enrollment of those eligible for Medicaid under pre-PPACA rules.

In the second scenario, we assume that the take-up rates will be higher than under the CBO-consistent assumptions. The justification for higher participation rate assumptions are that individuals will respond to the presence of the new legal requirement to have coverage even though this population is largely exempt from any financial penalties for non-compliance, expectations of strong outreach efforts on the part of advocacy organizations, and the incentives providers will face to enroll beneficiaries, particularly in the light of reductions of disproportionate share hospital payments. These factors will primarily affect take-up by the uninsured and the assumptions made are consistent with the participation rates embedded in the Urban Institute's Health Insurance Policy Simulation Model

(HIPSM). The assumptions are calibrated to reflect evidence on take-up rates in public programs as well as the literature on the crowding out of private coverage under public program expansions. The two alternative sets of take-up rates are presented in Table 2 (without the phase-in adjustment).

**Cost per Person.** We use estimates of the costs per enrollee from HIPSM. These estimates are based on the Medical Expenditure Panel Survey (MEPS) but calibrated to reflect differences in health status of Medicaid eligibles who are currently uninsured, have non-group coverage, or employer-sponsored insurance. HIPSM estimates are adjusted to be consistent with targets from the Medicaid Statistical Information System (MSIS). Costs per enrollee are then inflated to 2019 using growth rates from the CBO March 2009 baseline.

**The Baseline.** In order to assess the impacts of reform, we must first construct estimates of state and federal spending in the absence of PPACA, i.e., baseline spending. Baseline enrollment and national spending totals for the years 2009-2019 were calculated by applying CBO's predicted Medicaid enrollment and spending growth rates from the March 2009 baseline to data on enrollment and spending from the 2007 Medicaid Statistical Information Statistics (MSIS). We adjust MSIS spending data to spending on Medicaid benefits reported by the CMS-64, since the CMS-64 data is considered to be a more accurate data source due to its use in the calculation of federal matching payments for the states. The "adjusted" MSIS then provides 2007 estimates of enrollment and spending for children, adults, disabled and aged for each state. These 2007 federal spending counts were grown to match 2009 spending from the CBO by enrollment group at the national level. Then these same growth rates were applied to each state. Published 2009 FMAP rates were then used to calculate the state and total

spending amounts in 2009 (Federal Register, 2007). This process was repeated for each year, 2010 through 2019, using CBO estimates and the most recent FMAP rates for each year (Federal Register, 2008 & 2009), without the adjustments made by the American Recovery and Reinvestment Act (ARRA).

## **National Results**

**Impact on Coverage.** Table 3 presents the 2019 national coverage impacts of the Medicaid provisions in PPACA under the two alternative participation rate assumptions. Under the lower participation rate assumptions (keyed to CBO assumptions), 15.9 million low-income individuals will be added to Medicaid under PPACA. Of these, 15.0 million are those who will be newly eligible under PPACA rules; 94.1 percent of new enrollees would be those who become eligible after the PPACA Medicaid expansion. In addition, 200,000 will be individuals already eligible for Medicaid through Section 1115 waiver programs who would newly enroll because of reform. Another 0.8 million are those adults (primarily parents) who are currently eligible for Medicaid and who would take up coverage under reform. The table also shows that there are 400,000 childless adults already enrolled in Section 1115 waiver programs who would receive enhanced matching payments.

Under the higher participation rate assumption, significantly more of today's uninsured population who are currently eligible but not enrolled in Medicaid would enter the program, including "waiver" populations (i.e., childless adults currently eligible through 1115 waivers). In total, 2.8 million people who are currently eligible but not covered by Medicaid would enroll under the higher assumptions, in addition to 19.4 million made newly eligible for the program. Total new enrollment under this scenario would be 22.8 million, 85.0 percent of which would be newly eligible people.

Table 3 also shows that Medicaid enrollment would increase by 27.4 percent relative to the baseline under the lower participation rate assumption and by 39.3 percent under the higher participation rate assumption. Further, Table 3 also shows that the Medicaid coverage under the lower participation rate

assumption would reduce the number of uninsured by 11.2 million; 4.7 million new enrollees would have had other coverage in the absence of PPACA. Under the higher participation rate assumption, the Medicaid expansion would reduce the number of uninsured by about 17.5 million.

**Overall Impact on Cost.** In aggregate, across the years 2014-2019, state spending will increase by \$21.1 billion under the lower participation rate assumption and federal spending will increase by \$443.5 billion. Thus about 95 percent of all new spending will be paid for by the federal government.

Under the higher participation rate assumption, state spending will increase by \$43.2 billion while federal spending will increase by \$532.0 billion. The share of spending borne by the federal government will be somewhat lower under the higher participation assumptions, primarily due to higher take-up among those who are eligible under pre-PPACA rules. Since the states will receive lower federal matching rates for those previously eligible, states will be responsible for a higher share of their costs (Table 1).

The second panel of Table 4 shows that new spending in 2014 will be relatively small, particularly for states. Spending will be low in 2014 because enrollment is being phased-in and the federal matching rate for new eligibles is 100 percent. By 2019, new spending on Medicaid will be about \$105 billion under the lower participation rate assumptions or \$132 billion under the higher. The federal government will bear a slightly lower share of overall spending than in 2014. By 2019, enrollment is fully phased-in and the federal matching rates on new eligibles will be reduced to 93 percent (90 percent in 2020 and thereafter). Thus, overall spending is higher and the federal share is slightly lower. The share of spending borne by the federal government after 2019 will be slightly below the levels seen in 2019.

The third panel shows the six year estimates divided into new spending on current and new eligibles. Spending on current eligibles includes the waiver populations in Section 1115 waiver program states for whom there is an enhanced match under PPACA. Spending on new enrollees who are

currently eligible accounts for about one fifth of state spending under the lower participation assumption, because states pay a much higher share of the costs attributable to current eligibles than they do for those newly eligible. In contrast, spending by the federal government is predominantly for new eligibles because of the very high matching rates for this group.

Under the higher participation rate assumption, state spending on current eligibles exceeds that for new eligibles. This is because we assume higher participation rates for those who are currently eligible but not enrolled in this scenario. Again, states spend relatively little on new eligibles. Federal spending under this participation rate assumption is higher than under the lower participation assumption for both current and new eligibles. It is higher for current eligibles because more people are assumed to be covered. Federal spending is higher under this scenario for new eligibles because there would be more new enrollees and the federal government bears most of the costs associated with them.

The fourth panel shows new state and federal spending relative to the baseline, that is, spending that would have occurred without the PPACA Medicaid expansion. Under the lower participation rate assumption, state spending will increase by 1.4 percent while federal spending would increase by 22.1 percent under the new law. Again, the differential occurs because of the very high matching rate on new eligibles as well as the phase in of higher matching rates on prior state waiver populations.

Under the higher participation rate assumption, the number of new enrollees will be much greater, but there would still only be an increase in state spending of about 2.9 percent relative to the baseline. In contrast, the federal government will increase spending on Medicaid by 26.5 percent relative to the baseline. Overall (including state and federal spending), the Medicaid expansion envisioned in health reform will increase Medicaid spending by 13.2 percent under the lower participation rate assumption, and 16.4 percent under the higher. The percentage increases in spending relative to the baseline are lower than the percentage increases in enrollment (relative to the baseline) because the new enrollees are considerably less expensive than the individuals currently being covered.

## Results by State: Lower Participation Rates

*Increases in State and Federal Spending.* This section highlights results for individual states. Tables 5-8 provide results of the simulations using the lower participation rate assumptions. Table 5 shows that states with Section 1115 waiver programs -- Maine, Massachusetts, New York, Vermont, Delaware, Arizona, and Hawaii -- will have a very high share of PPACA Medicaid spending borne by the federal government. This occurs because the federal matching rate will increase each year for "waiver" states, as described earlier, until it reaches the same rate as is provided for new eligibles under the law. For the states that have already covered all or most childless adults with incomes below 133 percent FPL and are paying as much as 50 percent of the cost for these enrollees, the enhanced match provides substantial fiscal relief.

Hawaii, Maine, Massachusetts, and Vermont actually save money while states such as Arizona and Delaware will have relatively low new spending. Hawaii, Maine, Massachusetts, and Vermont benefit because the higher federal matching dollars that they will get for their waiver enrollees will exceed the additional state dollars that will be spent on increased enrollment among other previously eligible people. The other waiver states such as Arizona and Delaware also will benefit from the enhanced match. They have some new enrollees for whom they will receive very high federal matching rates. However, unlike Massachusetts and Vermont, spending by Arizona and Delaware on new enrollment among previous eligibles will not exceed their gains from the higher match on their waiver enrollees, although Hawaii just about breaks even.

New York will have over 99 percent of its new costs paid by the federal government. New York already covers parents with incomes above 133 percent FPL and will receive its current match on these enrollees, including any new enrollment among current eligibles. New York will benefit from the higher PPACA match on childless adults that it is currently covering (individuals with incomes up to 100 FPL)

and will receive the very high federal match for the new eligibles under PPACA with incomes between 100 and 133 percent of poverty.

In general, states with high levels of current eligibility receive a high, but somewhat lower share of new spending coming from the federal government. For example, California has relatively more current eligibles and fewer new eligibles than the average state, although it does not have a waiver program (i.e., it does not cover childless adults via 1115 waiver today). Nonetheless, the federal government will still pay 93.7 percent of new Medicaid costs for Californians over the 2014-2019 period.

The federal government will pay for at least 95 percent of new Medicaid spending for most lower-income states throughout the country under the PPACA. For example, Alabama, Mississippi, Oklahoma, and South Carolina will receive federal payments covering about 96 percent of expenditures, and Texas 95 percent of their costs.

There is another set of states including Pennsylvania, Minnesota, Wisconsin, and Washington that cover childless adults in programs funded entirely by the states. These states will benefit greatly from the PPACA because these groups will be considered new eligibles. They will receive the new higher matching rate which will greatly reduce current state spending. Other states that support hospitals and clinics providing large amounts of uncompensated care will also benefit from having much of their uninsured populations covered by insurance and heavily subsidized by the federal government.

***Increases in Spending by Current and New Eligibles.*** Table 6 provides the same information, divided by current eligibles and new eligibles. The results show federal spending by states on current eligibles is very high in the Section 1115 waiver states. Spending on current eligibles includes the “waiver population” (childless adults for which there will be a higher match) as well as new participation among other currently eligible adults. Table 6 shows that all of the new spending in Massachusetts and Vermont is on the current eligibles; these states save money under PPACA because of the higher

matching rate for the waiver population. A high share of new spending in New York will be on current eligibles; they will receive their current match on currently eligible parents and the higher match on childless adults. Thus, New York bears a higher share of new spending than states without as much prior eligibility. In contrast, in most other states, particularly in the south and west, the majority of the new spending is on new eligibles for whom they will receive an extremely high federal match rate.

***Increases in Enrollment Relative to Baseline; Impact on the Uninsured.*** Table 7 shows the impact of the PPACA Medicaid eligibility expansion on the uninsured population in 2019. Overall, the number of uninsured adults with incomes below 133 percent FPL will fall by 44.5 percent. In some states with broader eligibility and coverage, there are relatively few new eligibles. Since there are low take-up rates among current eligibles, there is less of an effect on the uninsured. This is the case, for example, in Arizona, Delaware, Massachusetts, New York, and Vermont.

Table 7 also shows increased enrollment relative to the baseline, that is, the number of individuals the state is already covering. The increase relative to the baseline will be lower in states with broad coverage and higher in states with more restrictive eligibility requirements regardless of the impact of the expansion. The results in Table 7 show that Massachusetts would have an increase in enrollment of 2.0 percent, Vermont 2.8 percent, New York 6.0 percent and Arizona 7.7 percent. These states have covered large numbers of childless adults through Section 1115 waiver programs and therefore would experience relatively little new enrollment. On the other hand, states with low levels of coverage prior to the PPACA would experience relatively high levels of new enrollment. For example, Alabama would increase enrollment by 36.9 percent, Oklahoma by 51.2 percent, Texas by 45.5 percent, and Nevada by 61.7 percent.

*Increases in Spending Relative to Baseline; Federal and State.* Table 8 shows state by state baseline spending in addition to the new Medicaid spending that will occur under PPACA. Overall, state spending will increase by 1.4 percent while federal spending will increase by 22.1 percent; overall Medicaid spending would increase by 13.2 percent. Thus new state spending is not large compared to the underlying baseline. This is particularly striking because of the increased enrollment of 27.4 percent. This is because the new enrollees are considerably less expensive than those already covered under Medicaid, as well as the very high federal matching payments.

The increases in spending under PPACA will be lower in states that have already covered a large share of these populations either through waivers or other programs. Hawaii, Maine, Massachusetts and Vermont will actually spend less relative to the baseline than they are spending today on Medicaid (Vermont also receives an additional 2.2 percent increase in their matching rate for baseline spending on parents which we have not accounted for). Again, this is because of the increased matching on waiver populations. Other waiver states will see very small increases in state spending relative to the baseline. The increases in spending relative to the baseline will also be lower for states with more long-term care coverage, which increases baseline expenditures. New York will spend very little compared to current levels because of the high match on their waiver population and on new enrollees, but also because of its large expenditure baseline that includes higher than average long-term care spending. California's own spending will increase by only 1.5 percent relative to the baseline, despite an overall increase of 12.3 percent.

States with more modest coverage today -- Alabama, Arkansas, Mississippi, Oklahoma, South Carolina, and Texas -- will see very large overall (federal and state) increases in spending relative to the current Medicaid base. But even these states will see relatively small increases in their own spending, both because they are low-income states and thus have higher than average matching rates on their current eligibles, but also because of the very favorable matching rate on new eligibles. Alabama will

have spending from state funds increased by 3.6 percent, Arkansas by 4.7 percent, Mississippi by 4.8 percent, Oklahoma by 4.0 percent, South Carolina by 3.6 percent, and Texas by 3.0 percent. Thus, despite rather substantial increases in overall spending on Medicaid in these states, only a relatively small share of the cost will be borne by the states themselves.

Table 8 also shows the change in effective federal matching rates. The federal matching rates pre-reform and pre-ARRA average 57.1 percent. The effective federal matching rate after reform is the combination of current matching rates on current eligibles, expanded matching rates on childless adults or Section 1115 waiver programs, and the higher federal matching rates on new PPACA eligibles. States that will experience large increases in the number of new eligibles will see the greatest increases in effective matching rates. For example, the FMAP in Texas will increase from 60.6 percent to 67.4 percent, in Oklahoma from 64.9 percent to 72.5 percent. In contrast, states that have greater current coverage, particularly of parents, will see relatively small increases in their effective federal matching rate. For example, the federal matching rate in New York will increase from 50.0 to 50.8 percent and Vermont from 58.7 to 59.3 percent.

### **Results by State: Higher Participation Rates**

***Increases in Federal and State Spending.*** Tables 9 through 12 show results from the higher participation rate scenario. In this scenario, there are higher participation rates among both current and new eligibles. But compared to the first scenario, a larger share of the increase in Medicaid spending under PPACA will be attributable to higher take-up among current eligibles. For these people, states will receive their current matching rates. Thus, the share of new spending borne by the federal government is somewhat lower under this scenario than under the other, but we still find that, in virtually all states, over 90 percent of new spending under reform will be paid for with federal dollars (Table 9).

Maine and Massachusetts continue to save money even in the higher participation rate scenario. Vermont no longer will save under this scenario because the new spending on current eligibles will exceed their savings from the higher match on waiver eligibles. New York has a very large share of current eligibles because of its coverage of parents with incomes above 133 percent FPL as well as its coverage of childless adults. The share borne by the federal government, however, falls relative to the scenario assuming lower participation rates because of the higher enrollment of current eligibles in this scenario. The share of spending borne by the federal government in low coverage states remains at or above 90 percent even under the higher participation rate scenario.

***Increases in Spending by Current and New Eligibles.*** Table 10 provides information on spending for current eligibles and new eligibles. Nationally, 87.2 percent of new spending will be for new eligibles, but there are some important exceptions. All new spending in Vermont and Massachusetts will be for current eligibles. Since currently covered waiver populations receive an enhanced match under PPACA, new state spending will be very low. In general, the share of new spending on new eligibles will be lower than the average in states with more current coverage, e.g. California and New York, because of the assumption of higher take-up rates among current eligibles. This has a bigger effect in those states with more current eligibles than in states with fewer. Again, the results show that over 90 percent of overall spending in most states in the south and west is on new eligibles.

***Increases in Enrollment Relative to Baseline; Impact on the Uninsured.*** Table 11 shows that under the higher participation rate scenario, Medicaid will cover 22.8 million additional Americans. Of these, 17.5 million would have been uninsured in the absence of PPACA. The number of uninsured adults with incomes less than 133 percent FPL would decline by 69.5 percent. The impact on the uninsured will be

greater in states with low current levels of coverage. This tends to occur because these states tend to have low rates of employer-sponsored insurance and higher uninsured rates to begin with.

Further, Table 11 shows the new enrollment as a percent of number of people projected to be enrolled in Medicaid in the baseline. This figure represents a 39.3 percent increase nationally. New enrollment is considerably lower in waiver states; 5.2 percent in Massachusetts, 9.7 percent in Vermont, 16.0 percent in New York, and 22.4 percent in Arizona. In contrast, states with lower coverage in the baseline experience much greater increases in enrollment. For example, in Alabama enrollment increases by 47.9 percent, in Oklahoma by 67.4 percent, in Texas by 63.5 percent, and in Nevada by 88.6 percent.

***Increases in Spending Relative to Baseline; Federal and State.*** Table 12 shows new state by state levels of Medicaid spending under reform, in addition to state by state baseline levels of spending. Again, as discussed in the previous section, new state spending relative to the baseline will be relatively small. Even with the higher participation rate assumptions, new state spending will amount to a 2.9 percent increase over baseline spending. Federal spending will increase by 26.5 percent relative to the baseline and overall Medicaid spending will increase by 16.4 percent.

The largest increases in state spending will be in states with less coverage to begin with. These are the same states that will have the largest increases in federal spending relative to the baseline. States that have had more generous coverage will see less of an increase in state spending as well as less of an increase in federal spending. Some of the increases in state spending relative to the baseline are affected by long-term care expenditures. Thus states in the northeast and Midwest with significant long-term care spending will see less of an increase in new spending relative to the total Medicaid baseline, all else being equal.

Massachusetts will save money under PPACA, even with the higher participation rate assumptions. Total Medicaid spending in Massachusetts will increase by only 1.8 percent, simply because there are fewer new people to be covered. Vermont and New York are in somewhat the same position. Even with the higher participation rates assumptions, state spending in New York and Vermont will increase little relative to the baseline, 1.2 percent and 0.2 percent respectively. Federal expenditures in New York and Vermont will increase by 7.1 and 4.9 percent, respectively.

Many states in the south and the west will see increases in federal spending of over 30 percent relative to the baseline. In general, these states have relatively low long-term care spending and the coverage expansion to individuals with incomes up to 133 percent of the FPL represents a sharp increase in coverage. Despite the large overall increases in total Medicaid spending, the increase in state spending relative to the baseline is still low, i.e. 5.3 percent Alabama, 2.8 percent in Louisiana, 4.7 percent in South Carolina, 5.1 percent in Texas, 3.0 percent in New Mexico, and 2.9 percent in Arizona.

Table 12 also shows increases in effective federal matching rates under the higher participation rate assumptions. The results are similar to those shown in Table 9, but because there is more new coverage under this scenario, the average new federal matching rate increase is slightly higher here, rising from 57.1 percent to 62.1 percent. Again, states that had substantial coverage of parents prior to reform will see relatively small increases in the average federal matching rate because these groups will continue to receive the current matching rate for these populations. Thus, New York's effective matching rate will increase from 50.0 to 51.4 percent and Vermont's from 58.7 to 59.8 percent. In contrast, the average matching rate in Texas will increase from 60.6 to 68.1 percent. In Oklahoma, the federal matching rate will effectively increase from 64.9 percent to 72.8 percent. In all of the states with substantial increases in new eligibles, we see that the average matching rate will increase by at least five percentage points under PPACA.

## Conclusion

The changes to the Medicaid program under the Patient Protection and Affordability Care Act (PPACA) will expand coverage by an estimated 15.9 to 22.8 million low-income individuals under the participation rate scenarios modeled in this paper. We have shown in this paper that most of the cost of the new expansion will be borne by the federal government. States will have relatively small increases in state spending, but these will be swamped by the new federal dollars that they will receive because of the reform. This is particularly true in the states that have low coverage today and will experience the largest increases in individuals newly eligible for the program. States that already have extensive coverage, particularly of parents, will benefit to a somewhat lesser degree, but will still have the overwhelming share of new spending borne by the federal government. States that have used Section 1115 waiver programs to cover childless adults will benefit from provisions that will provide them with higher federal matching rates over time. All states will also benefit from the fact that they no longer will either need to provide state funded insurance or finance uncompensated care for as large a population as they do today. New state spending relative to states' own baselines, what they would have spent in the absence of reform, is relatively small; there will be large increases in coverage in exchange for small net increases in state spending. By contrast, the increases in federal spending relative to the baseline will be quite large.

Of course, the impact of health reform will vary across states based on coverage levels in states today, state decisions about implementation and ultimately the number of individuals who sign up for coverage. It is impossible to know how individual states will respond, so this analysis looked at a range of participation assumptions that are applied uniformly across states, but in reality this will vary. Some states may not aggressively implement health reform and therefore not see significant reductions in the uninsured while other states will have higher levels of participation because of effective outreach and enrollment strategies and see greater reductions in the number of uninsured.

## Note

<sup>1</sup> The American Community Survey (ACS) has much larger samples and will offer an opportunity to make these estimates more precise in the future. There is also measurement error, not surprisingly, in the simulation of eligibility because the complexity in measuring income disregards both individuals and families, thus making the ability to discriminate between old and new eligibles difficult.

<sup>2</sup> In this analysis we increase Medicaid coverage to individuals with incomes up to 133 percent FPL using a gross income measure. The law would have states begin to use the modified adjusted gross income (MAGI). We conclude that the MAGI is close to gross income for those who might be Medicaid eligible. The MAGI contains both subtractions and additions to adjusted gross income (AGI). These largely affect the individual retirement account (IRA) conversions and rollovers which are deducted from AGI and IRA deductions, student loan interest deductions, tuition deductions, foreign income and housing deductions which are added back into AGI. Health savings accounts deductions are also included in MAGI. We conclude that these are not likely to affect the numbers of people eligible for Medicaid. In this analysis, we used a gross income measure of 133 percent FPL. The law allows another five percent for disregards. We estimate that this would add \$8.8 billion under the lower participation rate assumption and \$9.6 billion under the higher participation rate assumption to total Medicaid spending.

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**Table 1  
Federal Matching Rate Schedule**

	2014	2015	2016	2017	2018	2019
Current Eligibles	CMR	CMR	CMR	CMR	CMR	CMR
Waiver Population**	50%	60%	70%	80%	90%	100%
New Eligibles	100%	100%	100%	95%	94%	93%

\*CMR= the current federal matching rate as of 2009

\*\*Waiver population matching rates represent the percent of the difference between the Newly Eligibles Matching Rate (NER) and the Current Matching Rate (CMR) that will be applied in addition to the Current Matching Rate for this population. For example, the federal matching rate in 2014 for the waiver population would equal the following: CMR + .5(NER-CMR).

**Table 2  
Participation Rates by Simulation Scenario**

	Baseline Insurance Coverage	Participation Assumption I	Participation Assumption II
<b>Current Eligibles</b>			
	ESI	3%	5%
	Nongroup	7%	10%
	Uninsured	10%	40%
<b>Waiver Population</b>			
	ESI	3%	5%
	Nongroup	7%	10%
	Uninsured	10%	40%
<b>New Eligibles</b>			
	ESI	25%	25%
	Nongroup	54%	60%
	Uninsured	57%	75%

**Table 3**  
**National Totals**  
**Coverage Impacts from Medicaid Expansion in PPACA in 2019**

<b>Increases in Enrollment, By Population (in millions)</b>						
	New Eligibles	Current Eligibles	from Waiver Eligibles	Total New Enrollment	% New Eligibles	Waiver Enrollees
Participation Assumption I	15.0	0.8	0.2	15.9	94.1%	0.4
Participation Assumption II	19.4	2.8	0.6	22.8	85.0%	0.4

<b>Increase in Medicaid Enrollment Relative to the Baseline</b>			
	Baseline Enrollment	New Medicaid Enrollees	% Change in Enrollment
Participation Assumption I	58.0	15.9	27.4%
Participation Assumption II	58.0	22.8	39.3%

<b>Impact on Medicaid Enrollment and the Uninsured (in millions)</b>			
	Medicaid New Enrollees	Uninsured	% Decrease in Uninsured Adults under
Participation Assumption I	15.9	11.2	44.5%
Participation Assumption II	25.2	17.5	69.5%

**Table 4**  
**National Totals**  
**Expenditure Impacts from Medicaid Expansion in PPACA, 2014-2019**

	State and Federal Spending, 2019 (in billions)			2014-
	State Spending	Federal Spending	Total	% Federal Spending
Participation Rates Assumption I	\$21.1	\$443.5	\$464.7	95.4%
Assumption II	\$43.2	\$532.0	\$575.2	92.5%

	State and Federal Spending by Year (in billions)							
	2014				2019			
Participation Rates	State Spending	Federal Spending	Total	% Federal	State Spending	Federal Spending	Total	% Federal Spending
Assumption I	\$0.1	\$28.7	\$28.9	99.5%	\$7.8	\$97.0	\$104.8	92.5%
Assumption II	\$1.4	\$33.6	\$35.0	96.0%	\$13.3	\$118.6	\$132.0	89.9%

	State and Federal Spending For Current and New Eligibles, 2014-2019								
	State			Federal			Total		
	Current Eligibles	New Eligibles	Total	Current Eligibles	New Eligibles	Total	Current Eligibles	New Eligibles	Total
Participation Rates Assumption I	\$4.1	\$17.1	\$21.1	\$16.4	\$427.2	\$443.5	\$20.5	\$444.2	\$464.7
Assumption II	\$23.8	\$19.4	\$43.2	\$49.6	\$482.4	\$532.0	\$73.4	\$501.8	\$575.2

	Increases in Spending Over Baseline, 2014-2019 (in billions)					
	State		Federal		Total	
	Baseline	New	Baseline	New	Baseline	New
Participation Rates Assumption I	\$1,504.0	\$21.1 (1.4%)	\$2,005.5	\$443.5 (22.1%)	\$3,509.5	\$464.7 (13.2%)
Assumption II	\$1,504.0	\$43.2 (2.9%)	\$2,005.5	\$532.0 (26.5%)	\$3,509.5	\$575.2 (16.4%)

Table 5

**Medicaid Expansion to 133%: Additional Spending by States in Reform  
Lower Participation Rate Assumption  
(in millions)**

		2014-2019			
		Total State Spending	Total Federal Spending	Total Spending	% Federal Spending
<b>Northeast</b>					
	Connecticut	\$263	\$4,686	\$4,949	94.7%
	Maine	-\$118	\$1,857	\$1,738	100%*
	Massachusetts	-\$1,274	\$2,137	\$864	100%*
	New Hampshire	\$63	\$1,204	\$1,267	95.0%
	New Jersey	\$533	\$9,030	\$9,563	94.4%
	New York	\$50	\$8,049	\$8,099	99.4%
	Pennsylvania	\$1,054	\$17,086	\$18,140	94.2%
	Rhode Island	\$70	\$1,559	\$1,629	95.7%
	Vermont	-\$26	\$112	\$86	100%*
<b>Midwest</b>					
	Illinois	\$1,202	\$19,259	\$20,461	94.1%
	Indiana	\$478	\$8,535	\$9,013	94.7%
	Iowa	\$147	\$2,800	\$2,947	95.0%
	Kansas	\$166	\$3,477	\$3,643	95.4%
	Michigan	\$686	\$14,252	\$14,938	95.4%
	Minnesota	\$421	\$7,836	\$8,257	94.9%
	Missouri	\$431	\$8,395	\$8,826	95.1%
	Nebraska	\$106	\$2,345	\$2,451	95.7%
	North Dakota	\$32	\$595	\$627	94.9%
	Ohio	\$830	\$17,130	\$17,960	95.4%
	South Dakota	\$32	\$717	\$748	95.8%
	Wisconsin	\$205	\$4,252	\$4,457	95.4%
<b>South</b>					
	Alabama	\$470	\$10,305	\$10,776	95.6%
	Arkansas	\$455	\$9,401	\$9,856	95.4%
	Delaware	\$3	\$387	\$390	99.2%
	District of Columbia	\$42	\$902	\$944	95.6%
	Florida	\$1,233	\$20,050	\$21,283	94.2%
	Georgia	\$714	\$14,551	\$15,265	95.3%
	Kentucky	\$515	\$11,878	\$12,393	95.8%
	Louisiana	\$337	\$7,273	\$7,610	95.6%
	Maryland	\$533	\$9,112	\$9,645	94.5%
	Mississippi	\$429	\$9,865	\$10,294	95.8%
	North Carolina	\$1,029	\$20,712	\$21,741	95.3%
	Oklahoma	\$549	\$12,179	\$12,728	95.7%
	South Carolina	\$470	\$10,919	\$11,389	95.9%
	Tennessee	\$716	\$11,072	\$11,788	93.9%
	Texas	\$2,619	\$52,537	\$55,156	95.3%
	Virginia	\$498	\$9,629	\$10,127	95.1%
	West Virginia	\$164	\$3,781	\$3,945	95.9%
<b>West</b>					
	Alaska	\$117	\$2,046	\$2,163	94.6%
	Arizona	\$56	\$2,091	\$2,147	97.4%
	California	\$2,982	\$44,694	\$47,676	93.7%
	Colorado	\$286	\$5,917	\$6,203	95.4%
	Hawaii	-\$28	\$2,999	\$2,971	100%*
	Idaho	\$101	\$2,402	\$2,502	96.0%
	Montana	\$100	\$2,178	\$2,278	95.6%
	Nevada	\$188	\$3,445	\$3,633	94.8%
	New Mexico	\$194	\$4,510	\$4,704	95.9%
	Oregon	\$438	\$10,302	\$10,739	95.9%
	Utah	\$174	\$4,129	\$4,304	96.0%
	Washington	\$380	\$8,271	\$8,651	95.6%
	Wyoming	\$32	\$683	\$715	95.6%
<b>Total</b>		<b>\$21,148</b>	<b>\$443,530</b>	<b>\$464,678</b>	<b>95.4%</b>

\*Federal Government essentially picks up all of net new spending while the state actually saves money due to the federal government spending more on currently enrolled 1115 waiver non-parents

**Table 6**  
**Medicaid Expansion to 133%: Additional Spending by States in Reform by Eligibility Type**  
**Lower Participation Rate Assumption**  
(in millions)

	2014-2019						
	Current Eligibles*			New Eligibles			% New Eligible Spending
	State Spending	Federal Spending	Total Spending	State Spending	Federal Spending	Total Spending	
<b>Northeast</b>							
Connecticut	\$79	\$79	\$158	\$184	\$4,607	\$4,791	96.8%
Maine	-\$183	\$233	\$49	\$65	\$1,624	\$1,689	97.2%
Massachusetts	-\$1,274	\$2,137	\$864	\$0	\$0	\$0	0.0%
New Hampshire	\$16	\$16	\$32	\$47	\$1,188	\$1,235	97.5%
New Jersey	\$180	\$180	\$360	\$353	\$8,850	\$9,203	96.2%
New York	-\$94	\$4,426	\$4,332	\$145	\$3,623	\$3,767	46.5%
Pennsylvania	\$390	\$468	\$858	\$664	\$16,619	\$17,282	95.3%
Rhode Island	\$9	\$9	\$18	\$62	\$1,549	\$1,611	98.9%
Vermont	-\$26	\$112	\$86	\$0	\$0	\$0	0.0%
<b>Midwest</b>							
Illinois	\$452	\$458	\$909	\$751	\$18,801	\$19,552	95.6%
Indiana	\$148	\$266	\$413	\$330	\$8,270	\$8,600	95.4%
Iowa	\$38	\$63	\$101	\$109	\$2,737	\$2,846	96.6%
Kansas	\$29	\$44	\$73	\$137	\$3,433	\$3,570	98.0%
Michigan	\$124	\$188	\$312	\$562	\$14,064	\$14,626	97.9%
Minnesota	\$113	\$113	\$225	\$308	\$7,723	\$8,031	97.3%
Missouri	\$103	\$177	\$281	\$328	\$8,217	\$8,545	96.8%
Nebraska	\$13	\$20	\$33	\$93	\$2,325	\$2,418	98.7%
North Dakota	\$9	\$15	\$23	\$23	\$580	\$604	96.3%
Ohio	\$157	\$257	\$414	\$674	\$16,873	\$17,546	97.7%
South Dakota	\$3	\$5	\$9	\$28	\$711	\$740	98.9%
Wisconsin	\$38	\$55	\$92	\$168	\$4,197	\$4,365	97.9%
<b>South</b>							
Alabama	\$64	\$137	\$201	\$406	\$10,169	\$10,575	98.1%
Arkansas	\$90	\$240	\$329	\$366	\$9,161	\$9,527	96.7%
Delaware	-\$6	\$157	\$151	\$9	\$229	\$238	61.2%
District of Columbia	\$6	\$15	\$21	\$35	\$887	\$922	97.7%
Florida	\$455	\$565	\$1,019	\$778	\$19,486	\$20,264	95.2%
Georgia	\$144	\$261	\$404	\$571	\$14,290	\$14,861	97.4%
Kentucky	\$45	\$106	\$151	\$470	\$11,772	\$12,242	98.8%
Louisiana	\$51	\$128	\$179	\$285	\$7,145	\$7,430	97.6%
Maryland	\$176	\$176	\$353	\$357	\$8,936	\$9,293	96.3%
Mississippi	\$40	\$127	\$167	\$389	\$9,739	\$10,128	98.4%
North Carolina	\$217	\$397	\$614	\$811	\$20,316	\$21,127	97.2%
Oklahoma	\$68	\$132	\$200	\$481	\$12,047	\$12,528	98.4%
South Carolina	\$37	\$87	\$124	\$433	\$10,832	\$11,265	98.9%
Tennessee	\$295	\$531	\$826	\$421	\$10,541	\$10,962	93.0%
Texas	\$554	\$812	\$1,366	\$2,065	\$51,724	\$53,790	97.5%
Virginia	\$119	\$119	\$238	\$380	\$9,510	\$9,890	97.7%
West Virginia	\$14	\$40	\$54	\$149	\$3,741	\$3,890	98.6%
<b>West</b>							
Alaska	\$37	\$38	\$74	\$80	\$2,008	\$2,088	96.6%
Arizona	\$22	\$1,225	\$1,247	\$35	\$866	\$900	41.9%
California	\$1,247	\$1,247	\$2,494	\$1,735	\$43,447	\$45,182	94.8%
Colorado	\$52	\$52	\$103	\$234	\$5,866	\$6,100	98.3%
Hawaii	-\$141	\$189	\$48	\$112	\$2,810	\$2,923	98.4%
Idaho	\$5	\$13	\$18	\$95	\$2,389	\$2,484	99.3%
Montana	\$14	\$30	\$44	\$86	\$2,148	\$2,234	98.1%
Nevada	\$52	\$52	\$104	\$135	\$3,393	\$3,529	97.1%
New Mexico	\$16	\$38	\$53	\$179	\$4,472	\$4,650	98.9%
Oregon	\$28	\$47	\$75	\$409	\$10,255	\$10,665	99.3%
Utah	\$10	\$25	\$35	\$164	\$4,105	\$4,269	99.2%
Washington	\$52	\$54	\$106	\$328	\$8,217	\$8,545	98.8%
Wyoming	\$5	\$5	\$9	\$27	\$679	\$706	98.7%
<b>Total</b>	<b>\$4,092</b>	<b>\$16,362</b>	<b>\$20,454</b>	<b>\$17,056</b>	<b>\$427,169</b>	<b>\$444,224</b>	<b>95.6%</b>

\*Includes newly enrolled 1115 waiver eligible population

**Table 7**  
**Medicaid Expansion to 133% of FPL**

**Impact of Reform on Uninsured Populations; Increase in Enrollment Relative to Baseline**  
**Lower Participation Rate Assumption**

2019					
	Total New Medicaid Enrollees*	Previously Uninsured Newly Enrolled	% Decrease in Uninsured Adults <133%FPL	Baseline Medicaid Enrollment	% Change in Enrollment
<b>Northeast</b>					
Connecticut	114,083	75,864	48.0%	567,331	20.1%
Maine	43,468	27,877	47.4%	367,836	11.8%
Massachusetts**	29,921	10,401	10.2%	1,464,896	2.0%
New Hampshire	55,918	34,625	48.7%	144,072	38.8%
New Jersey	390,490	292,489	45.3%	1,025,757	38.1%
New York	305,945	223,175	14.8%	5,136,867	6.0%
Pennsylvania	482,366	282,014	41.4%	2,219,363	21.7%
Rhode Island	41,185	29,147	50.6%	205,565	20.0%
Vermont	4,484	3,214	10.2%	159,835	2.8%
<b>Midwest</b>					
Illinois	631,024	429,258	42.5%	2,449,446	25.8%
Indiana	297,737	215,803	44.2%	1,013,278	29.4%
Iowa	114,691	74,498	44.1%	452,614	25.3%
Kansas	143,445	89,265	50.9%	341,840	42.0%
Michigan	589,965	430,744	50.6%	1,952,376	30.2%
Minnesota	251,783	132,511	44.2%	764,717	32.9%
Missouri	307,872	207,678	45.5%	1,031,437	29.8%
Nebraska	83,898	50,364	53.9%	231,612	36.2%
North Dakota	28,864	17,198	45.1%	65,637	44.0%
Ohio	667,376	462,024	50.0%	2,088,824	31.9%
South Dakota	31,317	18,594	51.9%	121,115	25.9%
Wisconsin	205,987	127,862	50.6%	988,055	20.8%
<b>South</b>					
Alabama	351,567	244,804	53.2%	952,205	36.9%
Arkansas	200,690	154,836	47.6%	718,305	27.9%
Delaware	12,081	7,916	15.9%	181,158	6.7%
District of Columbia	28,900	15,308	49.1%	179,890	16.1%
Florida	951,622	683,477	44.4%	2,741,705	34.7%
Georgia	646,557	479,138	49.4%	1,598,648	40.4%
Kentucky	329,000	250,704	57.1%	880,957	37.3%
Louisiana	366,318	277,746	50.7%	1,130,318	32.4%
Maryland	245,996	174,484	46.2%	758,215	32.4%
Mississippi	320,748	256,920	54.9%	778,772	41.2%
North Carolina	633,485	429,272	46.6%	1,658,226	38.2%
Oklahoma	357,150	261,157	53.1%	697,357	51.2%
South Carolina	344,109	247,478	56.4%	896,326	38.4%
Tennessee	330,932	245,691	43.3%	1,584,178	20.9%
Texas	1,798,314	1,379,713	49.4%	3,955,352	45.5%
Virginia	372,470	245,840	50.6%	890,205	41.8%
West Virginia	121,635	95,675	56.7%	412,987	29.5%
<b>West</b>					
Alaska	42,794	33,106	48.4%	111,144	38.5%
Arizona	105,428	81,095	13.6%	1,364,237	7.7%
California	2,008,796	1,406,101	41.5%	9,985,807	20.1%
Colorado	245,730	166,471	50.0%	514,871	47.7%
Hawaii	84,130	42,381	50.0%	221,574	38.0%
Idaho	85,883	59,078	53.9%	217,961	39.4%
Montana	57,356	37,978	49.6%	105,156	54.5%
Nevada	136,563	100,813	47.0%	221,412	61.7%
New Mexico	145,024	111,279	52.6%	512,199	28.3%
Oregon	294,600	211,542	56.7%	485,926	60.6%
Utah	138,918	78,284	52.5%	247,841	56.1%
Washington	295,662	189,463	52.2%	1,175,565	25.2%
Wyoming	29,899	19,099	53.0%	74,760	40.0%
<b>Total</b>	<b>15,904,173</b>	<b>11,221,455</b>	<b>44.5%</b>	<b>58,045,730</b>	<b>27.4%</b>

\*Includes newly enrolled 1115 waiver eligible population

\*\*Massachusetts has a low share of uninsured within the newly enrolled due to low levels of uninsurance in the baseline.

**Table 8**  
**Medicaid Expansion to 133% of FPL**  
**Change in Total Spending (in millions)**  
**Lower Participation Rate Assumption**

	Total Spending 2014-2019						Percent Change in Spending			Federal Matching Rates		
	Baseline Spending			New Spending in Reform			State	Federal	Total	Baseline	Effective Post Reform	
	State Spending	Federal Spending	Total	State Spending	Federal Spending	Total						
<b>Northeast</b>												
Connecticut	\$22,336	\$22,336	\$44,672	\$263	\$4,686	\$4,949	1.2%	21.0%	11.1%	50.0%	54.5%	
Maine	\$8,147	\$14,358	\$22,504	-\$118	\$1,857	\$1,738	-1.5%	12.9%	7.7%	63.8%	66.9%	
Massachusetts	\$61,268	\$61,268	\$122,535	-\$1,274	\$2,137	\$864	-2.1%	3.5%	0.7%	50.0%	51.4%	
New Hampshire	\$5,656	\$5,656	\$11,312	\$63	\$1,204	\$1,267	1.1%	21.3%	11.2%	50.0%	54.5%	
New Jersey	\$43,267	\$43,267	\$86,534	\$533	\$9,030	\$9,563	1.2%	20.9%	11.1%	50.0%	54.4%	
New York	\$243,371	\$243,371	\$486,743	\$50	\$8,049	\$8,099	0.0%	3.3%	1.7%	50.0%	50.8%	
Pennsylvania	\$76,746	\$96,261	\$173,008	\$1,054	\$17,086	\$18,140	1.4%	17.7%	10.5%	55.6%	59.3%	
Rhode Island	\$9,504	\$10,704	\$20,208	\$70	\$1,559	\$1,629	0.7%	14.6%	8.1%	53.0%	56.2%	
Vermont	\$4,079	\$5,800	\$9,880	-\$26	\$112	\$86	-0.6%	1.9%	0.9%	58.7%	59.3%	
<b>Midwest</b>												
Illinois	\$73,760	\$74,352	\$148,112	\$1,202	\$19,259	\$20,461	1.6%	25.9%	13.8%	50.2%	55.5%	
Indiana	\$18,784	\$37,322	\$56,106	\$478	\$8,535	\$9,013	2.5%	22.9%	16.1%	66.5%	70.4%	
Iowa	\$10,672	\$17,886	\$28,558	\$147	\$2,800	\$2,947	1.4%	15.7%	10.3%	62.6%	65.7%	
Kansas	\$10,055	\$14,500	\$24,555	\$166	\$3,477	\$3,643	1.7%	24.0%	14.8%	59.1%	63.8%	
Michigan	\$34,465	\$66,281	\$100,746	\$686	\$14,252	\$14,938	2.0%	21.5%	14.8%	65.8%	69.6%	
Minnesota	\$35,561	\$35,561	\$71,123	\$421	\$7,836	\$8,257	1.2%	22.0%	11.6%	50.0%	54.7%	
Missouri	\$24,932	\$42,985	\$67,917	\$431	\$8,395	\$8,826	1.7%	19.5%	13.0%	63.3%	66.9%	
Nebraska	\$7,082	\$9,958	\$17,040	\$106	\$2,345	\$2,451	1.5%	23.5%	14.4%	58.4%	63.1%	
North Dakota	\$2,307	\$3,512	\$5,819	\$32	\$595	\$627	1.4%	16.9%	10.8%	60.4%	63.7%	
Ohio	\$50,823	\$89,146	\$139,969	\$830	\$17,130	\$17,960	1.6%	19.2%	12.8%	63.7%	67.3%	
South Dakota	\$2,762	\$4,366	\$7,129	\$32	\$717	\$748	1.1%	16.4%	10.5%	61.3%	64.5%	
Wisconsin	\$22,115	\$33,395	\$55,509	\$205	\$4,252	\$4,457	0.9%	12.7%	8.0%	60.2%	62.8%	
<b>South</b>												
Alabama	\$13,177	\$28,708	\$41,885	\$470	\$10,305	\$10,776	3.6%	35.9%	25.7%	68.5%	74.1%	
Arkansas	\$9,686	\$24,146	\$33,832	\$455	\$9,401	\$9,856	4.7%	38.9%	29.1%	71.4%	76.8%	
Delaware	\$5,488	\$6,226	\$11,713	\$3	\$387	\$390	0.1%	6.2%	3.3%	53.2%	54.6%	
District of Columbia	\$4,641	\$10,830	\$15,471	\$42	\$902	\$944	0.9%	8.3%	6.1%	70.0%	71.5%	
Florida	\$66,330	\$82,559	\$148,889	\$1,233	\$20,050	\$21,283	1.9%	24.3%	14.3%	55.5%	60.3%	
Georgia	\$26,677	\$50,268	\$76,945	\$714	\$14,551	\$15,265	2.7%	28.9%	19.8%	65.3%	70.3%	
Kentucky	\$14,733	\$36,944	\$51,677	\$515	\$11,878	\$12,393	3.5%	32.2%	24.0%	71.5%	76.2%	
Louisiana	\$19,267	\$33,679	\$52,946	\$337	\$7,273	\$7,610	1.7%	21.6%	14.4%	63.6%	67.6%	
Maryland	\$30,832	\$30,832	\$61,663	\$533	\$9,112	\$9,645	1.7%	29.6%	15.6%	50.0%	56.0%	
Mississippi	\$9,006	\$26,632	\$35,638	\$429	\$9,865	\$10,294	4.8%	37.0%	28.9%	74.7%	79.5%	
North Carolina	\$38,951	\$71,423	\$110,374	\$1,029	\$20,712	\$21,741	2.6%	29.0%	19.7%	64.7%	69.7%	
Oklahoma	\$13,640	\$25,264	\$38,903	\$549	\$12,179	\$12,728	4.0%	48.2%	32.7%	64.9%	72.5%	
South Carolina	\$12,984	\$30,353	\$43,336	\$470	\$10,919	\$11,389	3.6%	36.0%	26.3%	70.0%	75.4%	
Tennessee	\$28,115	\$54,214	\$82,329	\$716	\$11,072	\$11,788	2.5%	20.4%	14.3%	65.9%	69.4%	
Texas	\$88,000	\$135,124	\$223,124	\$2,619	\$52,537	\$55,156	3.0%	38.9%	24.7%	60.6%	67.4%	
Virginia	\$27,464	\$27,464	\$54,928	\$498	\$9,629	\$10,127	1.8%	35.1%	18.4%	50.0%	57.0%	
West Virginia	\$6,761	\$18,504	\$25,265	\$164	\$3,781	\$3,945	2.4%	20.4%	15.6%	73.2%	76.3%	
<b>West</b>												
Alaska	\$5,551	\$5,551	\$11,102	\$117	\$2,046	\$2,163	2.1%	36.9%	19.5%	50.0%	57.3%	
Arizona	\$25,571	\$49,308	\$74,879	\$56	\$2,091	\$2,147	0.2%	4.2%	2.9%	65.9%	66.7%	
California	\$194,004	\$194,004	\$388,007	\$2,982	\$44,694	\$47,676	1.5%	23.0%	12.3%	50.0%	54.8%	
Colorado	\$15,957	\$15,957	\$31,914	\$286	\$5,917	\$6,203	1.8%	37.1%	19.4%	50.0%	57.4%	
Hawaii	\$5,966	\$6,409	\$12,374	-\$28	\$2,999	\$2,971	-0.5%	46.8%	24.0%	51.8%	61.3%	
Idaho	\$4,009	\$8,860	\$12,869	\$101	\$2,402	\$2,502	2.5%	27.1%	19.4%	68.9%	73.3%	
Montana	\$2,706	\$5,447	\$8,153	\$100	\$2,178	\$2,278	3.7%	40.0%	27.9%	66.8%	73.1%	
Nevada	\$6,483	\$6,914	\$13,397	\$188	\$3,445	\$3,633	2.9%	49.8%	27.1%	51.6%	60.8%	
New Mexico	\$9,149	\$21,125	\$30,274	\$194	\$4,510	\$4,704	2.1%	21.3%	15.5%	69.8%	73.3%	
Oregon	\$12,038	\$20,366	\$32,404	\$438	\$10,302	\$10,739	3.6%	50.6%	33.1%	62.9%	71.1%	
Utah	\$4,742	\$11,683	\$16,425	\$174	\$4,129	\$4,303	3.7%	35.3%	26.2%	71.1%	76.3%	
Washington	\$31,830	\$31,830	\$63,661	\$380	\$8,271	\$8,651	1.2%	26.0%	13.6%	50.0%	55.5%	
Wyoming	\$2,553	\$2,553	\$5,107	\$32	\$683	\$715	1.2%	26.8%	14.0%	50.0%	55.6%	
<b>Total</b>	<b>\$1,504,003</b>	<b>\$2,005,461</b>	<b>\$3,509,464</b>	<b>\$21,148</b>	<b>\$443,530</b>	<b>\$464,678</b>	<b>1.4%</b>	<b>22.1%</b>	<b>13.2%</b>	<b>57.1%</b>	<b>61.6%</b>	

Table 9

**Medicaid Expansion to 133%: Additional Spending by States in Reform  
Higher Participation Rate Assumption  
(in millions)**

		2014-2019			
		Total State	Total	Total	% Federal
		Spending	Federal	Spending	Spending
			Spending		
<b>Northeast</b>					
	Connecticut	\$440	\$5,048	\$5,488	92.0%
	Maine	-\$65	\$2,105	\$2,040	100%*
	Massachusetts	-\$628	\$2,783	\$2,155	100%*
	New Hampshire	\$117	\$1,470	\$1,586	92.6%
	New Jersey	\$1,078	\$11,129	\$12,207	91.2%
	New York	\$2,859	\$17,170	\$20,030	85.7%
	Pennsylvania	\$2,041	\$19,489	\$21,530	90.5%
	Rhode Island	\$100	\$1,768	\$1,868	94.6%
	Vermont	\$8	\$283	\$291	97.4%
<b>Midwest</b>					
	Illinois	\$2,468	\$22,109	\$24,577	90.0%
	Indiana	\$899	\$10,112	\$11,010	91.8%
	Iowa	\$257	\$3,298	\$3,555	92.8%
	Kansas	\$260	\$4,033	\$4,293	93.9%
	Michigan	\$1,096	\$16,944	\$18,040	93.9%
	Minnesota	\$745	\$9,116	\$9,861	92.4%
	Missouri	\$773	\$10,228	\$11,001	93.0%
	Nebraska	\$155	\$2,732	\$2,886	94.6%
	North Dakota	\$57	\$709	\$766	92.5%
	Ohio	\$1,335	\$19,578	\$20,913	93.6%
	South Dakota	\$46	\$844	\$890	94.9%
	Wisconsin	\$314	\$4,912	\$5,226	94.0%
<b>South</b>					
	Alabama	\$693	\$11,404	\$12,097	94.3%
	Arkansas	\$761	\$11,523	\$12,284	93.8%
	Delaware	\$90	\$686	\$776	88.4%
	District of Columbia	\$62	\$1,068	\$1,129	94.5%
	Florida	\$2,537	\$24,260	\$26,797	90.5%
	Georgia	\$1,233	\$17,916	\$19,149	93.6%
	Kentucky	\$695	\$13,220	\$13,915	95.0%
	Louisiana	\$536	\$8,937	\$9,472	94.3%
	Maryland	\$1,060	\$10,881	\$11,941	91.1%
	Mississippi	\$581	\$10,959	\$11,539	95.0%
	North Carolina	\$1,791	\$24,720	\$26,511	93.2%
	Oklahoma	\$789	\$13,436	\$14,225	94.5%
	South Carolina	\$615	\$12,109	\$12,724	95.2%
	Tennessee	\$1,523	\$13,128	\$14,651	89.6%
	Texas	\$4,514	\$62,056	\$66,570	93.2%
	Virginia	\$863	\$11,129	\$11,992	92.8%
	West Virginia	\$217	\$4,182	\$4,399	95.1%
<b>West</b>					
	Alaska	\$219	\$2,379	\$2,598	91.6%
	Arizona	\$739	\$4,861	\$5,600	86.8%
	California	\$6,544	\$54,936	\$61,481	89.4%
	Colorado	\$470	\$6,925	\$7,395	93.6%
	Hawaii	\$30	\$3,414	\$3,444	99.1%
	Idaho	\$133	\$2,896	\$3,028	95.6%
	Montana	\$155	\$2,558	\$2,713	94.3%
	Nevada	\$338	\$4,100	\$4,438	92.4%
	New Mexico	\$278	\$5,608	\$5,885	95.3%
	Oregon	\$555	\$11,723	\$12,279	95.5%
	Utah	\$227	\$4,695	\$4,921	95.4%
	Washington	\$567	\$9,573	\$10,139	94.4%
	Wyoming	\$49	\$818	\$867	94.3%
<b>Total</b>		<b>\$43,218</b>	<b>\$531,958</b>	<b>\$575,176</b>	<b>92.5%</b>

\*Federal Government essentially picks up all of net new spending while the state actually saves money due to the federal government spending more on currently enrolled 1115 waiver non-parents

**Table 10**  
**Medicaid Expansion to 133%: Additional Spending by States in Reform by Eligibility Type**  
**Higher Participation Rate Assumption**  
(in millions)

	2014-2019						
	Current Eligibles*			New Eligibles			Total % New Eligible
	State Spending	Federal Spending	Total Spending	State Spending	Federal Spending	Total Spending	
<b>Northeast</b>							
Connecticut	\$247	\$247	\$494	\$193	\$4,802	\$4,995	91.0%
Maine	-\$137	\$317	\$180	\$72	\$1,788	\$1,860	91.2%
Massachusetts	-\$628	\$2,783	\$2,155	\$0	\$0	\$0	0.0%
New Hampshire	\$60	\$60	\$120	\$57	\$1,410	\$1,467	92.4%
New Jersey	\$656	\$656	\$1,313	\$422	\$10,473	\$10,895	89.2%
New York	\$2,679	\$12,679	\$15,358	\$181	\$4,491	\$4,672	23.3%
Pennsylvania	\$1,320	\$1,583	\$2,903	\$721	\$17,906	\$18,627	86.5%
Rhode Island	\$30	\$34	\$64	\$70	\$1,734	\$1,804	96.6%
Vermont	\$8	\$283	\$291	\$0	\$0	\$0	0.0%
<b>Midwest</b>							
Illinois	\$1,645	\$1,666	\$3,311	\$823	\$20,442	\$21,265	86.5%
Indiana	\$530	\$953	\$1,483	\$369	\$9,159	\$9,528	86.5%
Iowa	\$133	\$223	\$357	\$124	\$3,074	\$3,198	90.0%
Kansas	\$104	\$156	\$260	\$156	\$3,877	\$4,033	93.9%
Michigan	\$441	\$669	\$1,110	\$655	\$16,275	\$16,930	93.8%
Minnesota	\$393	\$393	\$787	\$351	\$8,723	\$9,074	92.0%
Missouri	\$388	\$667	\$1,055	\$385	\$9,561	\$9,946	90.4%
Nebraska	\$48	\$70	\$118	\$107	\$2,661	\$2,768	95.9%
North Dakota	\$31	\$53	\$84	\$26	\$656	\$683	89.1%
Ohio	\$585	\$961	\$1,546	\$749	\$18,617	\$19,367	92.6%
South Dakota	\$12	\$21	\$33	\$33	\$823	\$857	96.3%
Wisconsin	\$123	\$181	\$304	\$190	\$4,731	\$4,922	94.2%
<b>South</b>							
Alabama	\$256	\$543	\$798	\$437	\$10,861	\$11,299	93.4%
Arkansas	\$333	\$891	\$1,224	\$428	\$10,632	\$11,060	90.0%
Delaware	\$80	\$436	\$516	\$10	\$250	\$260	33.5%
District of Columbia	\$21	\$48	\$69	\$41	\$1,020	\$1,061	93.9%
Florida	\$1,643	\$2,040	\$3,683	\$895	\$22,219	\$23,114	86.3%
Georgia	\$552	\$1,002	\$1,553	\$681	\$16,914	\$17,595	91.9%
Kentucky	\$180	\$423	\$603	\$515	\$12,797	\$13,312	95.7%
Louisiana	\$195	\$486	\$681	\$340	\$8,451	\$8,791	92.8%
Maryland	\$648	\$648	\$1,296	\$412	\$10,233	\$10,645	89.1%
Mississippi	\$160	\$501	\$661	\$421	\$10,457	\$10,878	94.3%
North Carolina	\$859	\$1,567	\$2,426	\$932	\$23,153	\$24,085	90.9%
Oklahoma	\$269	\$520	\$789	\$520	\$12,916	\$13,436	94.5%
South Carolina	\$141	\$330	\$472	\$474	\$11,778	\$12,253	96.3%
Tennessee	\$1,072	\$1,930	\$3,002	\$451	\$11,199	\$11,649	79.5%
Texas	\$2,142	\$3,139	\$5,280	\$2,372	\$58,918	\$61,290	92.1%
Virginia	\$432	\$432	\$864	\$431	\$10,697	\$11,128	92.8%
West Virginia	\$55	\$155	\$210	\$162	\$4,027	\$4,189	95.2%
<b>West</b>							
Alaska	\$128	\$131	\$260	\$91	\$2,248	\$2,339	90.0%
Arizona	\$697	\$3,820	\$4,517	\$42	\$1,041	\$1,082	19.3%
California	\$4,515	\$4,515	\$9,029	\$2,030	\$50,422	\$52,452	85.3%
Colorado	\$199	\$199	\$398	\$271	\$6,726	\$6,997	94.6%
Hawaii	-\$97	\$242	\$145	\$128	\$3,171	\$3,299	95.8%
Idaho	\$18	\$42	\$60	\$115	\$2,854	\$2,969	98.0%
Montana	\$57	\$121	\$178	\$98	\$2,437	\$2,536	93.5%
Nevada	\$180	\$180	\$361	\$158	\$3,919	\$4,077	91.9%
New Mexico	\$58	\$140	\$198	\$220	\$5,468	\$5,688	96.6%
Oregon	\$89	\$149	\$238	\$466	\$11,575	\$12,041	98.1%
Utah	\$42	\$101	\$143	\$185	\$4,593	\$4,778	97.1%
Washington	\$189	\$197	\$386	\$377	\$9,376	\$9,753	96.2%
Wyoming	\$17	\$17	\$34	\$32	\$801	\$834	96.1%
<b>Total</b>	<b>\$23,799</b>	<b>\$49,599</b>	<b>\$73,398</b>	<b>\$19,419</b>	<b>\$482,359</b>	<b>\$501,777</b>	<b>87.2%</b>

\*Includes newly enrolled 1115 waiver eligible population

**Table 11**  
**Medicaid Expansion to 133% of FPL**  
**Impact of Reform on Uninsured Populations; Increase in Enrollment Relative to Baseline**  
**Higher Participation Rate Assumption**

2019					
	Total New Medicaid Enrollees*	Previously Uninsured Newly Enrolled	% Decrease in Uninsured Adults <133%FPL	Baseline Medicaid Enrollment	% Change in Enrollment
<b>Northeast</b>					
Connecticut	154,664	113,876	72.1%	567,331	27.3%
Maine	59,502	41,858	71.1%	367,836	16.2%
Massachusetts**	75,569	43,508	42.9%	1,464,896	5.2%
New Hampshire	76,744	52,146	73.4%	144,072	53.3%
New Jersey	567,852	455,627	70.6%	1,025,757	55.4%
New York	820,623	706,575	46.7%	5,136,867	16.0%
Pennsylvania	682,880	458,200	67.2%	2,219,363	30.8%
Rhode Island	53,841	40,850	70.9%	205,565	26.2%
Vermont	15,509	13,443	42.9%	159,835	9.7%
<b>Midwest</b>					
Illinois	911,830	694,012	68.8%	2,449,446	37.2%
Indiana	427,311	337,987	69.1%	1,013,278	42.2%
Iowa	163,264	117,621	69.6%	452,614	36.1%
Kansas	192,006	131,528	75.1%	341,840	56.2%
Michigan	812,818	635,231	74.6%	1,952,376	41.6%
Minnesota	348,684	211,781	70.7%	764,717	45.6%
Missouri	437,735	324,276	71.0%	1,031,437	42.4%
Nebraska	110,820	71,053	76.0%	231,612	47.8%
North Dakota	40,017	26,457	69.4%	65,637	61.0%
Ohio	901,023	670,992	72.6%	2,088,824	43.1%
South Dakota	41,847	27,160	75.8%	121,115	34.6%
Wisconsin	277,116	188,043	74.3%	988,055	28.0%
<b>South</b>					
Alabama	455,952	335,547	72.9%	952,205	47.9%
Arkansas	286,347	234,695	72.1%	718,305	39.9%
Delaware	28,839	23,317	46.9%	181,158	15.9%
District of Columbia	38,763	22,891	73.4%	179,890	21.5%
Florida	1,376,753	1,073,391	69.7%	2,741,705	50.2%
Georgia	907,203	721,558	74.4%	1,598,648	56.7%
Kentucky	423,757	337,987	77.0%	880,957	48.1%
Louisiana	507,952	409,869	74.8%	1,130,318	44.9%
Maryland	348,140	267,555	70.8%	758,215	45.9%
Mississippi	419,571	350,091	74.8%	778,772	53.9%
North Carolina	887,560	661,292	71.8%	1,658,226	53.5%
Oklahoma	470,358	367,541	74.8%	697,357	67.4%
South Carolina	443,020	334,296	76.2%	896,326	49.4%
Tennessee	474,240	372,894	65.7%	1,584,178	29.9%
Texas	2,513,355	2,055,888	73.6%	3,955,352	63.5%
Virginia	504,466	365,514	75.2%	890,205	56.7%
West Virginia	156,582	129,185	76.5%	412,987	37.9%
<b>West</b>					
Alaska	59,914	49,061	71.7%	111,144	53.9%
Arizona	305,634	273,008	45.6%	1,364,237	22.4%
California	2,986,362	2,291,221	67.6%	9,985,807	29.9%
Colorado	337,706	249,208	74.8%	514,871	65.6%
Hawaii	110,203	64,167	75.7%	221,574	49.7%
Idaho	115,730	85,523	78.1%	217,961	53.1%
Montana	78,840	56,889	74.3%	105,156	75.0%
Nevada	196,168	156,025	72.7%	221,412	88.6%
New Mexico	201,855	163,105	77.1%	512,199	39.4%
Oregon	386,845	292,651	78.4%	485,926	79.6%
Utah	180,478	113,872	76.3%	247,841	72.8%
Washington	395,577	276,096	76.1%	1,175,565	33.6%
Wyoming	40,041	27,488	76.2%	74,760	53.6%
<b>Total</b>	<b>22,809,862</b>	<b>17,524,046</b>	<b>69.5%</b>	<b>58,045,730</b>	<b>39.3%</b>

\*Includes newly enrolled 1115 waiver eligible population

\*\*Massachusetts has a lower share of uninsured within the newly enrolled due to low levels of uninsurance in the baseline.

**Table 12**  
**Medicaid Expansion to 133% of FPL**  
**Change in Total Spending, 2014-2019 (In millions)**  
**Higher Participation Rates**

	Total Spending 2014-2019						Percent Change in Spending			Federal Matching Rates		
	Baseline Spending			New Spending in Reform			State	Federal	Total	Baseline	Effective Post Reform	
	State Spending	Federal Spending	Total	State Spending	Federal Spending	Total						
<b>Northeast</b>												
Connecticut	\$22,336	\$22,336	\$44,672	\$440	\$5,048	\$5,488	2.0%	22.6%	12.3%	50.0%	54.6%	
Maine	\$8,147	\$14,358	\$22,504	-\$65	\$2,105	\$2,040	-0.8%	14.7%	9.1%	63.8%	67.1%	
Massachusetts	\$61,268	\$61,268	\$122,535	-\$628	\$2,783	\$2,155	-1.0%	4.5%	1.8%	50.0%	51.4%	
New Hampshire	\$5,656	\$5,656	\$11,312	\$117	\$1,470	\$1,586	2.1%	26.0%	14.0%	50.0%	55.2%	
New Jersey	\$43,267	\$43,267	\$86,534	\$1,078	\$11,129	\$12,207	2.5%	25.7%	14.1%	50.0%	55.1%	
New York	\$243,371	\$243,371	\$486,743	\$2,859	\$17,170	\$20,030	1.2%	7.1%	4.1%	50.0%	51.4%	
Pennsylvania	\$76,746	\$96,261	\$173,008	\$2,041	\$19,489	\$21,530	2.7%	20.2%	12.4%	55.6%	59.5%	
Rhode Island	\$9,504	\$10,704	\$20,208	\$100	\$1,768	\$1,868	1.1%	16.5%	9.2%	53.0%	56.5%	
Vermont	\$4,079	\$5,800	\$9,880	\$8	\$283	\$291	0.2%	4.9%	2.9%	58.7%	59.8%	
<b>Midwest</b>												
Illinois	\$73,760	\$74,352	\$148,112	\$2,468	\$22,109	\$24,577	3.3%	29.7%	16.6%	50.2%	55.9%	
Indiana	\$18,784	\$37,322	\$56,106	\$899	\$10,112	\$11,010	4.8%	27.1%	19.6%	66.5%	70.7%	
Iowa	\$10,672	\$17,886	\$28,558	\$257	\$3,298	\$3,555	2.4%	18.4%	12.4%	62.6%	66.0%	
Kansas	\$10,055	\$14,500	\$24,555	\$260	\$4,033	\$4,293	2.6%	27.8%	17.5%	59.1%	64.2%	
Michigan	\$34,465	\$66,281	\$100,746	\$1,096	\$16,944	\$18,040	3.2%	25.6%	17.9%	65.8%	70.1%	
Minnesota	\$35,561	\$35,561	\$71,123	\$745	\$9,116	\$9,861	2.1%	25.6%	13.9%	50.0%	55.2%	
Missouri	\$24,932	\$42,985	\$67,917	\$773	\$10,228	\$11,001	3.1%	23.8%	16.2%	63.3%	67.4%	
Nebraska	\$7,082	\$9,958	\$17,040	\$155	\$2,732	\$2,886	2.2%	27.4%	16.9%	58.4%	63.7%	
North Dakota	\$2,307	\$3,512	\$5,819	\$57	\$709	\$766	2.5%	20.2%	13.2%	60.4%	64.1%	
Ohio	\$50,823	\$89,146	\$139,969	\$1,335	\$19,578	\$20,913	2.6%	22.0%	14.9%	63.7%	67.6%	
South Dakota	\$2,762	\$4,366	\$7,129	\$46	\$844	\$890	1.6%	19.3%	12.5%	61.3%	65.0%	
Wisconsin	\$22,115	\$33,395	\$55,509	\$314	\$4,912	\$5,226	1.4%	14.7%	9.4%	60.2%	63.1%	
<b>South</b>												
Alabama	\$13,177	\$28,708	\$41,885	\$693	\$11,404	\$12,097	5.3%	39.7%	28.9%	68.5%	74.3%	
Arkansas	\$9,686	\$24,146	\$33,832	\$761	\$11,523	\$12,284	7.9%	47.7%	36.3%	71.4%	77.3%	
Delaware	\$5,488	\$6,226	\$11,713	\$90	\$686	\$776	1.6%	11.0%	6.6%	53.2%	55.3%	
District of Columbia	\$4,641	\$10,830	\$15,471	\$62	\$1,068	\$1,129	1.3%	9.9%	7.3%	70.0%	71.7%	
Florida	\$66,330	\$82,559	\$148,889	\$2,537	\$24,260	\$26,797	3.8%	29.4%	18.0%	55.5%	60.8%	
Georgia	\$26,677	\$50,268	\$76,945	\$1,233	\$17,916	\$19,149	4.6%	35.6%	24.9%	65.3%	71.0%	
Kentucky	\$14,733	\$36,944	\$51,677	\$695	\$13,220	\$13,915	4.7%	35.8%	26.9%	71.5%	76.5%	
Louisiana	\$19,267	\$33,679	\$52,946	\$536	\$8,937	\$9,472	2.8%	26.5%	17.9%	63.6%	68.3%	
Maryland	\$30,832	\$30,832	\$61,663	\$1,060	\$10,881	\$11,941	3.4%	35.3%	19.4%	50.0%	56.7%	
Mississippi	\$9,006	\$26,632	\$35,638	\$581	\$10,959	\$11,539	6.4%	41.1%	32.4%	74.7%	79.7%	
North Carolina	\$38,951	\$71,423	\$110,374	\$1,791	\$24,720	\$26,511	4.6%	34.6%	24.0%	64.7%	70.2%	
Oklahoma	\$13,640	\$25,264	\$38,903	\$789	\$13,436	\$14,225	5.8%	53.2%	36.6%	64.9%	72.8%	
South Carolina	\$12,984	\$30,353	\$43,336	\$615	\$12,109	\$12,724	4.7%	39.9%	29.4%	70.0%	75.7%	
Tennessee	\$28,115	\$54,214	\$82,329	\$1,523	\$13,128	\$14,651	5.4%	24.2%	17.8%	65.9%	69.4%	
Texas	\$88,000	\$135,124	\$223,124	\$4,514	\$62,056	\$66,570	5.1%	45.9%	29.8%	60.6%	68.1%	
Virginia	\$27,464	\$27,464	\$54,928	\$863	\$11,129	\$11,992	3.1%	40.5%	21.8%	50.0%	57.7%	
West Virginia	\$6,761	\$18,504	\$25,265	\$217	\$4,182	\$4,399	3.2%	22.6%	17.4%	73.2%	76.5%	
<b>West</b>												
Alaska	\$5,551	\$5,551	\$11,102	\$219	\$2,379	\$2,598	3.9%	42.9%	23.4%	50.0%	57.9%	
Arizona	\$25,571	\$49,308	\$74,879	\$739	\$4,861	\$5,600	2.9%	9.9%	7.5%	65.9%	67.3%	
California	\$194,004	\$194,004	\$388,007	\$6,544	\$54,936	\$61,481	3.4%	28.3%	15.8%	50.0%	55.4%	
Colorado	\$15,957	\$15,957	\$31,914	\$470	\$6,925	\$7,395	2.9%	43.4%	23.2%	50.0%	58.2%	
Hawaii	\$5,966	\$6,409	\$12,374	\$30	\$3,414	\$3,444	0.5%	53.3%	27.8%	51.8%	62.1%	
Idaho	\$4,009	\$8,860	\$12,869	\$133	\$2,896	\$3,028	3.3%	32.7%	23.5%	68.9%	73.9%	
Montana	\$2,706	\$5,447	\$8,153	\$155	\$2,558	\$2,713	5.7%	47.0%	33.3%	66.8%	73.7%	
Nevada	\$6,483	\$6,914	\$13,397	\$338	\$4,100	\$4,438	5.2%	59.3%	33.1%	51.6%	61.8%	
New Mexico	\$9,149	\$21,125	\$30,274	\$278	\$5,608	\$5,885	3.0%	26.5%	19.4%	69.8%	73.9%	
Oregon	\$12,038	\$20,366	\$32,404	\$555	\$11,723	\$12,279	4.6%	57.6%	37.9%	62.9%	71.8%	
Utah	\$4,742	\$11,683	\$16,425	\$227	\$4,695	\$4,921	4.8%	40.2%	30.0%	71.1%	76.7%	
Washington	\$31,830	\$31,830	\$63,661	\$567	\$9,573	\$10,139	1.8%	30.1%	15.9%	50.0%	56.1%	
Wyoming	\$2,553	\$2,553	\$5,107	\$49	\$818	\$867	1.9%	32.0%	17.0%	50.0%	56.4%	
<b>Total</b>	<b>\$1,504,003</b>	<b>\$2,005,461</b>	<b>\$3,509,464</b>	<b>\$43,218</b>	<b>\$531,958</b>	<b>\$575,176</b>	<b>2.9%</b>	<b>26.5%</b>	<b>16.4%</b>	<b>57.1%</b>	<b>62.1%</b>	

The Cancer Family Foundation is a non-profit, private operating foundation dedicated to providing information and analysis on health care issues to policymakers, the media, the health care community and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

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## ***State Legislators' Check List for Health Reform Implementation FY 2010***

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*July 15, 2010*

Rachel Morgan R.N., BSN, Senior Health Policy Specialist

*National Conference of State Legislatures*

*444 North Capitol Street, N.W., Suite 515*

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State Legislators' Check List for Health Reform Implementation FY 2010

**FY 2010 TASKS**

**INSURANCE REFORMS**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	September 2010	Within 6 months of enactment analyze and conform as necessary state laws regulating insurance with the provisions in the new federal law including the following:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		1. Prohibition on annual and lifetime limits on dollar value of coverage outside those limitations permitted by the secretary.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		2. Prohibition on rescission of coverage by insurers.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		3. Required coverage of preventive health services rated A or B by the U.S. Preventive Services
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		4. Task Force without cost sharing.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		5. Extension of adult dependent coverage to age 26 by group and individual plans.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		6. Prohibition on the use of preexisting condition exclusions for children.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		7. Prohibition on discrimination based on salary.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		8. Plan incorporation of revised internal and external appeals process requirements.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		9. Assurances of plan and provider compliance with patient protections.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	March 2010	Establish a health insurance consumer assistance office and ombudsmen (\$30 million in grant funding is available to states to establish and operate offices through HHS) (effective upon enactment)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY 2010	Establish a process for plan reporting requirements for annual review of premium increases ( <b>\$250 million in grant funding is available to states over a 5-year period to assist rate review activities.</b> ) (effective during the 2010 plan year)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Determine funding needs for an expansion of <b>outreach to and education</b> of consumers regarding new protections and rights.

**FY 2010 TASKS**

**HEALTH CARE COVERAGE**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>September 2010</b>	Requirements for plan information submission to the secretary and state for public use. <b>(effective 6 months after enactment)</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>June 2010</b>	<p>Determine the mechanism by which your state will comply with statutory requirements for a <b>high risk pool program</b> from the following options:</p> <ol style="list-style-type: none"> <li>1. Operation of a new high risk pool alongside of an existing state high risk pool,</li> <li>2. Establishment of a new high risk pool (in a state that does not currently have a high risk pool),</li> <li>3. Build upon other existing coverage programs designed to cover high risk individuals,</li> <li>4. Contract with a current HIPAA carrier of last resort or other carrier, to provide subsidized coverage for the eligible population, or</li> <li>5. Do nothing, in which case HHS would carry out a coverage program in the state,</li> </ol> <p><b>(Provides \$5 billion to fund pools through 2013) (effective 90 days after enactment)</b></p>



**FY 2010 TASKS**

**HEALTH CARE WORKFORCE/HEALTH CARE PROVIDERS**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date	
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY 2010	<p><b>School-Based Health Clinic/ Center Grants (SBHCs) (Grant Opportunity)</b>                      Establishes a grant program for the establishment and operation of school-based health centers (SBHC). To be eligible for a grant an entity must:</p> <ul style="list-style-type: none"> <li>• Be a SBHC or a sponsoring facility of an SBHC, and</li> <li>• Submit an application containing information that awarded funds will only be used for authorized services or allowed by federal, state or local law.</li> <li>• In awarding grants preference will be given to SBHC that serve a large population of children eligible for medical assistance or the state child health plan.</li> <li>• Funds may be used for;                             <ul style="list-style-type: none"> <li>• Facilities including acquisition or improvement of land, acquisition, construction, expansion, replacement, or other improvements of any building or other facility,</li> <li>• Equipment, or</li> <li>• Similar expenditures.</li> </ul> </li> <li>• No funds may be used for personnel or to provide services.</li> <li>• Appropriates \$50 million for fiscal years 2010 through 2013</li> <li>• <b>No matching funds requirement is imposed.</b></li> </ul>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY 2010	<p><b>Continuing Educational Support for Health Professionals Serving in Underserved Communities (Grant Opportunity)</b></p> <ul style="list-style-type: none"> <li>• Establishes grants for eligible entities including health professions schools, academic health centers, State or local governments, or other appropriate public or private nonprofit entities for the purpose of supportive activities to enhance education through distance learning, continuing educational activities, collaborative conferences, and electronic and tele-learning activities, with priority for primary care.</li> <li>• Authorizes \$5 million for FY 2010 through 2014 and such sums as necessary for subsequent fiscal years.</li> </ul>
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**FY 2010 TASKS**

**HEALTH CARE WORKFORCE/HEALTH CARE PROVIDERS**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date	
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY 2010	<p><b>Issue of State Interest</b></p> <p><b>Funding for Public Health Service Act Nursing Programs</b>            Authorizes \$338 million for FY 2010 and sums as necessary for fiscal years 2011 through 2016 to fund the Public Health Service Act nursing development programs.</p>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY 2010	<p><b>Issues of State Interest</b></p> <p><b>Nursing Student Loan Program</b>            Raises the cap on the maximum annual loan amount each student may receive from \$2,500 to \$3,300, loan amounts for the final two academic years from \$4,000 to \$5,200, and raises the overall aggregate amount to \$17,000 from \$13,000 beginning in FY 2010 and 2011. After fiscal year 2011, the amounts will be adjusted to provide for a cost-of-attendance increase for the yearly loan rate.</p>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<p><b>Medical Residency Training</b></p> <ul style="list-style-type: none"> <li>• Modifies rules governing when hospitals can receive indirect medical education (IME) and direct graduate medical education (DGME) funding for residents who train in a non-provider setting.</li> <li>• Modifies current law to allow hospitals to count resident time spent in didactic conference to IME costs in the provider setting and toward DGME in the non-provider setting.</li> <li>• Directs the secretary to redistribute medical residency slots from a hospital that closes on or after the date that is two years before enactment of health reform legislation.</li> </ul>
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**FY 2010 TASKS**

**HEALTH CARE WORKFORCE/HEALTH CARE PROVIDERS**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY 2010
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**Issues of State Interest**

**Pediatric Specialty Loan Repayment Program**

- Establishes a pediatric specialty loan repayment program.
- Eligible recipients must agree to be employed full-time for a period of not less than two years providing pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care, including substance abuse prevention and treatment services.
- Services will be provided in an area with a shortage of the specified services but with a sufficient pediatric population to support the subspecialty.
- Payments will be made on behalf of the recipient by the Department of Health and Human Services on the principle and interest of undergraduate, graduate, or graduate medical education loans of not more than \$35,000 per year for each year of service for a period of not more than three years.

Preference will be given to applicants who are or will be working in a school setting, have familiarity with evidence-based methods, and cultural and linguistic competence health care services, and demonstrate a financial need.

- Authorizes the appropriation of \$30 million for fiscal years (FY) 2010 through 2014 for applicants in a pediatric medical subspecialty, pediatric surgical specialty, and \$20 million for FY 2010 through 2013 for applicants in child and adolescent mental and behavioral health care, including substance abuse prevention and treatment.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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**Primary Care Student Loan Funds**

- Amends existing agreement requirements of a federally supported student loan to include an option for repayment by a recipient to practice for 10 years, including residency training in primary health care, or until the date the loan has been repaid.
- Establishes a payment penalty interest rate of two percent per year for noncompliance with the original agreement.
- Revises current student loan guidelines pertaining to submission of parental financial information for an independent student to determine financial need to allow the determination of need to be at the discretion of the applicable school loan officer.

**FY 2010 TASKS**

**LONG-TERM CARE**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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**Issue of State Interest**

**Sec. 8002 Community Living Assistance Service and Supports**

- Establishes a new, voluntary, self-funded public long-term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations. Requires the Secretary to develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides cash benefit that is not less than an average of \$50 per day. No taxpayer funds will be used to pay benefits under this provision.
- Creates a new national insurance program to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities.
- Financed through voluntary payroll deductions (with opt-out enrollment similar to Medicare Part B), this program will remove barriers to independence and choice (e.g., housing modifications, assistive technologies, personal assistance services, transportation) by providing a cash benefit to individuals unable to perform two or more functional activities of daily living.

**Definitions**

- "Active enrollee" means an individual who has enrolled and paid premiums to maintain enrollment. "Activities of daily living" include eating, toileting, transferring, bathing, dressing, and incontinence or the cognitive equivalent.
- An "eligible beneficiary" has paid premiums for at least 60 months and for at least 12 consecutive months. (§ 3203).

**FY 2010 TASKS**  
**LONG-TERM CARE**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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**Issue of State Interest**

**Sec. 8002 Community Living Assistance Service and Supports (continued)**

**CLASS Independent Benefit Plan**

- Directs the Secretary of Health & Human Services to develop two alternative benefit plans within specified limits.
- The monthly maximum premiums will be set by the Secretary to ensure 75 years of solvency.
- There is a five year vesting period for benefit eligibility.
- The benefit triggers when an individual is unable to perform not less than two activities of daily living for at least 90 days.
- The cash benefit will be not less than \$50 per day.

Not later than October 1, 2012, the Secretary will designate a CLASS benefit plan, taking into consideration the recommendations of the CLASS Independence Advisory Council.

**Enrollment and Disenrollment**

- The Secretary will establish procedures to allow for voluntary automatic enrollment by employers, as well as alternative enrollment processes for self-employed, employees of non-participating employers, spouses and others. Individuals may choose to waive enrollment in CLASS in a form and manner to be established by the Secretary.
- Premiums will be deducted from wages or self-employment income according to procedures established by the Secretary.

**Benefits**

- Eligible beneficiaries will receive appropriate cash benefits to which they are entitled, advocacy services, and advice and assistance counseling.
- Cash benefits will be paid into a Life Independence Account to purchase non-medical services and supports needed to maintain a beneficiary's independence at home or in another residential setting, including home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and added nursing support.

**FY 2010 TASKS**  
**LONG-TERM CARE**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**Issue of State Interest**  
**Sec. 8002 Community Living Assistance Service and Supports (continued)**

**CLASS Independence Fund**

- The CLASS Independence Fund will be located in the Department of the Treasury and the Secretary of the Treasury will act as the Managing Trustee.
- A CLASS Independence Fund Board of Trustees will include the Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, the Secretary of Health & Human Services, and two members of the public.

**CLASS Independence Advisory Council**

- The CLASS Independence Advisory Council, created under this Title, will include not more than 15 members, named by the President, a majority of whom will include representatives of individuals who participate or are likely to participate in the CLASS program.
- The Council will advise the Secretary on matters of general policy relating to CLASS

**FY 2010 TASKS**

<b>MEDICAID</b>			
<b>NOT STARTED</b>	<b>IN PROGRESS</b>	<b>COMPLETED</b>	<b>Implementation Date</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>FY 2010</b></p> <p>Analyze and conform as necessary state laws regulating the following provisions related to the State Medicaid programs:</p> <p><b>Sec. 2001 Maintenance of Medicaid Income Eligibility (MOE)</b></p> <p><b>General Provisions</b></p> <ul style="list-style-type: none"> <li>Requires states to maintain existing income eligibility levels for all Medicaid populations upon enactment. The imposition of any changes in eligibility standards, methodologies or procedures that is more restrictive than those in place on the <b>date of enactment</b> will result in the loss of federal matching funding.</li> <li>This maintenance of effort for eligibility (MOE) provision will expire when the HHS Secretary determines that the state health exchange is fully operational, except as it applies to coverage of:               <ol style="list-style-type: none"> <li>individuals with income at or below 133 percent of FPL, for which it will continue through December 31, 2013; and</li> <li>children under age 19 (or higher if provided for in the state plan), for which it will continue through September 30, 2019.</li> </ol> </li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>December 1, 2010</b></p> <p><b>State Financial Hardship Exemption</b></p> <ul style="list-style-type: none"> <li>Between January 1, 2011 and January 1, 2014, a state is exempt from the maintenance of effort for optional nonpregnant, non-disabled adult populations above 133 percent of the federal poverty level if the state certifies to the Secretary that the state is currently experiencing a budget deficit or projects to have a budget deficit in the following state fiscal year.</li> <li><b>The state may make the necessary certification on or after December 1, 2010.</b></li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>April 1, 2010</b></p> <ul style="list-style-type: none"> <li><b>Mandating coverage of former foster care children through age 26.</b> (See Sec. 2004 for additional detail) (effective April 1, 2010),</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>March 2010</b></p> <ul style="list-style-type: none"> <li><b>Concurrent care for children</b> who are eligible for Medicaid or CHIP, to receive hospice services without forgoing any other service to which the child is entitled under Medicaid. (see sec. 2302 for additional detail) (effective upon enactment),</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>March 2010</b></p> <ul style="list-style-type: none"> <li><b>Optional Coverage for Freestanding Birth Center Services-</b> Makes coverage of services provided by free-standing birthing centers a mandatory benefit under Medicaid. (See Sec. 2301 for additional details) (effective upon enactment).</li> </ul>

**FY 2010 TASKS**

**FUNDING**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	October 1, 2010	<ul style="list-style-type: none"> <li><b>Comprehensive Tobacco Cessation Services</b> - conform state laws as necessary to provide state Medicaid coverage for comprehensive tobacco cessation services for pregnant women without cost-sharing for the services as is mandatory in the. (Effective October 1, 2010)</li> </ul> <p>Analyze and respond as necessary according to state needs related to the State Medicaid programs:</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2011	<p><b>State Financial Hardship Exemption</b></p> <ul style="list-style-type: none"> <li>Between January 1, 2011 and January 1, 2014, a state is exempt from the maintenance of effort for optional nonpregnant, non-disabled adult populations above 133 percent of the federal poverty level if the state certifies to the Secretary that the state is currently experiencing a budget deficit or projects to have a budget deficit in the following state fiscal year.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2011	<p><b>Sec. 2006 Special Adjustment to FMAP Determination for Certain States Recovering from a Major Disaster</b></p> <ul style="list-style-type: none"> <li>Reduces projected decreases in federal Medicaid matching funds as a result of the regular updating process, for states that have experienced major disaster.</li> <li>To qualify as a "disaster recovery FMAP adjustment state", a state must have over the past seven fiscal years received a Presidential declaration of a major disaster under the provisions of sec. 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act <b>and</b> every county or Parrish in the state statewide was eligible for both individual and public assistance.</li> </ul> <p><b>Effective Date</b></p> <ul style="list-style-type: none"> <li>January 1, 2011.</li> </ul>

**FY 2010 TASKS**

**MEDICAID**

**TREATMENT OF PUERTO RICO AND THE TERRITORIES**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date	
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2011	<b>Sec. 2005 Puerto Rico and the Territories</b>
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- Beginning in January 1, 2011, and for each fiscal year thereafter, all territories' FMAP rate and spending caps will be increased.
- Requires territories in 2014 to provide coverage to childless adults who met income eligibility standards consistent with those already established for parents by the territories.
- Provides that the cost of providing coverage to newly eligible individuals will not count towards the spending cap.

**Territories and the Health Insurance Exchanges**

- Each territory will have a one-time option to "opt-in" to state (or territory)-based insurance exchanges in 2014.

**FY 2010 TASKS**

**MEDICAID**

DUAL-ELIGIBLES				
NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<p><b>Sec. 2601-Waiver Authority for Dual-Eligible Demonstrations</b></p> <ul style="list-style-type: none"> <li>Clarifies that Medicaid demonstration authority for coordinating care for dual-eligibles is as long as five years.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	March 1, 2010	<p><b>Issue of State Interest</b></p> <p><b>Sec. 2602-Improved Coordination and Protection for Dual-Eligibles</b></p> <p><b>Federal Coordinated Health Care Office (CHCO)</b></p> <ul style="list-style-type: none"> <li>Establishes the Federal Coordinated Health Care Office (CHCO) within the Centers for Medicare &amp; Medicaid Services (CMS) <b>no later than March 1, 2010.</b></li> <li>The CHCO would report directly to the CMS Administrator. The purpose of the CHCO would be to bring together officials of the Medicare and Medicaid programs at CMS to (1) more effectively integrate benefits under the Medicare and Medicaid programs, and (2) improve the coordination between the Federal and state governments for individuals eligible for benefits under both such programs in order to ensure that such individuals get full access to the items and services to which they are entitled.</li> <li>Establishes the specific responsibilities of the CHCO as follows:               <ol style="list-style-type: none"> <li>Providing states, specialized MA plans for special needs individuals; physicians and other relevant entities or individuals with the education and tools necessary for developing programs that align benefits under the Medicare and Medicaid programs for dual eligible individuals.</li> <li>Supporting state efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program.</li> <li>Providing support for coordination of contracting and oversight by states and the CMS with respect to the integration of the Medicare and Medicaid programs in a manner that is supportive of the goals described above.</li> </ol> </li> <li>Requires the Secretary, as part of the budget, to submit to Congress an annual report containing recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.</li> </ul>

**FY 2010 TASKS**  
**MEDICAID**

**EXPANSION OPTIONS**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	April 1, 2010	<p><b>Determine participation in state optional expansions as follows:</b></p> <p><b>Optional Eligibility Expansion to Childless Adults</b></p> <ul style="list-style-type: none"> <li>• Permitting states to extend Medicaid coverage to non-elderly, non-pregnant adults through a state plan amendment (SPA) at their current matching rate.</li> <li>• States may phase-in coverage based on income.</li> <li>• Lower income individuals must be phased-in first.</li> <li>• If a state expands eligibility they are required to extend coverage to individuals with lower incomes before extending coverage to individuals with higher incomes.</li> <li>• <b>Effective April 1, 2010.</b></li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	April 1, 2010	<p><b>Treatment of Individuals with Incomes above 133 Percent of FPL</b></p> <ul style="list-style-type: none"> <li>• States may provide Medicaid coverage to individuals with a Modified Adjusted Gross Income (MAGI) above 133 percent of FPL through traditional Medicaid or in the form of supplemental wrap benefits. Individuals with MAGI above 133 percent of FPL who receive only a benefit wrap from Medicaid may be eligible for tax credits in the state exchange.</li> <li>• States may phase-in coverage based on categorical group, provided that lower income individuals are phased-in first.</li> <li>• States must ensure that all children of parents who choose state exchange coverage will continue to receive the benefits, including early and periodic screening, diagnostic, and testing benefits (EPSDT), that they were entitled to receive under Medicaid. The Medicaid cost-sharing rules and the out-of-pocket limit of five percent of family income would continue to apply for children.</li> <li>• <b>Effective April 1, 2010.</b></li> </ul>

**FY 2010 TASKS**

**MEDICAID**

**EXPANSION OPTIONS**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	March 2010
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**Determine participation in state optional expansions as follows:**

**New Optional Eligibility Category**

- State option to add a new categorically-needy eligibility group to Medicaid.
- The new group would be comprised of:
  1. non-pregnant individuals with income up to the highest level applicable to pregnant women covered under the Medicaid or CHIP state plan, and
  2. at state option, individuals eligible under the standards and processes of existing section 1115 waivers that provide family planning services and supplies.

**Benefits**

- Benefits would be limited to family planning services and supplies and would also include related medical diagnosis and treatment services.

**Presumptive Eligibility**

- States may make a presumptive eligibility determination for individuals eligible for these services through the new optional eligibility group. This means that states may enroll these individuals for a limited period of time before completed Medicaid applications are filed and processed, based on a preliminary determination by Medicaid providers of likely Medicaid eligibility.
- States will not be allowed to provide Medicaid coverage through benchmark plans unless the coverage includes family planning services and supplies.

**Effective Date**

**Effective upon enactment** and applicable to services provided on or after that date.



**FY 2010 TASKS**

**MEDICAID**

**DEMONSTRATION PROJECTS/ PILOT PROGRAMS**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2010
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**Pediatric Accountable Care Organization (ACO) Demonstration Program**

- Establishes a demonstration project, authorizing participating states to allow pediatric medical providers who meet certain criteria to be recognized as accountable care organizations (ACOs) for the purposes of receiving incentive payments, in the same manner as an ACO would be recognized and provided with incentive payments under Medicare (as provided for in section 3022 of the bill).
- Requires the Secretary, in consultation with states and pediatric providers, to develop performance guidelines to ensure that the quality of care delivered to individuals by the ACOs would be at least as high as it would have been absent the demonstration project.
- Requires participating states, in consultation with the Secretary, to establish an annual minimum level of savings in expenditures for items and services covered under Medicaid and CHIP that would need to be achieved by an ACO in order for the ACO to receive an incentive payment.
- Provides that ACOs that meet the performance guidelines established by the Secretary and achieve savings greater than the annual minimal savings level established by the state will receive an incentive payment for the year equal to a portion (as determined appropriate by the Secretary) of the amount of the excess savings.
- Authorizes the Secretary to establish an annual cap on incentive payments for an ACO.

**Authorizes the demonstration from January 1, 2010 through December 31, 2016.**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY 2010
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**Medicaid Global Payments Demonstration**

- A demonstration project available to 5 states which establishes the Medicaid Global Payment System Demonstration Project, which creates an alternative payment methodology for safety net hospital systems.
- Participating states must adjust their payments made to an eligible safety net hospital system or network from a fee for- service payment structure to a global, capitated payment model.
- Operation during fiscal FY 2010 to FY 2012.

**FY 2010 TASKS**

**MEDICAID**

**DEMONSTRATION PROJECTS/ PILOT PROGRAMS**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	April 2010	<p><b>Money Follows the Person Rebalancing Demonstration</b></p> <ul style="list-style-type: none"> <li>• Extends the authorization for the Money Follows the Person Rebalancing Demonstration through September 30, 2016.</li> <li>• Changes the eligibility rules for individuals to participate in the demonstration project by requiring that individuals reside in an inpatient facility for not less than 90 consecutive days.</li> <li>• Excludes Medicare-covered short-term rehabilitative services from the counting of the 90-day period.</li> </ul> <p><b>Effective 30 days after enactment.</b></p>



**FY 2010 TASKS**

**MEDICAID**

**PROMOTING DISEASE PREVENTION AND WELLNESS**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
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January 1, 2011

**Program for Healthy Lifestyles** *(Grant Opportunity)*

Sec. 4108 creates a **grant program for states** to provide incentives to Medicaid beneficiaries who participate in a program to develop a healthy lifestyle.

These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions.

**(Appropriates \$100 million for this purpose, and grant awards will be awarded beginning January 1, 2011).** Grants will be awarded over a five-year period, and the program must be carried out by a State within a three-year period.

**State Plan Option Promoting Health Homes for Enrollees with Chronic Conditions** *(Grant Opportunity)*

- Creates a new Medicaid state plan option under which Medicaid enrollees with at least two chronic conditions or with one chronic condition and at risk of developing another chronic condition, could designate a provider as their health home.
- Requires qualifying providers to meet certain standards established by the Secretary, including demonstrating that they have the systems and infrastructure in place to provide comprehensive and timely high-quality care either in-house or by contracting with a team of health professionals.
- The designated provider or a team of health professionals will offer the following services: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; and referral to community and social support services, if relevant and as feasible use health information technology to link such services.
- Teams of providers could be free-standing, virtual, or based at a hospital, community health center, clinic, physician's office, or physician group practice.
- Requires designated providers to report to the state on all applicable quality measures in the state Medicaid program.

**FY 2010 TASKS**

**MEDICAID**

**PROMOTING DISEASE PREVENTION AND WELLNESS**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2011

**State Plan Option Promoting Health Homes for Enrollees with Chronic Conditions (continued)**

- Directs the state to develop a mechanism to pay the health home for services rendered. The state plan amendment will include a plan for tracking avoidable hospital readmissions and plan for producing savings resulting from improved chronic care coordination and management.

**Federal Match Payments**

- Provides an **enhanced match of 90 percent** FMAP for two years for states that take up this option.
- In addition, small planning grants may be available to help states intending to take up this option. Regular FMAP rules would apply.

**Effective Date**

- The state option would be available beginning on January 1, 2011.

**FY 2010 TASKS**

**MEDICAID**

**LONG-TERM CARE SERVICES AND SUPPORTS**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY 2010	<p><b>Removal of Barriers to Providing Home and Community-Based Services (HCBS)</b></p> <ul style="list-style-type: none"> <li>• Applies specific measures to remove barriers to providing HCBS.</li> <li>• These measures include:               <ol style="list-style-type: none"> <li>1. state-level oversight and assessment of HCBS resources,</li> <li>2. coordination of HCBS across all providers, and</li> <li>3. procedures for patients to file complaints.</li> </ol> </li> <li>• <b>Gives states the option</b> to provide more types of HCBS through a state plan amendment to individuals with higher levels of need rather than through a waiver.</li> <li>• Permits states to extend full Medicaid benefits to individuals receiving HCBS under a state plan amendment.</li> <li>• Provides that states will not be required to comply with requirements for state wideness and will be able to phase-in services and eligibility as they become available, targeting the services to specific populations.</li> <li>• <b>Effective</b> on the first day of the first fiscal year quarter that begins after the date of enactment of this Act.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<p><b>Aging and Disability Resource Centers</b></p> <ul style="list-style-type: none"> <li>• Allocates \$10 million each fiscal year, beginning in FY 2010 - FY 2014 to continue funding ADRCs.</li> </ul>

**FY 2010 TASKS**  
**MEDICAID**

**LONG-TERM CARE SERVICES AND SUPPORTS**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date FY 2010	Budget Item
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<p><b>Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers</b></p> <ul style="list-style-type: none"> <li>• conduct screening and criminal history background checks;</li> <li>• monitor compliance by LTC facilities and providers;</li> <li>• provide for a provisional period of employment of a direct patient access employee, as specified;</li> <li>• provide procedures for an independent process by which a provisional employee or an employee may request an appeal, or dispute the accuracy of, the information obtained in a background check, as specified;</li> <li>• provide for the designation of a single State agency with specified responsibilities;</li> <li>• determine which individuals are direct patient access employees;</li> <li>• as appropriate, specify disqualifying offenses, including convictions for violent crimes; and</li> <li>• describe and test methods that reduce duplicative fingerprinting, as specified.</li> <li>• <b>Requires states to guarantee</b> (directly or through donations from public or private entities) a designated amount of nonfederal contributions to the program. <b>The federal government will provide a match equal to three times the amount a state guarantees.</b></li> <li>• Federal funds will not exceed \$3 million for newly participating states and \$1.5 million for previously participating states.</li> <li>• Requires the Secretary of the Treasury to transfer to HHS an amount specified by the HHS Secretary as necessary (not to exceed \$160 million) to carry out the nationwide program for FY 2010 - FY 2012. Amounts provided will remain available until expended.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
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**FY 2010 TASKS**  
**MEDICAID**

PROGRAM INTEGRITY				
NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2011	Requires States to implement fraud, waste, and abuse programs before January 1, 2011 as follows: <b>Sec. 10201 Waiver Transparency</b> - Applies to applications for or renewal of experimental projects, pilots or demonstration projects under Section 1115 of the Social Security Act.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2011	<b>Sec. 6401 Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP</b> - establishing procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2011	<b>Sec. 6402 Enhanced Medicare and Medicaid program integrity provisions;</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<ul style="list-style-type: none"> <li>• <b>Overpayments</b> - Requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report was due, whichever is later</li> <li>• <b>National Provider Identifier</b> - Requires the Secretary to issue a regulation mandating that all Medicare, Medicaid, and CHIP providers include their NPI on enrollment applications.</li> <li>• <b>Medicaid Management Information System</b> - Authorizes the Secretary to withhold the Federal matching payment to States for medical assistance expenditures when the State does not report enrollee encounter data in a timely manner to the State's Medicaid Management Information System (MMIS).</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2011	<b>Sec. 6411 Expansion of the Recovery Audit Contractor (RAC) program</b> - Requires States to establish contracts with one or more Recovery Audit Contractors (RACs). These state RAC contracts would be established to identify underpayments and overpayments and to recoup overpayments made for services provided under state Medicaid plans as well as state plan waivers.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2011	<b>Sec. 6501 Termination of provider participation under Medicaid if terminated under Medicare or other State plan</b> - Requires States to terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another state's Medicaid program.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2011	<b>Sec. 6502 Medicaid exclusion from participation relating to certain ownership, control, and management affiliations</b> Requires Medicaid agencies to exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that: (1) has failed to repay overpayments during the period as determined by the Secretary; (2) is suspended, excluded, or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.



**FY 2010 TASKS**  
**MEDICAID**

**PROGRAM INTEGRITY**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date	
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Requires States to implement fraud, waste, and abuse programs before January 1, 2011 as follows:  
(continued)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2011	<b>Sec. 6504 Requirement to report expanded set of data elements under MMIS to detect fraud</b> - Requires states and Medicaid managed care entities to submit data elements from MMIS as determined necessary by the Secretary for program integrity, program oversight, and administration.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2011	<b>Sec. 6505 Prohibition on payments to institutions or entities located outside of the United States</b> - Prohibits states from making any payments for items or services provided under a Medicaid state plan or waiver to any financial institution or entity located outside of the United States.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2011	<b>Sec. 6506 Overpayments</b> - Extends the period for states to repay overpayments to one year when a final determination of the amount of the overpayment has not been determined due to an ongoing judicial or administrative process. When overpayments due to fraud are pending, state repayments of the Federal portion would not be due until 30 days after the date of the final judgment.

**FY 2010 TASKS**

**MEDICAID**

**PROGRAM INTEGRITY**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date	
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	October 1, 2010	
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- Sec. 6507 Mandatory State use of National Correct Coding Initiative (NCCI) –**
- Requires states to use the National Correct Coding Initiative (NCCI) in Medicaid.
  - Amends the Medicaid statute to require states to have an MMIS that, effective for claims filed on or after October 1, 2010, incorporates compatible elements of the NCCI (or any successor initiative) and other elements of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with specified requirements.
  - **Provides that not later than September 1, 2010**, the Secretary will be required to:
    1. identify those methodologies of the NCCI (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under Medicaid;
    2. identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under Medicaid with respect to items and services for which no national correct coding methodologies have been established under such Initiative with respect to Medicare;
    3. notify states of the elements identified (and of any other national correct coding methodologies identified) and how states are to incorporate such elements (and methodologies) into claims filed under Medicaid; and
    4. submit a report to Congress that includes the notice to states and an analysis supporting the identification of the elements (or methodologies).

**Rule for changes requiring State legislation**

If the Secretary determines that state legislation is required in order for a Medicaid state plan to meet the additional requirements imposed by the provision, the state plan will not be regarded as failing to comply before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment. In the case of a state that has a 2-year legislative session, each year of the session would be considered a separate regular session of the state legislature.

**FY 2010 TASKS**

**MEDICAID**

**PRESCRIPTION DRUG PROVISIONS**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2011	<p><b>Medicaid Pharmacy Reimbursement (AMP Fix)</b></p> <ul style="list-style-type: none"> <li>Changes the Federal upper payment limit (FUL) to no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recent AMPs for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies.</li> <li><b>Effective</b> on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<p><b>Sec. 2501-Increase Minimum Rebate Percentage for Single Source Drugs</b></p> <ul style="list-style-type: none"> <li>Increases the minimum manufacturer rebate for brand-name drugs purchased by state Medicaid programs from 15.1% of average manufacturer price to 23.1% of average manufacturer price</li> </ul> <p><b>Increase Minimum Rebate Percentage for Clotting Factors and Drugs Approved by the FDA for Pediatric Use Only</b></p> <ul style="list-style-type: none"> <li>Increases the minimum manufacturer rebate for brand-name drugs purchased by state Medicaid programs from 15.1% of average manufacturer price to 17.1% of average manufacturer price</li> </ul> <p><b>Limit on Total Rebate Liability</b></p> <ul style="list-style-type: none"> <li>Limits total rebate liability on an individual single source or innovator multiple source drug to 100 percent of AMP for that drug product. Other features of the drug rebate program, such as the Medicaid's best price provision, would remain unchanged.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<p><b>Sec. 2501-Increase Minimum Rebate Percentage for Generic Drugs</b></p> <ul style="list-style-type: none"> <li>Increases the minimum manufacturer rebate for non innovator, multiple source drugs to 13% of average manufacturer price (AMP).</li> <li>Requires the Comptroller General to review state laws that have a negative impact on generic drug utilization in federal programs due to restrictions such as but not limited to limits on pharmacists' ability substitute a generic drug or carve-outs of certain classes of drugs from generic substitution.</li> </ul>

**FY 2010 TASKS**

**MEDICAID**

**PRESCRIPTION DRUG PROVISIONS**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<p><b>Sec. 2501-Increase Minimum Rebate Percentage for Generic Drugs</b> (continued)</p> <p><b>Limit on Total Rebate Liability</b></p> <ul style="list-style-type: none"> <li>Limits total rebate liability on an individual single source or innovator multiple source drug to 100 percent of AMP for that drug product. Other features of the drug rebate program, such as the Medicaid's best price provision, would remain unchanged.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<p><b>Application of Rebates to New Formulations of Existing Drugs</b></p> <p>For purposes of applying the additional rebate, the bill narrows the definition of a new formulation of a drug to a line extension (i.e., extended release formulations) of a single source or innovator multiple source drug that is an oral solid dosage form of the drug.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<p><b>Sec. 2503 Medicaid Pharmacy Reimbursement (AMP Fix)</b></p> <ul style="list-style-type: none"> <li>Changes the Federal upper payment limit (FUL) to no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recent AMPs for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies.</li> <li>Clarifies what transactions, discounts, and other price adjustments were included in the definition of AMP.</li> <li>Clarifies that retail survey prices do not include mail order and long term care pharmacies.</li> <li>Expands the disclosure requirement to include monthly weighted average AMPs and retail survey prices.</li> </ul>

**FY 2010 TASKS**  
**MEDICAID**

QUALITY INITIATIVES			
NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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**Sec. 2701 Quality Measures for Maternity and Adult Health Services under Medicaid and CHIP**

- Similar to the quality provisions enacted in CHIPRA, directs the HHS Secretary, in consultation with the states, to develop an initial set of health care quality measures specific to adults who are eligible for Medicaid.
- Establishes the Medicaid Quality Measurement Program which will expand upon existing quality measures, identify gaps in current quality measurement, establish priorities for the development and advancement of quality measures and consult with relevant stakeholders.
- Requires the Secretary, along with states, to regularly report to Congress the progress made in identifying quality measures and implementing them in each state's Medicaid program.
- States would receive grant funding to support the development and reporting of quality measures.



**FY 2010 TASKS**

MEDICARE			Implementation Date	
NOT STARTED	IN PROGRESS	COMPLETED		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY 2010	<p><b>Sec. 3106 Extension for Certain Payment Rules for Long-term Care Hospital Services (LTCHs) and of Moratorium on the Establishment of Certain Hospitals and Facilities</b></p> <ul style="list-style-type: none"> <li>Extends the moratorium on the application of payment policies for certain LTCHs which began in 2007. This moratorium will permit LTCH facilities to receive full payment for patients admitted to their facilities until December 29, 2012 that are over a threshold set by CMS.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2011	<p><b>Conform state standards of practice for physician assistants to include the following:</b></p> <p><b>Sec. 3108 Permitting Physician Assistants to Order Post-Hospital Extended Care Services</b></p> <p>On or after January 1, 2011, physician assistance will be permitted to certify the need for post hospital extended care services for Medicare payment.</p> <p>The following provisions may impact the coverage provided to dual eligibles</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	March 2010	<p><b>Sec. 3110 Part B Special Enrollment Period for Disabled TRICARE Beneficiaries</b></p> <p>Creates a special twelve-month special enrollment period (SPE) for military retirees, their spouses (including widows/widowers) and dependent children, who are eligible for TRICARE and entitled to Medicare Part A based on disability or ESRD, but who have been declined Part B. The twelve-month SPE would be available once in their lifetime and begin on the day after the last day of the initial enrollment period and may choose Part B coverage retroactively to the first month of the enrollment period.</p> <p><b>Effective on enactment.</b></p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	March 2010	<p><b>Sec. 3111 Payment for Bone Density</b></p> <p>Medicare will pay for a bone density study (DXA) 70 percent of the 2006 reimbursement rates once every two years, or more frequently if the procedure is determined to be medically necessary during.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	March 2010	<p><b>Sec. 3114 Improved Access for Certified Nurse-Midwife Services</b></p> <p>Amends the Social Security Act by adding that services provided on or after January 1, 2011, the fee schedule for certified nurse-midwife services would not be allowed to exceed 100 percent of the amount provided for the same service performed by a physician. This amount is an increase from the 80 percent previously covered.</p>

**FY 2010 TASKS**

**MEDICARE**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY 2010

**New Medicare Category**

**Sec. 10323 Medicare Coverage Pilot Program for Individuals Exposed to Environmental Health Hazards**

- Adds to the existing list of **individuals eligible for coverage under Medicare** individuals exposed to environmental health hazards.
- An individual with one or more specified lung diseases or type of cancer who lived for six months during a specified period prior to diagnosis in an area subject to a public health emergency declaration by the Environmental Protection Agency (EPA) as of June 17, 2009, would be deemed entitled to benefits under Part A and eligible to enroll in Part B.
- Also authorizes the secretary to deem any other individual diagnosed with an illness caused by an environmental hazard to which an EPA emergency declaration has occurred to be held under the same criteria as eligible.
- Defines an infected individual as follows:
  1. Being diagnosed with one or more of the following diagnosis:
    - Asbestosis, pleural thickening, or pleural plaques,
    - Mesothelioma, or malignancies of the lung, colon, rectum, larynx, stomach, esophagus, pharynx, or ovary, or as specified by the Secretary concerning a diagnosis caused by the exposure.
  2. Has been present for an aggregate total of six months in the geographic area subject to an emergency declaration during a period not less than 10 years prior to the diagnosis, and prior to removal actions.
  3. Has filed an application for benefits, and
  4. Is determined to meet the criteria.
- Grants authority for determinations of eligibility to the Commissioner of Social Security, in consultation with the Secretary of Health and Human Services.



**FY 2010 TASKS**

**MEDICARE**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY 2010

**Sec. 2009 Program for Early Detection of Certain Medical Conditions Related to Environmental Health Hazards (Grant Opportunity)**

- Establishes a program of competitive **grants** for the purpose of screening at-risk individuals for environmental health conditions, and
- Development and dissemination of public information concerning the availability of screening, treatment, and Medicare coverage under the program.

**Eligible Entities**

- Entities eligible to apply for this grant include:
  1. A hospital or community health center,
  2. A federally qualified health center (FQHC),
  3. A facility of the Indian Health Service,
  4. A National Cancer Institute-designated cancer center,
  5. **An agency of any state or local government,**
  6. A nonprofit organization, and
  7. Any other entity the secretary determines appropriate.

**Funding**

- Appropriates \$23 million for FY2010 through 2014, and
- \$20 million for each five fiscal year period thereafter.

**Sec. 3139 Payment for Biosimilar Biological Products**

- Permits a Part B biosimilar product approved by the Food and Drug Administration to be reimbursed at the average sales price (ASP) of the reference drug.

FY 2010 TASKS			
MEDICARE			
NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY 2010
<p><b>Sec. 3205 Extension for Specialized Medicare Advantage Plans for Special Needs Individuals</b></p> <ul style="list-style-type: none"> <li>• Extends special needs plans (SNPs) authority created in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 through December 31, 2013.</li> <li>• Directs the secretary to establish a frailty payment adjustment, similar to PACE<sup>1</sup>, for fully-integrated dual-eligible SNPs.</li> <li>• Authorizes the secretary to adjust payments to dual-eligible SNP when those plans had fully integrates Medicare and Medicaid benefits, including long-term care, and met other criteria.</li> <li>• Temporarily extends authority through the end of 2012 for SMPs that do not contract with state Medicaid programs to continue to operate, but not to expand their area of operation.</li> <li>• Provides for a transition process for SNP beneficiaries that do not qualify as special needs individuals, to fee-for-service Medicare and other Medicare Advantage plans.</li> <li>• Provides an exception process for beneficiaries who lose Medicaid coverage to reapply for benefits.</li> </ul>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2011
<p><b>Sec. 3314 Including Costs Incurred By AIDS Drug Assistance Programs and Indian Health Service In Providing Prescription Drugs Toward The Annual Out of Pocket Threshold Under Part D</b></p> <ul style="list-style-type: none"> <li>• Allows costs paid by the Indian Health Service or under an AIDS Drug Assistance Program to count toward the out-of-pocket threshold for costs incurred on or after January 1, 2011.</li> </ul> <p><b>Implications for Medicare Assistance Programs</b></p>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY 2010
<p><b>Sec.3315 Immediate Reduction in Coverage Gap in 2010</b></p> <ul style="list-style-type: none"> <li>• Increases the 2010 standard initial coverage limit from \$2,830 to \$3,330, decreasing the period of time a Part D beneficiary would need to be in the coverage gap.</li> </ul>			

<sup>1</sup> Program of All Inclusive Care for the Elderly (PACE) is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The program is modeled on the system of acute and long term care services developed by On Lok Senior Health Services in San Francisco, California. The model was tested through CMS (then HCFA) demonstration projects that began in the mid-1980s. The PACE model was developed to address the needs of long-term care clients, providers, and payers.

**FY 2010 TASKS**

**MEDICARE**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
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**Title IV—Prevention of Chronic Disease and Improving Public Health**

**Subtitle B-Increasing Access to Clinical Prevention Services**

Conform state Medicaid program payment policies to accommodate for benefit changes in the Medicare program for dual eligibles.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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January 1, 2011

**Sec.4103 as modified by 10402(b). Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan**

- Amends the Social Security Act to require that Medicare Part B cover, without costs sharing, personalized prevention plan services including a comprehensive health risk assessment beginning on January 1, 2011.

**FY 2010 TASKS**  
**QUALITY, PREVENTION & WELLNESS**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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**PREVENTIVE SERVICES**

Conform state insurance laws to reflect the following;

**Sec. 1001 Regarding Coverage of Preventive Services**

- Requires the group and individual health market to cover the following preventive services without cost-sharing requirements:
  1. Items or services with a grade of A or B as recommended by the U.S. Preventive Services Task Force (UCPSTF),
  2. Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP),
  3. For infants, children and adolescents, preventive care and screenings provided for in comprehensive guidelines supported by HRSA,
  4. For women, such additional preventive care and screenings not described by the USPSTF as provided in comprehensive guidelines supported by HRSA.

**FY 2010 TASKS**

**QUALITY, PREVENTION & WELLNESS**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	September 2010
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Provide budget support sufficient to conduct the following required assessment:

**Sec. 2951 Maternal, Infant, and Early Childhood Home Visiting Programs**

- Requires each state to conduct an assessment of needs within six months of enactment and separate from the needs assessment conducted as a condition for receipt of maternal child block grant funding that identifies:
  1. Communities with a concentration of
    - a. premature birth;
    - b. low birth weight infants;
    - c. at-risk for infant death due to neglect, or prenatal, maternal , newborn or child health;
    - d. poverty; crime; domestic violence;
    - e. high rates of high-school drop-outs;
    - f. substance abuse; unemployment, or
    - g. child maltreatment,
  2. The quality and capacity of existing programs or initiatives for early childhood home visitation in the state including
    - a. the number and types of individuals and family who receive services under the programs;
    - b. the gaps in early childhood home visitation in the state, and
    - c. the extent to which the initiatives are meeting the needs of eligible families in the state.
  3. The state's capacity for providing substance abuse treatment and counseling services to individuals and families in need of treatment or services.
- Directs each state to coordinate with other assessments including the assessment for the Maternal Child Block grant, the communitywide strategic planning and needs assessment for the Head Start Act, and inventory of current unmet needs.
- Directs each state to submit with the assessment a description of how the state intends to address the needs identified, which may include an application for a grant to conduct an early childhood home visitation program.

FY 2010 TASKS			
QUALITY, PREVENTION & WELLNESS			
NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	September 2010

**Sec. 2951 (continued) Grants for Early Childhood Home Visitation Programs (Grant Opportunity)**

- Authorizes the secretary to award grants to states for the purpose of establishing an early childhood home visitation program to promote the following:
  1. Improvements in maternal and prenatal health,
  2. Infant health,
  3. Child health and development,
  4. Parenting related to child development outcomes, and
  5. School readiness in child abuse, neglect and injuries
- Authorizes grant awardees to use funds in the initial six month period for the purpose of for planning and implementation activities to assist with the establishment of the program.
- Program requirements include:
  1. Quantifiable, measurable improvements in benchmark areas for eligible families participating in the program in each of the following areas:
    - Improved maternal newborn health,
    - Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits,
    - Improvement in school readiness and achievement,
    - Reduction in crime or domestic violence,
    - Improvements in the coordination and referral of community resources and supports.
- Awardees are expected to develop and implement a plan to improve outcomes in each of the areas listed.
- Directs states to file a report with the secretary information demonstrating improvements in at least four of these areas after the end of the first three year period. Failure to comply or demonstrate improvement will result in termination of the grant.

**FY 2010 TASKS**

**QUALITY, PREVENTION & WELLNESS**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	September 2010
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**Sec. 2951 (continued) Grants for Early Childhood Home Visitation Programs (Grant Opportunity)**

- Requires submission of a final report to the secretary no later than December 31, 2015.
- Core Program Components
  1. Service Delivery Model or Models
    - Requires that the model conforms to a clear consistent home visitation model that has been in existence for at least three years and is researched-based, grounded in empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education with quality home visitation program standards, with demonstrated positive outcomes, or
    - The model conforms to a promising and new approach to achieve the benchmark areas specified and the participant outcomes and has been developed or identified by a national organization or institute of higher education, and will be evaluated through a well-designed and rigorous process.
  2. Majority of grant funding is used for evidence-based models. Prohibits the use of more than 25 percent of awarded funding to in a given fiscal year for operation of the service delivery model program.
  3. Criteria for evidence of effectiveness of models. Directs the secretary to establish criteria for evidence of effectiveness of the service delivery models.
- Requires that the program employ well-trained staff such as nurses, social workers, educators, and child development specialists.

FY 2010 TASKS			
QUALITY, PREVENTION & WELLNESS			
NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
			September 2010
<p><b>Sec. 2951 (continued) Grants for Early Childhood Home Visitation Programs (Grant Opportunity)</b></p> <ul style="list-style-type: none"> <li>▪ Service Priorities               <ol style="list-style-type: none"> <li>1. Eligible families in the community in need of services as identified by the state needs assessment,</li> <li>2. Low-income families,</li> <li>3. Families including those,                   <ul style="list-style-type: none"> <li>▪ who are pregnant women under age 21,</li> <li>▪ with a history of child abuse or neglect,</li> <li>▪ with a history of substance abuse,</li> <li>▪ who are users of tobacco products at home,</li> <li>▪ have children with low student achievement,</li> <li>▪ have children with developmental delays, and</li> <li>▪ include individuals who are serving or have formerly served in the Armed Forces.</li> </ul> </li> </ol> </li> <li>▪ <b>Maintenance of Effort Requirement</b>—Requires states to maintain funding for other sources for early childhood home visitation programs and initiatives.</li> <li>▪ <b>Funding</b>—Appropriates \$100 million for fiscal year (FY) 2010, \$250 million for FY 2011, \$350 million for FY 2012, \$400 million for FY 2013, and \$400 million for FY 2014. Reserves three percent of available funding for grants to Indian tribes.</li> <li>▪ Eligible entities are defined as meaning a state, an Indian tribe, tribal organization, or urban Indian organization, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa</li> </ul>			

**FY 2010 TASKS**

**American Health Benefit Exchange**

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	March 2011

**SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS** *(Grant Opportunity)*

**State Planning Grants**

- Authorizes the Secretary of Health and Human Services to award grants to states to support planning efforts in the establishment of the American Health Benefit Exchange.
- Grants must be awarded within one year of enactment of the Affordable Care Act, March 2011.
- The amount of the grants to each state will be determined by the secretary.
- Planning grant recipients may renew the grant if the recipient—
  1. is making progress toward establishing an Exchange; and implementing the insurance reforms that comply with the provisions within the health reform law; and
  2. is meeting any benchmarks as established by the Secretary.
- **No grants may be awarded after January 1, 2015.**

# HEALTH CARE REFORM



Moving Forward

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# Implementation Timeline

May 2010



American Hospital  
Association

[www.aha.org](http://www.aha.org)

# Background

In March, President Obama signed into law the *Patient Protection and Affordable Care Act* (PPACA) and the *Health Care and Education Reconciliation Act* (HCERA), which made modifications to the PPACA. Together, this historic legislation constitutes the largest change to America's health care system since the creation of Medicare and Medicaid.

To help hospitals understand the numerous provisions, programs, pilots and deadlines associated with implementing the health care reform legislation, the AHA developed this detailed timeline exclusively for our members. It graphically depicts key milestones in three-month increments from 2010 until 2020 and organizes the legislation into the following sections.

**Consumers and Purchasers:** The new law expands coverage to 32 million people through a combination of public program and private-sector health insurance expansions. Key insurance reforms include a mandate for individuals to have insurance; employer responsibility to provide or contribute to health insurance; low-income subsidies to help individuals purchase insurance; an expansion of Medicaid eligibility; and the creation of state-based health insurance "exchanges."

**Payment and Revenue:** The law takes a number of steps to reduce the rate of increase in Medicare and Medicaid spending through reduced payment updates, decreases in disproportionate share hospital payments, and financial penalties. The new law is financed by taxing high-premium health insurance plans, raising the Medicare tax for high-income individuals and imposing annual fees on the pharmaceutical, medical device, clinical laboratory and health insurance industries.

**Delivery System Reform and Quality:** The law adopts several key delivery system reforms to better align provider incentives to improve care coordination and quality and reduce costs. These reforms include value-based purchasing; pilot projects to test bundled Medicare payments; voluntary pilot programs where qualifying providers – including hospitals – can form Accountable Care Organizations and share in Medicare cost savings; and financial penalties for hospitals with "excessive" readmissions.

**Wellness and Workforce:** The law provides grants and loans to enhance workforce education and training, to support and strengthen the existing workforce, and to help ease health care workforce shortages. It requires public and private insurers to cover recommended preventive services, immunizations and other screenings with zero enrollee cost sharing. It also initiates policies to encourage wellness in schools, workplaces and communities, and takes steps to modernize the public health care system.

**Other:** The law includes provisions to reduce waste, fraud and abuse in the Medicare and Medicaid programs and new reporting requirements are imposed on tax-exempt hospitals. In addition, the law also incorporates several oversight programs including new requirements for physician-owned hospitals.

## HEALTH CARE REFORM MOVING FORWARD

This timeline provides only a brief description and not every provision is depicted. (We recommend printing the timeline in color.) For a detailed summary of the health care reform legislation, refer to the AHA's April 19 *Legislative Advisory*. It is available at [www.aha.org](http://www.aha.org) under "Health Care Reform Moving Forward." This section of our website features numerous resources and tools to help hospital leaders understand health care reform and inform their board, employees and community about the implications for the hospital.

## Assumptions/Notes

- When changes are permanent, they are listed only once in the timeline, followed by “thereafter.”
- Some provisions did not include a specific date within a year. If only a year was listed, it was included in 1st Quarter of the listed year.
- Few provisions did not include any reference to a due date. Those provisions are listed in Appendix A.
- A number of provisions extended previous legislative due dates. The assumed start date for those extensions is the date of enactment. Only the expiration date will be reflected in the timeline.
- If a provision began prior to the date of enactment or was a retrospective adjustment, it was included in 2010: 1st Quarter.
- Many items in the timeline have the PPACA and HCERA section numbers listed in parentheses. We encourage you to use these section numbers as a crosswalk to the April 19 AHA *Legislative Advisory* and the PPACA and HCERA. Assume the section number refers to the PPACA unless noted as HCERA.

## Acronyms

**ACO:** Accountable Care Organization  
**AGI:** Adjusted Gross Income  
**ASC:** Ambulatory Surgical Center  
**CAH:** Critical Access Hospital  
**CDC:** Centers for Disease Control & Prevention  
**CHIP:** Children’s Health Insurance Program  
**CLASS:** Community Living Assistance Services and Supports Act  
**CMI:** Center for Medicare & Medicaid Innovation  
**CMP:** Civil Monetary Penalty  
**CMS:** Centers for Medicare & Medicaid Services  
**CPI:** Consumer Price Index  
**CY:** Calendar Year  
**DGME:** Direct Graduate Medical Education  
**DME:** Durable Medical Equipment  
**DOL:** Department of Labor  
**DRG:** Diagnosis-Related Group  
**DSH:** Disproportionate Share Hospital  
**EFT:** Electronic Funds Transfer

**FICA:** Federal Insurance Contribution Act  
**FMAP:** Federal Medical Assistance Percentage  
**FPL:** Federal Poverty Level  
**FQHC:** Federally Qualified Health Center  
**FTE:** Full-Time Employee  
**FY:** Fiscal Year  
**GAO:** Government Accountability Office  
**GME:** Graduate Medical Education  
**HAC:** Hospital-Acquired Condition  
**HCERA:** Health Care and Education Reconciliation Act of 2010  
**HCFAC:** Health Care Fraud and Abuse Control  
**HHA:** Home Health Agency  
**HHS:** Health and Human Services  
**HIPAA:** Health Insurance Portability and Accountability Act  
**HIT:** Health Information Technology  
**HPSA:** Health Professional Shortage Area  
**HRSA:** Health Resources and Services Administration  
**HVBP:** Hospital Value-Based Purchasing

**IME:** Indirect Medical Education  
**IPAB:** Independent Payment Advisory Board  
**IPF:** Inpatient Psychiatric Hospital  
**IPPS:** Inpatient Prospective Payment System  
**IRC:** Insurance Research Council  
**IRF:** Inpatient Rehabilitation Facility  
**LTCH:** Long-Term Care Hospital  
**MA:** Medicare Advantage  
**MAC:** Medicare Administrative Contractor  
**MACPAC:** Medicaid and CHIP Payment Access Commission  
**MB:** Market Basket  
**MEDPAC:** Medicare Payment Advisory Commission  
**MIP:** Medicare Program Integrity  
**MMSEA:** Medicare, Medicaid, and S-CHIP Extension Act of 2007  
**MUA:** Medically Underserved Area  
**NAIC:** National Association of Insurance Commissioners  
**NF:** Nursing Facility  
**NPI:** National Provider Identifier

**OPM:** Office of Personnel Management  
**OPPS:** Outpatient Prospective Payment System  
**PFS:** Physician Fee Schedule (Medicare)  
**PI:** Program Integrity  
**PPACA:** Patient Protection and Affordable Care Act  
**PQRI:** Physician Quality Reporting Initiative  
**PSO:** Patient Safety Organization  
**PSTF:** Prevention Services Task Force  
**RAC:** Recovery Audit Contractor  
**ROI:** Return on Investment  
**RRC:** Rural Referral Center  
**RTC:** Report to Congress  
**RY:** Rate Year  
**SCH:** Sole Community Hospital  
**SECA:** Self-Employment Contribution Act  
**SNF:** Skilled Nursing Facility  
**VBP:** Value-Based Purchasing  
**USPSTF:** U. S. Preventive Services Task Force



# Health Care Reform Implementation Timeline

ENACTMENT (MARCH 23, 2010)

2010

WELLNESS & WORKFORCE

DELIVERY SYSTEM REFORM & QUALITY

PAYMENT & REVENUE CONSUMERS & PURCHASERS

OTHER

Nonprofit hospitals are required to conduct a community needs assessment; adopt financial assistance policy; limit charges to charity care patients to the amount billed to insured patients (10903)

Publication of certain information on *Nursing Home Compare* (6103)

States required to maintain CHIP through Sept 30, 2019 (2101)

Requires hospitals to publicize an annual updated list of their standard charges, including DRGs beginning in plan years after March 23, 2010 (1001)

Establish medical reimbursement data centers to collect, and publish publicly, reimbursement data from health insurers (10101)

Extends (from Oct 1, 2009 through Sept 30, 2010) Section 508 Medicare hospital payment protections

Creates IPAB (3403)

Extends the gainsharing demonstration's completion date (3027)

Establishes a nationwide program for national and state background checks on direct care providers in long-term care facilities (6701-6703)

Establishes the patient-centered outcomes research institute to set a national research agenda and conduct comparative clinical effectiveness research (6301, 10602)

Creates 3-year demonstration program for up to 15 urban/rural hospices

Establishes grants for teaching health center GME programs (5508)

Establishes an Office for Women's Health in the Office of the HHS Secretary and several HHS agencies

Provides grants and contracts to support and develop a primary care training program (5201-5202)

Requires better coordination between the USPSTF and Community PSTF (4003)

Establishes grants, through FY 2014, to support "school-based health centers" (4101)

Retroactively establishes (Oct 1, 2009) grant programs (FY 2010-2014) through CDC to community-based organizations to reduce chronic disease, address health disparities, and promote evidence-based community preventive health activities; not less than 20% of grants must be awarded to rural and frontier areas

Retroactively establishes (Oct 1, 2009) community-based prevention programs for Medicare beneficiaries and others (4202)

Directs negotiated rulemaking, with stakeholders, to establish a methodology and criteria for designating medically underserved populations and HPSAs (5602)

Extends the National Health Service Corps Scholarship and Loan Repayment Program for 2011-2015 (5207, 10503)

Establishes a Prevention and Public Health Investment Fund to improve health and restrain cost growth (4002)

Implements a national public-private partnership for a prevention and health promotion outreach and education campaign (4004)

Allows for redistribution of residency positions from a hospital closed on or after March 23, 2008 (5506)

Prohibits physician-owned hospitals from converting to ASCs

MAC authority to perform additional PI reviews (1302 of HCERA)

Authority to suspend Medicare and Medicaid payments to a provider/supplier pending an investigation of fraud

Requires Medicare and Medicaid administrative contractors to submit performance statistics on fraud referrals, overpayments, and ROI

Requires SNFs and NFs to implement compliance and ethics programs

Establishes Health Reform Implementation Fund within HHS to implement the PPACA legislation with a \$1 billion appropriation (1005)

Expands of existing PI programs, data sources, and data sharing across Federal agencies (6402)

Requires any person with knowledge of an overpayment to return it

Provides \$10 million each year, for 10 years, to the HCFAC program

Requires that all Medicare claims be submitted within 1 year after the date of service (previously allowed 3 years), beginning with services rendered after Jan 1, 2010 (6404)

Establishes additional requirements for Section 501(c)(3) charitable hospital organizations (pertains to conducting community needs assessments in 2012)

Modification to SNF cost reporting (staff wages and benefits) by staff type

Authority to impose administrative penalties if a beneficiary knowingly participates in a Federal health care offense

Violation of claims processing statutes constitutes false or fraudulent claims; amends CMP and anti-kickback statutes (6403)

Authorizes annual CPI adjustment to HCFAC and MIP funding

FIRST QUARTER  
2010

CONSUMERS & PURCHASERS

PAYMENT & REVENUE

DELIVERY SYSTEM REFORM & QUALITY

WELLNESS & WORKFORCE

OTHER

Retroactively provides small business tax credit of up to 35% of premiums for the purchase of coverage for employees (1421, 10105) **(Jan 1)**

Requires drug manufacturers to pay rebates for beneficiaries in managed care plans (2501-2503) **(Jan 1)**

Retroactively requires MB - 0.25% for OPPI (Jan 1)

Retroactively extends 340B expansion to children's hospitals, free standing cancer hospitals, CAHs, RRCs and SCHs that meet certain outpatient criteria; orphan drugs excluded **(Jan 1)**

Retroactively extends payment for the technical component for certain lab services; through Dec 31, 2010 **(Jan 1)**

Reinstates Medicare Dependent Hospital Program through Sept 30, 2012 **(Jan 1)**

Retroactively establishes the Medicaid global payment demonstration in 5 states (2705) **(Oct 1)**

Retroactively authorizes modification of certain preventive services covered by Medicare; prohibits payment for preventive services that have been graded A, B, C, or I by the USPSTF (4105) **(Jan 1)**

No provision to be implemented

Extends Medicaid drug rebate program to drugs dispensed through managed care plans (2501) **(Jan 1)**

Provides \$250 rebate for Medicare Part D beneficiaries who have reached prescription drug "donut hole" (3301) **(Jan 1)**

Retroactively extends MMSEA LTCH provisions and therapy caps through Dec 31, 2012 **(Jan 1)**

Extends and revises the Medicare Rural Hospital Flexibility Program through FY 2012 (3129) **(Jan 1)**

Retroactively extends Rural Community Hospital Demonstration Program; through Dec 31, 2014 **(Jan 1)**

Extends the 1.0 floor for the geographic index for physician work through 2010 **(Jan 1)**

Retroactively establishes the Federal Coordinated Health Care Office within CMS to coordinate coverage and payment for dually eligible beneficiaries (2602) **(March 1)**

Authorizes \$11 million for MAC-PAC (2802) **(Jan 1)**

Retroactively increases PFS payment rate for psychiatric services by 5% for 1 year; through Dec 31, 2010 (3107) **(Jan 1)**

Retroactively modifies how power wheel chairs are reimbursed (3109) **(Jan 1)**

Requires a medical loss ratio of 85% or higher in order for non-profit Blue Cross Blue Shield organizations to take advantage of their special tax benefits (9016) **(Jan 1)**

SECOND QUARTER  
2010

CONSUMERS & PURCHASERS

PAYMENT & REVENUE

DELIVERY SYSTEM REFORM & QUALITY

WELLNESS & WORKFORCE

OTHER

Allows state Medicaid option to cover parents and childless adults up to 133% FPL and receive current law FMAP (2001) **(April 1)**

Establishes temporary national high risk pools for adults with pre-existing conditions and who have been uninsured for 6 months through Jan 1, 2014 (1101) **(June 21)**

Establishes a temporary national reinsurance pool for early retirees (55-64) and their families through Jan 1, 2014 (1102) **(June 21)**

MB - 0.25% for IPPS hospitals, IRFs, and LTCHs **(April 1)**

Reinstates 3% add-on payment for rural home health providers through 2015 (3131, 10315)

Medication management in the treatment of chronic diseases program begins (3503) **(May 1)**

No provision to be implemented

Publication on HHS website of a list of all authorities provided under PPACA **(April 23)**

SECOND QUARTER  
2011

WELLNESS & WORKFORCE

No provision to be implemented

DELIVERY SYSTEM REFORM & QUALITY

No provision to be implemented

PAYMENT & REVENUE

Deadline for congressional committees of jurisdiction to report legislation with targeted level of savings (3403) **(April 1)**

CONSUMERS & PURCHASERS

No provision to be implemented

OTHER

No provision to be implemented

THIRD QUARTER

WELLNESS & WORKFORCE

Final rule on MUAs and HPSAs due (5602) **(July 1)**

Redistribution of unused residency position for DGME and IME cost reporting periods beginning after July 1, 2011 (5503) **(July 1)**

DELIVERY SYSTEM REFORM & QUALITY

Regulations prohibiting federal Medicaid payment for health care-acquired conditions due (2702) **(July 1)**

Establishes and announces performance standards for HVBP (3001) **(Aug 1)**

Gainsharing demonstration extension ends (3027) **(Sept 30)**

PAYMENT & REVENUE

MB – 0.25% for IPF **(July 1)**

Demonstration project altering payment for laboratory services rendered in an inpatient setting begins (3113) **(July 1)**

Requires a 10% tax paid by individuals for indoor tanning services (10907) **(July 1)**

CONSUMERS & PURCHASERS

Establishes the Community First Choice Medicaid Benefit option for community-based services provided to Medicaid beneficiaries with disabilities (2401)

Medicaid FMAP to Puerto Rico and territories increased by 5% (2005) **(July 1)**

OTHER

Secretary shall adopt operating rules for electronic eligibility determinations for health plans and health claim status transactions (10109) **(July 1)**

Establishes physician ownership policies for Stark compliance audits (6001) **(Sept 23)**

FOURTH QUARTER

WELLNESS & WORKFORCE

Provides grants (FY 2011-2015) for training GME residents in preventive medicine specialties (10501) **(Oct 1)**

No provision to be implemented

DELIVERY SYSTEM REFORM & QUALITY

Publication of Medicare quality measures; annually thereafter (3011 – 3015) **(Dec 1)**

Initial performance period begins for HVBP (3001) **(Oct 1)**

PAYMENT & REVENUE

MB – (0.1% + productivity) for IPPS, LTCH and IRF **(Oct 1)**

MB – productivity for SNF **(Oct 1)**

Expands temporary Medicare payment adjustment to certain low-volume hospitals through 2012 **(Oct 1)**

MB – (0.3% + productivity) for hospice

Delays for 1 year the implementation of certain “RUGs-IV” Medicare payment changes

CMS plan for Medicare wage index reform plan due (3137, 3141, 10317) **(Dec 31)**

CONSUMERS & PURCHASERS

Establishes new state option with enhanced FMAP for Community First Choice Medicaid Benefit to provide home and community-based services to Medicaid beneficiaries (2401) **(Oct 1)**

CONSUMERS & PURCHASERS

Freezes income thresholds at 2010 levels for income-related Part B premium through Dec 31, 2019 (3402) (Jan 1)

Creation of a voluntary long-term care insurance program for adults (CLASS), financed by payroll deductions (8002) (Jan 1)

Federal grant money available to states to establish or expand health insurance consumer assistance and ombudsman programs (1001) (March 23)

Requires HHS Secretary to establish a basic health program for individuals below 200% FPL and not eligible for state Medicaid programs (1331)

Requires employers to disclose the cost of employer-sponsored health insurance coverage on employee's annual W-2 form for taxable year after Dec 31, 2010 (9004) (Jan 1)

Requires insurance company annual reporting on the share of premium dollars spent on medical care and where appropriate, includes medical loss ratio requirements as determinants by minimum medical loss ratios (1003, 10101) (Jan 1)

Federal assistance must be available to states to start health insurance exchanges; funds available through Jan 1, 2015 (1311) (March 23)

Deadline for proposed regulation on nutritional labeling of menu items at chain restaurants (4205) (March 23)

PAYMENT & REVENUE

MB - 0.25% for OPPI (Jan 1)

Annual fee for branded prescription pharmaceuticals begins (Jan 1)

Special FMAP adjustment for states recovering from major disasters (LA hurricane relief) (2006) (Jan 1)

Study on whether costs incurred under OPPI by cancer hospitals exceed costs incurred by other hospitals (3138) (Jan 1)

MA payments frozen at 2010 level (Jan 1)

MB - productivity for ASCs, Certain DME, Ambulance (Jan 1)

Additional 10% Medicare payment bonus to primary care practitioners and general surgeons through 2015 (Jan 1)

Increases reimbursement for certified nurse-midwife services from 65% to 100% of PFS rate (3114) (Jan 1)

Exclusion of over-the-counter medicines, unless prescribed by a physician, for health reimbursement arrangements, health flexible spending accounts and Archer medical savings accounts (9003) (Jan 1)

Increases the medical expense tax from 10% to 20% for early withdrawal from health savings accounts for those under age 65 (9004) (Jan 1)

MB - 1.0% for HHAs (Jan 1)

Establishes minimum floors for the IPPS, OPPI, and PFS in certain states where at least 50% of counties are frontier (less than 6 people/square mile)

Payment cuts for imaging services based on equipment utilization factors begin (3135) (Jan 1)

Requires an annual flat fee on the pharmaceutical manufacturing sector for branded prescription drugs (9008) (Jan 1)

MB - (1.75% + productivity) for Clinical Laboratories (Jan 1)

Provider-specific HHA outlier cap of 10%; annually thereafter (Jan 1)

DELIVERY SYSTEM REFORM & QUALITY

Secretary shall publish for comment, a recommended core set of adult health quality measures for Medicaid eligible adults (2701) (Jan 1)

Extends voluntary Medicare PQRI Program through 2014; Maintenance of Certification may serve as a substitute for submission of quality measures in PQRI; PQRI informal appeals process begins; 0.5% bonus for PQRI (Jan 1)

Establishes the CMI to test 20 possible models of payment reform and provides \$1 billion/year for 10 years (3021) (Jan 1)

Development of a *Physician Compare* website due (10331) (Jan 1)

Phase down of Part D co-insurance to 25% (3301) (Jan 1)

Awards for state planning grants for the Medicaid health home program for enrollees with chronic conditions begin (2703) (Jan 1)

Five year community-based care transitions program to reduce readmissions in PPS hospitals begins (3026) (Jan 1)

Permits physician assistants to order SNF services (3108) (Jan 1)

Manufacturers provide 50% discount on drugs to participate in Part D (3301) (Jan 1)

WELLNESS & WORKFORCE

Expands coverage for an annual Medicare wellness visit during which personalized prevention plan is provided (4103) (Jan 1)

Eliminates cost sharing requirements for certain Medicare covered preventive and screening services (initial physician exam and personalized prevention services and colorectal screening) (4104, 10406) (Jan 1)

Provides grants (5-years) to states to implement incentives to Medicaid beneficiaries who successfully participate in programs for healthy lifestyles (4108) (Jan 1)

Secretary to submit to Congress an implementation plan for VBP in ASCs (3306, 10301) (Jan 1)

OTHER

ICD-9-CM crosswalk to ICD-10 due (Jan 1)

Deadline for all Medicare and Medicaid providers and suppliers to include national provider identifier on claims and enrollment applications (6402) (Jan 1)

FIRST QUARTER 2011

SECOND QUARTER

2011

OTHER  
WELLNESS & WORKFORCE

DELIVERY SYSTEM  
REFORM & QUALITY

PAYMENT & REVENUE

CONSUMERS  
& PURCHASERS

No provision to be implemented

No provision to be implemented

No provision to be implemented

Deadline for congressional committees of jurisdiction to report legislation with targeted level of savings (3403) (April 1)

No provision to be implemented

THIRD QUARTER

OTHER  
WELLNESS & WORKFORCE

DELIVERY SYSTEM  
REFORM & QUALITY

PAYMENT  
& REVENUE

CONSUMERS  
& PURCHASERS

Establishes physician ownership policies for Stark compliance audits (6001) (Sept 23)

Secretary shall adopt operating rules for electronic eligibility determinations for health plans and health claim status transactions (10109) (July 1)

Redistribution of unused residency position for DGME and IME cost reporting periods beginning after July 1, 2011 (5503) (July 1)

Final rule on MUAs and HPSAs due (5602) (July 1)

Gainsharing demonstration extension ends (3027) (Sept 30)

Establishes and announces performance standards for HVBP (3001) (Aug 1)

Regulations prohibiting federal Medicaid payment for health care-acquired conditions due (2702) (July 1)

Requires a 10% tax paid by individuals for indoor tanning services (10907) (July 1)

Demonstration project altering payment for laboratory services rendered in an inpatient setting begins (3113) (July 1)

MB – 0.25% for IPF (July 1)

Medicaid FMAP to Puerto Rico and territories increased by 5% (2005) (July 1)

Establishes the Community First Choice Medicaid Benefit option for community-based services provided to Medicaid beneficiaries with disabilities (2401)

FOURTH QUARTER

OTHER  
WELLNESS & WORKFORCE

DELIVERY SYSTEM  
REFORM & QUALITY

PAYMENT & REVENUE

CONSUMERS  
& PURCHASERS

No provision to be implemented

Provides grants (FY 2011-2015) for training GME residents in preventive medicine specialties (10501) (Oct 1)

Initial performance period begins for HVBP (3001) (Oct 1)

Publication of Medicare quality measures; annually thereafter (3011 – 3015) (Dec 1)

CMS plan for Medicare wage index reform plan due (3137, 3141, 10317) (Dec 31)

Delays for 1 year the implementation of certain “RUGs-IV” Medicare payment changes

MB – (0.3% + productivity) for hospice

Expands temporary Medicare payment adjustment to certain low-volume hospitals through 2012 (Oct 1)

MB – productivity for SNF (Oct 1)

MB – (0.1% + productivity) for IPPS, LTCH and IRF (Oct 1)

Establishes new state option with enhanced FMAP for Community First Choice Medicaid Benefit to provide home and community-based services to Medicaid beneficiaries (2401) (Oct 1)

CONSUMERS & PURCHASERS

Requires regulatory standards to be issued by the Architectural and Transportation Barriers Compliance Board for medical diagnostic equipment based in hospitals, emergency rooms, clinics and physician offices to be accessible to individuals with disabilities (4203) **(March 23)**

Health plans will be required to provide information about the plans' benefits and coverage to applicants and enrollees; failure to provide information results in \$1,000 fine/failure for each enrollee (1001) **(March 23)**

Deadline for proposed regulation on providing break time for nursing mothers (4207) **(March 23)**

PAYMENT & REVENUE

MB – (0.1% + productivity) for OPPS **(Jan 1)**

MB – 1.0% for HHAs **(Jan 1)**

Revision of practice expense geographic adjustment factor under the PFS due (3102; 1108 of HCERA) **(Jan 1)**

Requires businesses that pay any amount over \$600 per year to corporate providers of property and services to file an information report with each provider and with the IRS (9006) **(Jan 1)**

MB – productivity for ASCs, Dialysis, Certain DME, Ambulance **(Jan 1)**

MB – (1.75% + productivity) for Clinical Laboratories **(Jan 1)**

MA plan payment cut phase-in begins (3201-3210) **(Jan 1)**

FIRST QUARTER  
2012

DELIVERY SYSTEM REFORM & QUALITY

Final recommended core set of adult health quality measures for Medicaid enrollees published (2701) **(Jan 1)**

Plan for integrating PQRI physician data with Meaningful Use due; 0.5% PQRI bonus through 2014 (3002, 10327) **(Jan 1)**

Medicare shared savings ACO program begins (3022) **(Jan 1)**

Performance quality measurement data made available to qualified entities (10331) **(Jan 1)**

HHS Secretary shall develop health plan quality reporting requirements including care coordination and prevention of hospital readmissions (1001) **(March 23)**

State Medicaid health home demonstration begins and continues through Dec 31, 2015 (2703) **(Jan 1)**

Episode grouper and physician resource use reports due (3003) **(Jan 1)**

8-State Medicaid bundled payment pilot begins and continues through Dec 31, 2016 (2704) **(Jan 1)**

Secretary shall recommend to Congress options to expand Medicare's hospital-acquired conditions payment policy to other settings of care, including LTCH, IRF, IPF and OPPS (3008) **(Jan 1)**

PSO program to support quality improvement efforts to reduce IPPS readmissions begins (3025) **(March 23)**

Pediatric ACO demonstration with states and pediatric providers begins and continues through Dec 31, 2016 (2706) **(Jan 1)**

Publication of specific physician value-based modifier measures for implementation and identification of the performance period due (3007) **(Jan 1)**

Independence at home Medicaid demonstration begins (3024) **(Jan 1)**

CAH and hospitals with "small numbers" HVBP demonstrations begin (3001) **(March 23)**

WELLNESS & WORKFORCE

Establishes a 5-year national public education campaign focused on oral health care prevention and education (4102) **(March 23)**

Requires all federally funded programs to collect data on race, ethnicity, primary language and other factors (4302) **(March 23)**

Secretary to implement approaches to collect health disparities data in Medicaid and CHIP (4302) **(March 23)**

OTHER

Deadline for HHS regulations on the process that grandfathered physician-owned hospitals must comply with in order to expand (6001) **(Jan 1)**

Deadline for implementation of the process that grandfathered physician-owned hospitals must comply with in order to expand (6001) **(Feb 1)**

Mandates screening of all providers and suppliers enrolled in Medicare, Medicaid and CHIP before granting billing privileges (6401) **(March 23)**

Annual treasury RTC on levels of charity care, bad debt, unreimbursed costs and costs of community benefit activities (9007)

Community needs assessment requirement for hospitals (9007)

**SECOND QUARTER**  
**2012**

**OTHER**

Deadline for the HHS audit process that ensures compliance with the regulations for physician-owned hospital expansion **(May 1)**

**WELLNESS & WORKFORCE**

No provision to be implemented

**DELIVERY SYSTEM REFORM & QUALITY**

No provision to be implemented

**PAYMENT & REVENUE**

No provision to be implemented

**CONSUMERS & PURCHASERS**

No provision to be implemented

**OTHER**

Secretary shall adopt operating rules for electronic funds transfers and health care payment and remittance advice **(July 1)**

**WELLNESS & WORKFORCE**

No provision to be implemented

**DELIVERY SYSTEM REFORM & QUALITY**

CMS to Inform each hospital of the HVBP adjustments to payments (3001) **(Aug 1)**

Medicaid global payment demonstration ends (2705) **(Sept 30)**

**PAYMENT & REVENUE**

MB – (0.1% + productivity) for IPF **(July 1)**

**CONSUMERS & PURCHASERS**

HHS Secretary shall establish federal guidance on the initial enrollment process for state exchanges (1311) **(July 1)**

**OTHER**

Effective date for unique health plan identifier (1104) **(Oct 1)**

**WELLNESS & WORKFORCE**

No provision to be implemented

**DELIVERY SYSTEM REFORM & QUALITY**

Selection and publication of LTCH, IRF, IPF, PPS-exempt cancer hospital, and hospice quality measures due (3004, 3005, 10322) **(Oct 1)**

HVBP Medicare program begins; 1.0% of IPPS MB tied to HVBP; Risk adjustment of HVBP quality outcome measures due; (3001) **(Oct 1)**

Appropriation of Medicare Trust funds to the Patient-Centered Outcomes Research Trust Fund (6301) **(Oct 1)**

Maximum reduction to IPPS MB update under readmissions policy is 1%

**PAYMENT & REVENUE**

Year 2 geographic variation payments to hospitals in low-cost counties (1109 of HCERA)

MB – (0.3% + productivity) for hospice through FY 2019 (depending upon number of insured individuals nationwide) (10391) **(Oct 1)**

MB – productivity for SNF **(Oct 1)**

MB – (0.1% + productivity) for IPPS, IRF, LTCH **(Oct 1)**

**CONSUMERS & PURCHASERS**

Secretary shall promulgate regulations concerning the standards for a CLASS independence benefit plan (8002) **(Oct 1)**

HHS Secretary certifies state-based exchanges will be operational by Jan 1, 2014 and HHS will establish a federally operated exchange in any state failing certification (1321, 1322) **(Jan 1)**

New tax on insured and self-insured health plans; levied to fund the Patient-Centered Outcomes Research Institute (6301) **(Jan 1)**

Secretary will determine whether a state will have a qualified exchange operational by Jan 1, 2014 (1321) **(Jan 1)**

Drug manufacturers shall provide a 50% discount on prescriptions when a beneficiary is in the "donut hole" (3301-3315; 1101 of HCERA) **(Jan 1)**

Employers must notify employees of the availability of state exchanges and potential eligibility for federal subsidies for insurance purchased through the exchange (1512) **(March 1)**

HIT rules become operational that allow use of a machine-readable insurance identification card (1104, 10109) **(Jan 1)**

MB – (0.1% + productivity) for OPPS **(Jan 1)**

MB – productivity for ASCs, Dialysis, Certain DME, Ambulance **(Jan 1)**

MB – 1.0% for HHAs **(Jan 1)**

MB – (1.75% + productivity) for Clinical Laboratories **(Jan 1)**

Requires states to pay Medicare rates to primary care physicians serving Medicaid enrollees. Fully funds (100% FMAP) additional state costs; through Dec 31, 2014 (1202) **(Jan 1)**

\$2,500 cap on annual tax-free contribution to a flex spending account begins for tax years after Dec 31, 2012 (1403) **(Jan 1)**

Requires an annual tax on the sale of taxable medical devices by a manufacturer, producer or importer equal to 2.3% of the sales price (1405 of HCERA) **(Jan 1)**

Increases the adjusted gross income threshold for claiming the itemized deduction for medical expenses from 7.5% to 10% for tax years after Dec 31, 2012 (9013) **(Jan 1)**

Imposes a new \$500,000 limit on the amount that can be deducted from executive compensation for insurance providers if at least 25% of the insurance provider's gross premium income from health business is derived from health insurance plans (9014) **(Jan 1)**

Increases Medicare hospital payroll tax by 0.9 percentage points on wages in excess of \$200,000 (\$250,000 for married couples filing jointly). Increases unearned income Medicare contribution of individuals, estates, and trusts 3.8% for taxable year starting with 2013 (9015) **(Jan 1)**

Secretary issues standard format for reporting adult quality measures (2701) **(Jan 1)**

Public reporting of physician performance information on *Physician Compare* begins (10331) **(Jan 1)**

Deadline for establishing the national voluntary (5-year) Medicare bundled payment pilot for hospitals, physicians and post-acute care providers through Dec 31, 2018 – may be extended nationwide by the Secretary (3023, 10308) **(Jan 1)**

Amends Medicaid state option to include any clinical preventive service assigned grade A, B, C, or I by the USPSTF. Provides 1% FMAP increase when states cover these clinical preventive services with no cost sharing. Approves vaccines and certain services for adults. (4106) **(Jan 1)**

Drug, device, and supply manufacturers that pay or transfer items of value to a physician or teaching hospital must submit information to the Secretary; annually thereafter **(March 31)**

Eliminates the deduction subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees (9012) **(Jan 1)**

**SECOND QUARTER  
2013**

WELLNESS & WORKFORCE

DELIVERY SYSTEM REFORM & QUALITY

PAYMENT & REVENUE

CONSUMERS & PURCHASERS

No provision to be implemented

**THIRD QUARTER**

WELLNESS & WORKFORCE

DELIVERY SYSTEM REFORM & QUALITY

PAYMENT & REVENUE

CONSUMERS & PURCHASERS

No provision to be implemented

No provision to be implemented

IPAB must submit first annual draft report to MedPAC and HHS with a proposal to reduce Medicare spending by targeted amounts (3403) 10320) (Sept 1)

MB penalty (2%) for failure to report IPF quality measures (10322) (July 1)

Complex laboratory tests payment demonstration ends (3113)

MB – (0.1% + productivity) for IPF (July 1)

Health Care Choice Compact (2 or more states agree to offer one or more plans in both or all states) regulations due (1333) (July 1)

Consumer Operated and Oriented Plan (CO-OP) Program established (1322) (July 1)

**FOURTH QUARTER**

WELLNESS & WORKFORCE

DELIVERY SYSTEM REFORM & QUALITY

PAYMENT & REVENUE

CONSUMERS & PURCHASERS

Requires health plans to file a statement with HHS certifying that their data and information systems are in compliance with federal applicable HIPAA standards and associated operating rules for electronic fund transfers, eligibility, health claim status, health care payment, and remittance advice (Dec 31)

No provision to be implemented

1.25% of IPPS MB update withheld for HVBP redistribution.

Mandatory quality reporting program begins for PPS-exempt cancer hospitals (3004, 10322) (Oct 1)

Inclusion of efficiency measures in HVBP and 1.25% of IPPS MB tied to HVBP (3001) (Oct 1)

Medicare DSH payment reductions begin; annually thereafter (Oct 1)

\$500 million reduction to funds available for Medicaid DSH (2551) (Oct 1)

MB – productivity for SNF (Oct 1)

MB – (0.3% + productivity) for IPPS, IRF, LTCH, Hospice (Oct 1)

MB penalty (2%) for LTCHs, IRFs and Hospices that fail to report quality measures (3004 and 3005) (Oct 1)

Requires an annual flat fee of \$6.7 billion on the health insurance sector (9010) (Oct 1)

Increased federal match of 23 percentage points up to 100% for CHIP-covered items and services begins (2101) (Oct 1)

No provision to be implemented

Prohibits health insurers and health plans from pre-existing condition exclusions for adults, prohibits annual limits, requires guaranteed issue and renewability of coverage, and limits premium rating (1201) (Jan 1)

Prohibits all health plans from applying excessive waiting periods exceeding 90 days (1201) (Jan 1)

Medicaid FMAP for newly eligible enrollees (children, childless adults and parents) is set at 100% through FY 2017 (2001) (Jan 1)

Medicaid FMAP for childless adults in early expansion states (AZ, DE, DC, HI, ME, MA, MN, NY, PA, VT, WA and WI) increases to 50% (2001) (Jan 1)

Health insurance exchanges open in each state to individual and small group markets (1311) (Jan 1)

OPM enters into contracts with health insurers to offer at least 2 multi-state qualified health plans in each state (1334) (Jan 1)

Creates transitional re-insurance program to cover costs for high-risk individuals in the individual and group markets for 2014 – 2016 (1341) (Jan 1)

Tax credits and cost-sharing subsidies available through the state exchanges for individuals and families between 100-400% of FPL (1401) (Jan 1)

Tax credits for small employers begin with full tax credit available for those with 10 or fewer employees (1421) (Jan 1)

Imposes individual mandate on purchase of acceptable health insurance subject to penalties for non-compliance for taxable years after Dec 31, 2013 (1501) (Jan 1)

Employers with 200 or more employees must automatically enroll employees in their health plans (1511) (Jan 1)

“Free Rider” employer assessment is imposed on employers with 50 or more employees that either do not offer coverage or have employees that purchase coverage through the exchange with federal subsidies (1512) (Jan 1)

Medicaid program expansion to 133 percent of FPL for parents, children and childless adults (2001) (Jan 1)

Requires states to offer premium assistance and wrap around benefits to Medicaid beneficiaries offered employer-sponsored insurance if it is cost effective (2003) (Jan 1)

Permits Medicaid-participating hospitals and eligible providers to make presumptive eligibility determinations (2202) (Jan 1)

Free choice vouchers available for workers who qualify for an affordability exemption (10108) (Jan 1)

Requires plans to cover routine patient care costs of qualified individuals participating in certain clinical trials (10103) (Jan 1)

Secretary of Labor to report to Congress annually on self-insured plans (1253, 10103) (Jan 1)

MB – (0.3% + productivity) for OPPI (Jan 1)

MB – (1.75% + productivity) for Clinical Laboratories (Jan 1)

Rebasing of HHA payments begins; 4-year phase-in period

Secretary must submit proposed to Congress and the President if IPAB fails to submit a proposal (3403) (Jan 25)

MB – productivity for ASCs, Dialysis, Certain DME, Ambulance (Jan 1)

Requires health plans participating in an exchange to pay FQHCs at Medicaid rates or higher (1302) (Jan 1)

IPAB must present proposals to the President to reduce cost growth and improve quality and it must be transmitted to Congress within 2 calendar days. Exempts IPPS hospitals (3403) (Jan 15)

Interim report on state Medicaid health home program participants due (2703) (Jan 1)

Employer-sponsored health plans can offer financial rewards in the form of discounts or rebates on premiums or cost-sharing waivers (subject to certain requirements) for participation in wellness programs (1201) (Jan 1)

Establishes non-discrimination requirements for employer-provided health promotion or disease prevention (wellness) programs (1201) (Jan 1)

HIT rules become operational that allow for EFT and health care payment and readmittance advice (1104, 10109) (Jan 1)

# 2016 FIRST QUARTER

## WELLNESS & WORKFORCE

No provision to be implemented

## DELIVERY SYSTEM REFORM & QUALITY

Secretary may expand scope and duration of the national Medicare voluntary bundling pilot (3023, 10308) (Jan 1)

Secretary must initiate separate programs to test VBP for LTCHs, IRFs, IPFs, PPS-exempt cancer hospitals and hospices (10326) (Jan 1)

2.0% penalty applied to PFS update for physicians who fail to submit PQRI measures successfully; annually thereafter (3002, 10327) (Jan 1)

## PAYMENT & REVENUE

MB – (0.2% + productivity) for OPFS (Jan 1)

MB – productivity for ASC, Dialysis, Certain DME, Ambulance, HHAs and Clinical Laboratories (Jan 1)

## CONSUMERS & PURCHASERS

Medicaid FMAP for childless adults in early expansion states (AZ, DE, DC, HI, ME, MA, MN, NY, PA, VT, WA and WI) increases to 70% (2001) (Jan 1)

States can enter into health care choice compacts to allow health benefits to be sold across state lines (1333) (Jan 1)

## OTHER

Claims and encounter information operating rules enforced (Jan 1)

## SECOND QUARTER

### WELLNESS & WORKFORCE

No provision to be implemented

### DELIVERY SYSTEM REFORM & QUALITY

No provision to be implemented

### PAYMENT & REVENUE

No provision to be implemented

### CONSUMERS & PURCHASERS

No provision to be implemented

## OTHER

No provision to be implemented

## THIRD QUARTER

### WELLNESS & WORKFORCE

No provision to be implemented

### DELIVERY SYSTEM REFORM & QUALITY

No provision to be implemented

### PAYMENT & REVENUE

MB – (0.2% + productivity) for IPF (July 1)

### CONSUMERS

No provision to be implemented

## OTHER

No provision to be implemented

## FOURTH QUARTER

### WELLNESS & WORKFORCE

No provision to be implemented

### DELIVERY SYSTEM REFORM & QUALITY

State Medicaid health home demonstration ends (2703) (Dec 31)

Medicaid bundled payment demonstration ends (2704) (Dec 31)

Pediatric ACO demonstration ends (2706) (Dec 31)

### PAYMENT & REVENUE

MB – (0.75% + productivity) for IPPS, IRF, LTCH (Oct 1)

MB – productivity for SNF (Oct 1)

MB – (0.3% + productivity) for Hospice; Potential for “give back” (Oct 1)

\$1.8 billion cut to funds available for Medicaid DSH (2551) (Oct 1)

### CONSUMERS & PURCHASERS

States may enroll CHIP eligible children in exchange based qualified health plans if the children are denied CHIP coverage due to enrollment caps (2101) (Oct 1)

## OTHER

No provision to be implemented

# 2015

## FIRST QUARTER

OTHER WELLNESS & WORKFORCE

DELIVERY SYSTEM REFORM & QUALITY

PAYMENT & REVENUE

CONSUMERS & PURCHASERS

Medigap plans C & F shall require nominal cost sharing to encourage the appropriate use of physician services (3210) **(Jan 1)**

State-based exchanges shall be financially self-sustaining (1311) **(Jan 1)**

States shall begin annual reporting on the number and characteristics of Medicaid enrollees, including estimates of the number of newly enrolled individuals (2001,10201) **(Jan 1)**

MB – (1.75% + productivity) for Clinical Laboratories **(Jan 1)**

MB – productivity for ASCs, Dialysis, Certain DME, Ambulance and HHAs **(Jan 1)**

Regulations updating the Medicaid adult quality measures program due and annually thereafter (2701) **(Jan 1)**

1.5% penalty applied to PFS update for physicians who fail to submit PQRI measures successfully (3002, 10327) **(Jan 1)**

No provision to be implemented

No provision to be implemented

Medicaid FMAP for childless adults in early expansion states (AZ, DE, DC, HI, ME, MA, MN, NY, PA, VT, WA and WI) increases to 60% (2001) **(Jan 1)**

Qualified health plans in state-based exchanges can no longer contract with hospitals with more than 50 beds unless the hospital participates in a PSO and implements a mechanism for a comprehensive program for hospital discharges (1311) **(Jan 1)**

MB – (0.2% + productivity) for OPPS **(Jan 1)**

IPAB to submit recommendation to Congress and the President on slowing growth in national health expenditures (3403) **(Jan 15)**

Implements a budget neutral value-based payment adjustment to vary physician payments based on quality of care relative to costs (3007) **(Jan 1)**

CAH and hospitals with “small numbers” demonstrations on HVBP ends (3001) **(March 23)**

## SECOND QUARTER

OTHER

WELLNESS & WORKFORCE

DELIVERY SYSTEM REFORM & QUALITY

PAYMENT & REVENUE

CONSUMERS & PURCHASERS

No provision to be implemented

## THIRD QUARTER

OTHER

WELLNESS & WORKFORCE

DELIVERY SYSTEM REFORM & QUALITY

PAYMENT & REVENUE

CONSUMERS & PURCHASERS

No provision to be implemented

No provision to be implemented

No provision to be implemented

MB – (0.2% + productivity) for IPF **(July 1)**

No provision to be implemented

## FOURTH QUARTER

OTHER

WELLNESS & WORKFORCE

DELIVERY SYSTEM REFORM & QUALITY

PAYMENT & REVENUE

CONSUMERS & PURCHASERS

No provision to be implemented

No provision to be implemented

Community-based care transitions of care program targeting readmissions ends (3026) **(Dec 31)**

1.75% of IPPS MB withheld for HVBP redistribution (3001) **(Oct 1)**

\$600 million cut to funds available for Medicaid DSH (2551) **(Oct 1)**

MB – (0.3% + productivity) for Hospice; Potential for “give back” **(Oct 1)**

MB – productivity for SNF **(Oct 1)**

MB – (0.2% + productivity) for IPPS, IRE, LTCH **(Oct 1)**

Increases FMAP for each state for CHIP through FY 2019 (2101, 10203) **(Oct 1)**

# 2016 FIRST QUARTER

OTHER  
WELLNESS &  
WORKFORCE

Claims and encounter information operating rules enforced (Jan 1)

DELIVERY SYSTEM  
REFORM & QUALITY

Extends Medicaid "Money Follows the Person" rebalancing demonstration (2403) (Jan 1)

Secretary may expand scope and duration of the national Medicare voluntary bundling pilot (3023, 10308) (Jan 1)

Secretary must initiate separate programs to test VBP for LTCHs, IRFs, IPFs, PPS-exempt cancer hospitals and hospices (10326) (Jan 1)

2.0% penalty applied to PFS update for physicians who fail to submit PQR measures successfully; annually thereafter (3002, 10327) (Jan 1)

PAYMENT & REVENUE

MB – productivity for ASC, Dialysis, Certain DME, Ambulance, HHAs and Clinical Laboratories (Jan 1)

MB – (0.2% + productivity) for OPPS (Jan 1)

Medicaid FMAP for childless adults in early expansion states (AZ, DE, DC, HI, ME, MA, MN, NY, PA, VT, WA and WI) increases to 70% (2001) (Jan 1)

States can enter into health care choice compacts to allow health benefits to be sold across state lines (1333) (Jan 1)

CONSUMER & PURCHASER

OTHER

No provision to be implemented

WELLNESS & WORKFORCE

No provision to be implemented

SECOND QUARTER

DELIVERY SYSTEM  
REFORM & QUALITY

No provision to be implemented

PAYMENT & REVENUE

No provision to be implemented

No provision to be implemented

OTHER

No provision to be implemented

WELLNESS & WORKFORCE

No provision to be implemented

THIRD QUARTER

DELIVERY SYSTEM  
REFORM & QUALITY

No provision to be implemented

PAYMENT & REVENUE

MB – (0.2% + productivity) for IPF (July 1)

No provision to be implemented

OTHER

No provision to be implemented

WELLNESS & WORKFORCE

No provision to be implemented

DELIVERY SYSTEM  
REFORM & QUALITY

Pediatric ACO demonstration ends (2706) (Dec 31)

Medicaid bundled payment demonstration ends (2704) (Dec 31)

State Medicaid health home demonstration ends (2703) (Dec 31)

2.0% of IPPS MB tied to HVBP; annually thereafter (3001) (Oct 1)

\$1.8 billion cut to funds available for Medicaid DSH (2551) (Oct 1)

MB – (0.3% + productivity) for Hospice; Potential for "give back" (Oct 1)

MB – productivity for SNF (Oct 1)

MB – (0.75% + productivity) for IPPS, IRF, LTCH (Oct 1)

PAYMENT & REVENUE

States may enroll CHIP eligible children in exchange based qualified health plans if the children are denied CHIP coverage due to enrollment caps (2101) (Oct 1)

FOURTH QUARTER

# 2017

## FIRST QUARTER

OTHER

No provision to be implemented

WELLNESS & WORKFORCE

No provision to be implemented

DELIVERY SYSTEM REFORM & QUALITY

Value-based payment modifier applied to PFS update with respect to all physicians, physician groups and eligible professionals (3007) (Jan 1)

PAYMENT & REVENUE

MB - productivity for ASC, Dialysis, Certain DME, Ambulance, HHAs and Clinical Laboratories (Jan 1)

MB – (0.75% + productivity) for OPPS (Jan 1)

CONSUMERS & PURCHASERS

States may allow for large groups to obtain coverage in the exchanges (1312) (Jan 1)

Medicaid FMAP for childless adults in early expansion states (AZ, DE, DC, HI, ME, MA, MN, NY, PA, VT, WA and WI) increases to 80% (2001) (Jan 1)

Medicaid FMAP for newly eligible enrollees (children, childless adults and parents) decreases to 95% (2001) (Jan 1)

## SECOND QUARTER

OTHER

No provision to be implemented

WELLNESS & WORKFORCE

No provision to be implemented

DELIVERY SYSTEM REFORM & QUALITY

No provision to be implemented

PAYMENT & REVENUE

No provision to be implemented

CONSUMERS & PURCHASERS

No provision to be implemented

## THIRD QUARTER

OTHER

No provision to be implemented

WELLNESS & WORKFORCE

No provision to be implemented

DELIVERY SYSTEM REFORM & QUALITY

No provision to be implemented

PAYMENT & REVENUE

MB – (0.75% + productivity) for IPF (July 1)

CONSUMERS & PURCHASERS

No provision to be implemented

## FOURTH QUARTER

OTHER

No provision to be implemented

WELLNESS & WORKFORCE

No provision to be implemented

DELIVERY SYSTEM REFORM & QUALITY

No provision to be implemented

PAYMENT & REVENUE

\$5 billion cut to funds available for Medicaid DSH (2551) (Oct 1)

MB – (0.3% + productivity) for Hospice; Potential for “give back” (Oct 1)

MB – productivity for SNF (Oct 1)

MB – (0.75% + productivity) for IPPS, IRF, LTCH (Oct 1)

CONSUMERS & PURCHASERS

No provision to be implemented

# 2018

## FIRST QUARTER

OTHER  
WELLNESS & WORKFORCE

No provision to be implemented

DELIVERY SYSTEM REFORM & QUALITY

Decision due on whether to expand SNF, HHA, and ASC VBP pilot programs (10326) **(Jan 1)**

PAYMENT & REVENUE

MB – (0.75% + productivity) for OPSS **(Jan 1)**

MB – productivity for ASCs, Dialysis, Certain DME, Ambulance, HHAs and Clinical Laboratories **(Jan 1)**

Imposes an excise tax on insurers that offer high cost plans (“Cadillac” tax); Subject to threshold of \$10,200 for individuals and \$27,500 for families; Exempts separate vision and dental coverage policies from premium amounts (9001) **(Jan 1)**

CONSUMERS & PURCHASERS

Medicaid FMAP for childless adults in early expansion states (AZ, DE, DC, HI, ME, MA, MN, NY, PA, VT, WA and WI) increases to 90% (2001) **(Jan 1)**

Medicaid FMAP for newly eligible enrollees (children, childless adults and parents) decreases to 94% (2001) **(Jan 1)**

## SECOND QUARTER

OTHER

No provision to be implemented

WELLNESS & WORKFORCE

No provision to be implemented

DELIVERY SYSTEM REFORM & QUALITY

No provision to be implemented

PAYMENT & REVENUE

No provision to be implemented

CONSUMERS & PURCHASERS

No provision to be implemented

## THIRD QUARTER

OTHER

No provision to be implemented

WELLNESS & WORKFORCE

No provision to be implemented

DELIVERY SYSTEM REFORM & QUALITY

No provision to be implemented

PAYMENT & REVENUE

MB – (0.75% + productivity) for IPF **(July 1)**

CONSUMERS & PURCHASERS

No provision to be implemented

## FOURTH QUARTER

OTHER

No provision to be implemented

WELLNESS & WORKFORCE

No provision to be implemented

DELIVERY SYSTEM REFORM & QUALITY

National Medicare voluntary bundled payment pilot ends (3023, 10308) **(Dec 31)**

PAYMENT & REVENUE

MB – (0.3% + productivity) for Hospice; Potential for “give back” **(Oct 1)**

MB – productivity for SNF **(Oct 1)**

MB – (0.75% + productivity) for IPPS, IRF, LTCH **(Oct 1)**

CONSUMERS & PURCHASERS

No provision to be implemented

# 2019

OTHER

WELLNESS & WORKFORCE

DELIVERY SYSTEM REFORM & QUALITY

PAYMENT & REVENUE

CONSUMERS & PURCHASERS

Medicaid FMAP for newly eligible enrollees (children, childless adults and parents) decreases to 93% (2001) **(Jan 1)**

Medicaid FMAP for childless adults in early expansion states (AZ, DE, DC, HI, ME, MA, MN, NY, PA, VT, WA and WI) increases to 100% thereafter (2001) **(Jan 1)**

MB – (0.75% + productivity) for OPSP **(Jan 1)**

MB – productivity for ASC, Dialysis, Certain DME, Ambulance, HHA and Clinical Laboratories **(Jan 1)**

MB – (0.75% + productivity) for IPF **(July 1)**

First year IPAB proposal to reduce Medicare spending can include recommendations to reduce hospital or hospice payments (3403) **(Sept 1)**

MB – productivity for IPPS, IRF, LTCH, SNF; annually thereafter **(Oct 1)**

MB – (0.3% + productivity) for Hospice; Potential for “give back” **(Oct 1)**

\$4 billion cut to national state allotments for Medicaid DSH (2551) **(Oct 1)**

Allows Secretary to establish a demonstration to provide financial incentives to beneficiaries who receive services from high-quality physicians (10331) **(Jan 1)**

No provision to be implemented

No provision to be implemented

# 2020

OTHER

WELLNESS & WORKFORCE

DELIVERY SYSTEM REFORM & QUALITY

PAYMENT & REVENUE

CONSUMERS & PURCHASERS

Medicaid FMAP for newly eligible enrollees (children, childless adults and parents) decreases to 90% (2001) **(Jan 1)**

MB – productivity for OPSP, ASC, HHA, Dialysis, Certain DME, Ambulance and Clinical Laboratories and annually thereafter **(Jan 1)**

MB – productivity for IPF; annually thereafter **(July 1)**

MB – productivity for Hospice; annually thereafter **(Oct 1)**

No provision to be implemented

No provision to be implemented

No provision to be implemented

# Health Care Reform Appendix

## Appendix A

PROVISIONS THAT DID NOT INCLUDE A DUE DATE

### No Date

- Requirements and definitions for qualified health plans and essential health benefits will be determined by HHS Secretary with opportunities for public comment (1301 and 1302)
- Improvements to the demonstration project on community health integration models in certain rural counties (3126)
- Health care delivery system research; quality improvement technical assistance (3501)
- Establishing community health teams to support the patient-centered medical home (3502)
- Program to establish shared decision making (3506)
- Patient navigator program (3510)
- Community-based collaborative care networks (10333)
- Community college and career training grant program (1501)
- CDC study and evaluation of the best employer-based wellness practices; Educational campaign to promote benefits of workplace wellness programs to employers (4303)

## Appendix B

REPORT DUE DATES

### 2010

- Report on the National Prevention, Health Promotion and Public Health Council due to the President and Congress and annually at the beginning of the CY thereafter **July 1**
- Biosimilar disposal user fee RTC due (7001-7003) **Oct 1**
- HHS study due on additional payment for urban MDHs (3142) **Dec 23**
- Plan to modernize CMS data systems due (10330) **Dec 23**
- Inter-agency quality working group RTC due (3011 – 3015) **Dec 31**

### 2011

- National quality strategy RTC and internet website due; annually thereafter (3011 – 3015) **Jan 1**
- HHS study due on cancer hospitals (3138) **Jan 1**
- National Prevention, Health Promotion and Public Health Council RTC due; annually thereafter through 2015 **Jan 1**
- Efforts with states and Medicaid enrollees to reduce obesity RTC due; every 3-years through 2017 thereafter (4004) **Jan 1**
- RTC for SNF, HHA, and ASC VBP programs due (10301) **Jan 1**
- MEDPAC RTC on Medicare payment accuracy for rural health care providers due (3125, 10314) **Jan 1**
- HHS RTC on providing HHA in low-income or medically underserved areas due (3131) **March 1**
- MACPAC first annual RTC **March 15**
- RTC on prescription drug labeling due (3507) **March 23**
- RTC on the effects of insurance reforms on large group markets and self-insured group plans (10103) **March 23**
- GAO study on the cost, affordability, and rates of denial for plans offered in the exchanges **March 23**
- GAO study on oral drugs in the treatments of end-stage renal disease due (10336) **March 23**
- National Health Care Workforce Commission high priority area RTC due; every year thereafter (5105, 10501) **April 1**
- National Health Care Workforce Commission general RTC due; every year thereafter (5105, 10501) **Oct 1**
- RTC for SNF, HHA, and ASC VBP programs due (3006) **Oct 1**
- GAO study on improving the 340B program due **Oct 1**
- Secretary of Labor RTC on self-insured health plans due (10103)

### 2012

- Adjusting the FPL for different geographic regions RTC due **Jan 1**
- HAC RTC due (3008) **Jan 1**
- Multi-stakeholder group quality measure input due; annually thereafter (3011 – 3015) **Feb 1**
- HHS assessment of National Quality Strategy due; at least once every three years thereafter (3011 – 3015) **March 1**
- Health professional patient safety training RTC due; annually thereafter (3508) **March 23**
- CMI RTC due; once every other year thereafter (3021) **Dec 31**

### 2013

- Gainsharing demonstration RTC due (3027) **March 31**
- RTC with recommended legislation and administrative actions to promote healthy lifestyles and chronic-disease self-management for Medicare beneficiaries due (4202) **Sept 30**
- RTC on pre-Medicare population (55-64) wellness pilot due (4202) **Sept 30**
- Medicaid global payment demonstration RTC due (2705) **Oct 1**
- Emergency psychiatric demonstration RTC and recommendations for expansion due (2707) **Dec 31**

### 2014

- GAO RTC on competition and market concentration in the reformed health insurance market due every other year thereafter (1322) **Dec 31**
- Medicaid adult quality measure program RTC due; every 3 years thereafter (2701) **Jan 1**
- Medicaid healthier lifestyles grant program RTC due (4108) **Jan 1**
- Interim preventive care and obesity-related services available via Medicaid RTC due (4004) **Jan 1**
- IPAB RTC; annually thereafter **Jan 15**
- Effectiveness of vaccine grant program RTC due (4204) **March 23**
- RTC with recommendations on improving and identifying health care disparities among Medicaid and CHIP beneficiaries due (4302) **March 23**

### 2015

- Physician Compare RTC due (10330) **Jan 1**
- MEDPAC HHA payment RTC due (3131) **Jan 1**
- GAO IPAB RTC due **July 1**
- GAO interim HVBP RTC due (3001) **Oct 1**

### 2016

- HHS HVBP RTC due (3001) **Jan 1**
- RTC on Medicaid healthier lifestyles due (4108) **Jan 1**
- Final preventive care and obesity-related services available via Medicaid RTC due (4004) **Jan 1**
- HVBP CAH and hospitals with “small numbers” demonstration RTCs due (3001) **Sept 23**
- MEDPAC and MACPAC tort reform alternative payment RTCs due **Dec 23**

### 2017

- State health home program RTC due (2703) **Jan 1**
- GAO final HVBP RTC due (3001) **Oct 1**
- Nurse in-hospital training program RTC due (5509) **Oct 17**
- Medicaid bundled payment demonstration RTC due (2407) **Dec 31**

## Appendix C

ADVISORY BOARDS, COMMISSIONS, COUNCILS AND COMMITTEES

- Advisory Boards for State Cooperatives (1322)
  - Appointments made no later than **June 23, 2010**
  - Terminates by **Dec 31, 2015**
- Independent Payment Advisory Board (IPAB) (3403)
  - IPAB Consumer Advisory Council
- Advisory Group on Prevention, Health Promotion, and Integrative and Public Health (4001)
- Interagency Pain Research Coordinating Committee (4305)
  - Appointments made no later than **March 23, 2011**
- National Health Care Workforce Commission (5101)
  - Appointments made no later than **Sept 30, 2010**
- Commission on Key National Indicators (5605)
  - Appointments made no later than **April 22, 2010**
- Patient-Centered Outcomes Research Institute (6301)
  - Appointments made no later than **Sept 23, 2010**
  - Clinical Trials Advisory Panel
  - Rare Disease Advisory Panel
  - Standing Methodology Committee for the Institute
- Advisory Board on Elder Abuse, Neglect and Exploitation (6703)
- CLASS Independence Advisory Council (8002)
- Personal Care Attendant’s Workforce Advisory Panel (8002)
  - Appointments made no later than **June 21, 2010**
- Cures Acceleration Network Review Board (10409)
- Advisory Committee for Young Women’s Breast Health Awareness Education Campaign (10413)
  - Appointments made no later than **May 22, 2010**

# 5

**LR 467 Select Committee**  
**Interim Hearing – Patient Protection & Affordable Care Act**  
**October 7, 2010**

Comments on Nebraska Health Workforce Data  
Steve Pitkin, Assistant Dean, University of Nebraska Medical Center College of Nursing, Kearney Division

**Introduction**

Thank you for the opportunity to comment. I am Steve Pitkin, Assistant Dean of the UNMC College of Nursing located on the University of Nebraska Kearney campus.

At the September hearing UNMC Asst Dean of Nursing Pamela Bataillon and Dr. Thomas Tape of General Medicine addressed the Primary Care workforce demographics, distribution, supply and demand, and aging of providers; the need to develop innovative approaches for educating primary care providers who can use a team approach in providing care; and the need for development of a multifaceted state wide approach to workforce development, recruitment and retention efforts which involves public a private partnership to ensures an adequate health workforce in Nebraska.

Predicting where the health workforce shortages will be in the state is essential to planning for how to meet that shortage. We have tools available in the state to collect the data, but they need to interact more to generate information useful to address the shortages.

**Current Nebraska Health Workforce Efforts**

Currently three groups — UNMC Health Professions Tracking Service (HPTS), Nebraska Department of Health & Human Services Licensing Information System (DHHS), and The Nebraska Center for Nursing (CFN) — collect and make available health workforce data with varying levels of detail, delivery modes, and analysis. The data collected and reported by each group is important but is not sufficient to support a statewide approach to workforce development, recruitment, retention, and educational pipeline.

**UNMC Health Professions Tracking Service**

The Health Tracking Center produces a Directory of Healthcare Resources every two years (See Appendix A for the information provided in the directory). In addition HPTS provides summary data and charts for selected topics, customized reports, market share assessments, professional profiles, statistical summaries, county and community directories, and Geographical mapping analysis.

**Nebraska Department of Health & Human Services Licensing Information System**

The State of Nebraska licensure database is protected by a secure firewall, updated nightly to reflect any changes, and provides web accessible "read only" information for credentialed persons, health care facilities and services and child care programs.

Lists of health related occupations and professions, health care facilities and services may be purchased on line for a fee (<https://www.nebraska.gov/hhs/lists/>). The data is provided as a "csv" file and contains License #, Prefix, First Name, Middle Name, Last Name, Suffix, Entity Name, License Type, Address, City, State, Zip Code, County, Telephone #, License Status, Issue Date, and Expiration Date.

**The Nebraska Center for Nursing**

The Nebraska Center for Nursing was created by the legislature to address the nursing shortage. Since its inception the Center has created a nursing supply and demand model, published annual reports, fact sheets, employer vacancy reports, LPN workforce reports, and RN workforce reports all of which are available on its website <http://www.center4nursing.com/>.

License Renewal Notices and Workforce Surveys are mailed to each RN and LPN licensed by the State of Nebraska. RNs and LPNs may renew their license and complete workforce surveys online or by US mail. Greater numbers of RNs and LPNs are renewing their license and completing their surveys online thus decreasing the amount of clerical time required to get the data into the two databases. The responses to the Registered

Nursing Workforce Survey and the LPN Workforce Survey are merged by license number with preexisting demographic data pertaining to each registered nurse and licensed practical nurse in Nebraska Department of Health and Human Services database. RN and LPN Biannual Workforce Reports have been generated and posted on the Centers web site since 2001 to the present.

The Center for Nursing has begun to code its data so the data can be reported on its website using Cloud (GIS) Geographic Information System technology. Using this no cost GIS technology option will allow anyone to graphically represent multiple layers of data to plan workforce needs and demand.

The tracking data and data analysis reports have been used by a variety of nursing stakeholders to address workforce issues and inform public policy concerns. Stakeholders have reduced the nursing shortage by:

- Increasing the number of students admitted to and graduating from Nebraska Nursing programs.
- Increasing the number of graduate programs that prepare students to become nursing faculty at both the Master and doctoral level.
- Increasing the number of students prepared to practice as Advanced Practice Registered Nurses (APRN)
- Improving or added infrastructure that supports the education of nursing students at all levels.

### **Educating the Health Workforce**

Multiple national reports have identified the need to transform health workforce students' education. UNMC students' abilities and opportunities to be effective practitioners in the health care delivery system have been enhanced by responding to these reports. UNMC's response to the national reports includes:

- Revising College and Schools curriculums.
- Incorporating learner centered teaching strategies and delivery modes to educate students.
- Providing students with interprofessional learning experiences.
- Opening a College of Public Health, Sorrell Center for Health Science Education, and College of Nursing Center for Nursing Science.
- Entering into a public private partnership involving citizens of Nebraska's Northeast region, Northeast Community College, UNMC College of Nursing, and Faith Regional Medical Center in Norfolk. Through the partnership a facility was built to house an innovative program that educates nursing students from two nursing programs in a rural setting. Now a Northeast region citizen has the opportunity to receive a nursing education ranging from Nurses Aide through a Ph.D. while remaining in the region.

The ACA offers a variety of programs that can assist in increasing the number of nursing faculty and nursing workforce. One of the most significant reform efforts in this law for nursing education is the reauthorization of the Title VIII Nursing Workforce Development Programs. The Title VIII programs are the largest source of federal funding for nursing education and have not been reauthorized since 2002. The law includes other opportunities such as the Demonstration Grants for Family Nurse Practitioners to increase Access to Quality Primary Care" (Sec. 5316); Programs to expand the Nurse Education, Practice and Retention Grant program; Graduate Nurse Education Demonstration (Sec. 5509); and updates the loan amounts for nursing students who receive nursing student loan program and the nurse faculty loan program.

### **Conclusion**

The tools exist in the state to identify where the nursing workforce shortages are going to occur, but there needs to be more interoperability between these entities. The Legislature can assist by making the data more accessible so it can be used to better predict where shortages will occur rather than just stored in a database.

Given that students educated in rural settings have a greater rate of remaining in the rural area, innovative opportunities to educate health workforce students must be created and funded.

### **Recommendations**

- Designate a Health Workforce Development and Tracking function.

- Be open to and support efforts to pursue grants, pilot programs and demonstration projects that offer the chance to increase the workforce.
- Authorize acceptance of Federal Health Reform funds for pilot projects that enhance innovative programs which educate health work students in rural areas.
- Use the Northeast Region public-private partnership model to increase the number and educational level of health science students in rural areas.
- Create a centralized Health Workforce database which is populated with data taken from DHHS licensure and re-licensure data base and Business/Service licensure.
- Authorize DHHS to:
  - Provide data to populate and update a Health Workforce Database.
  - Add and link Workforce Surveys to re-licensure applications of key health care personnel (Dentists, Pharmacists, Medicine-Osteopathic Physician & Surgeon, Physician, Physician Assistant, Nursing-APRN, RN & LPN, Occupation Therapy, Physical Therapy, Respiratory Care, Radiography, Mental Health Practice, Social Workers, Audiology/Speech-Language Pathology, and Perfusionist.
  - Add and link Employer Vacancy Reports to Licensure and Re-Licensure applications for Hospitals, Health Clinics, Home Health Agencies, Hospice, Long Term Care Facilities, Mental Health Centers, Rural Health Clinics, Laboratories, Pharmacies, Nursing Homes, and Substance Abuse Treatment Centers.
  - Encourage on line licensure and re licensure for select practitioners and facilities.

Thank you for the opportunity to comment on Health Workforce Data and Education Issues in Nebraska.

## Appendix

### Web Sites

Agency	Web Site
HPTS	<a href="http://app1.unmc.edu/healthprof/">http://app1.unmc.edu/healthprof/</a>
DHHS	<a href="http://www.dhhs.ne.gov/list/listindex.htm/">http://www.dhhs.ne.gov/list/listindex.htm/</a>
CFN	<a href="http://www.center4nursing.com/nebraskanursingworkforce.shtml">http://www.center4nursing.com/nebraskanursingworkforce.shtml</a>

### Data Sources

Agency	Data Source
HPTS	DHHS Licensure Data and Annual Surveys of Practitioners & Practice Locations
DHHS	Licensing and Licensure Renewal of Practitioner & Agencies
CFN	Nursing DHHS Licensing and Licensure Renewal of LPN, RN, & APRN Additional Survey sent with Renewal of LPN & RN licensure renewal

### Information Collected

Agency	Information Collected
HPTS	Data
DHHS	Licensing and Licensure Renewal of Practitioner & Agencies
CFN	Nursing DHHS Licensing and Licensure Renewal of LPN, RN, & APRN Additional Survey sent with Renewal of LPN & RN licensure renewal

### Information Delivery Mode

HPTS	DHHS	CFN
Directory published every 2 Years	Directories Of Individual Practitioners and Agencies Individual Licensure Data	Web Site Fact Sheets Annual Reports RN Workforce Reports LPN Workforce Reports Employer Vacancy Reports Supply and Demand Model for RNs and LPNs

### UNMC Health Professions Tracking Service

The Health Tracking Center produces a Directory of Healthcare Resources every two years. The directory includes:

**Practice Location** in Nebraska and Western Iowa — Community, State, County, Business Name, Practice Type, Street Address, Phone Number, Fax Number, and Associated professional and their respective practicing specialties.

**Dental Practice Locations** in Nebraska — Community, State, County, Business Name, Practice Type, Street Address, City, State, Zip Code, Phone Number, Fax Number, and Associated professionals and their respective practicing specialties.

**Pharmacies in Nebraska** — Community, State, County, Pharmacy Business Name, Street Address, City, State, Zip Code, Phone Number, and Fax Number.

**Hospitals In Nebraska and Western Iowa** — Community, State, County, Hospital/Health System Name, Street Address, City, State, Zip Code, Administrator/CEO, Switchboard Number, Phone Number, Fax Number, Total number of licensed Acute, Long-Term, Psychiatric, And Rehabilitation Beds.

**Life Care Communities and Homes in Nebraska** — Community, State, County, Facility Name, Street Address, City, Zip Code Phone Number, Fax Number.

**Professionals** – Licensed Medical and Osteopathic Physicians, Nurse Practitioners, and Physician Assistants in Nebraska and Western Iowa — Name, Primary Specialty, NPI, Primary Practice Clinic Name, Street Address, City, State, and Zip Code. 85% compliance.

#9

**LR 467 Select Committee**  
**Interim Hearing – Patient Protection & Affordable Care Act (ACA)**  
**October 7, 2010**

Impact & Opportunities  
Allied Health Practitioners Providing Rural Health Care  
Darwin Brown, PA-C, MPH  
Clinical Coordinator of the Physician Assistant Program, UNMC School of Allied Health

### **Overview**

Thank you for the opportunity to address the committee. I will focus my comments today on the potential impacts of the Patient Protection & Affordable Care Act (ACA) on rural health care, with an emphasis on the role of the allied health workforce in the delivery of this care.

The current conditions of rural poverty, a limited rural health workforce—especially of primary care providers, an aging population with poorer health status—particularly in rural Nebraska, and disparities in minority health outcomes, create both significant challenges to the delivery of, and the absolute need for, accessible, affordable, high quality care to citizens in rural Nebraska. According to a recent report by the Rural Policy Research Institute many of the provisions of the Patient Protection & Affordable Care Act may serve to promote this outcome.

(Available at [http://www.unmc.edu/ruprihealth/Pubs/PPACA%20Rural%20Provision%20Summary.06\\_08\\_10.pdf](http://www.unmc.edu/ruprihealth/Pubs/PPACA%20Rural%20Provision%20Summary.06_08_10.pdf))

### **Rural Nebraska**

Nebraska, like many states, has an aging population and this is particularly true of rural Nebraska. In 2008 the population over age 65 in the U.S. was 12.8%, while the proportion in rural Nebraska was 16%. In 46 of Nebraska's 93 counties, 20% or more of the population is 65, and the population over age 65 in Nebraska is projected to increase by 61.9% by 2030. Health problems and related consequences from chronic conditions increase with age and rural elders pay fewer visits to health care providers even though they have more chronic illness. Additionally, the rural minority elderly often lack Medicare supplemental insurance and are more likely to report that they cannot afford to see a doctor. Available and affordable care is of particular concern for rural Nebraskans. The percentage of rural Nebraska adults (ages 18-65) with no health insurance rose from 16% in 2002 to 19% in 2006.

The provision of the ACA requiring health care coverage for approximately 220,000 uninsured Nebraskans starting in 2014 will improve access to care for Nebraskans, particularly the poor in rural areas. The key concern remains, whether there will be sufficient providers to deliver care. The expanding number of insured, an aging population requiring chronic disease management, and a renewed emphasis on primary care will significantly increase the demand for physical therapists, physician assistants, medical nutritionists and highly skilled laboratory and imaging technologists.

### **Primary Care – Definition & Providers**

One strategy for increasing access is to increase primary care providers. These providers are generally defined as medical doctors in family practice, general internal medicine, and pediatrics. Federal primary care Health Profession Shortage Area (HPSA) designations have not considered mid-level providers, such as physician assistants (PAs) and nurse practitioners (NPs) as primary care providers. However, Section 5501 of the ACA defines a primary care practitioner as an “individual who is a physician with a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine or a *nurse practitioner, clinical nurse specialist, or physician assistant*, and for whom primary care services are at least 60% of the allowed charges in a prior period determined appropriate by the Secretary.”

In many primary care practices, the presence of PAs and/or NPs allows patients with routine health problems to be seen more promptly. Nurse Practitioners in primary care in the state grew by 9% during the last ten years and currently 33% of NPs in Nebraska practice in primary care in almost 60 different counties. The number of Physician Assistants in primary care has grown by 4% over the past ten years; 50% of Nebraska PAs practice in primary care. The 2007 data identified that PAs and NPs in primary care increased the state's primary care workforce by nearly 40%.

The inclusion of PAs and NPs as primary care providers is critical for Nebraska to meet the anticipated demand for health services, as PAs and NPs often play a significant role in providing primary care, especially in rural areas. Research shows that physician assistants and nurse practitioners, working in collaboration with physicians, deliver high quality patient care in a cost-effective manner that result in excellent patient outcomes. PAs and NPs also enhance health care coordination, often guiding the day-to-day care of patients.

### **Allied Health Workforce Shortages**

Approximately 60% of the total healthcare workforce is comprised of health professionals in allied health fields. The UNMC School of Allied Health Professions (SAHP) comprises 11 educational programs. Workforce shortages exist throughout all of these professions. According to the Bureau of Labor Statistics of the U.S. Department of Labor, projected increases in workforce demand over the ten year period 2008-2018 for the 11 UNMC professions range from a low of 9% for dietitians to a high of 39% for physician assistants, with increased demand for the majority of these eleven professions projected in the high teens. Relative to these national workforce predictions we need more detailed workforce data on allied health professionals in Nebraska to understand more accurately the characteristics and geographic distribution of the allied health workforce and where specific needs exist.

We do know that 10%-20% of allied health professionals in Nebraska are older than 55 years of age. One allied health profession, clinical laboratory scientists (CLS-formerly called medical technologists), illustrates the significant problem with an aging workforce. The median age of CLS is 49.2 years. In the next 5 years, 13% of the baccalaureate laboratory professionals will retire. In the next ten years, 25% of the workforce will be eligible to retire. Currently, only 2 laboratory professionals enter the field for every 7 that retire. When approximately 70% of clinical decisions are based on laboratory results, a shortage of laboratory professionals could have a significant impact on the quality and timeliness of patient care.

### **Interprofessional Education & Key Competencies**

Interprofessional education (IPE) is part of the solution to these workforce shortages. Interprofessional education is defined as students from two or more professions learning together with the goal of promoting collaborative practice. IPE has been shown to increase a student's understanding of systems thinking and quality improvement processes, improve professional relationships and identity, and increase collaborative teamwork. Improving teamwork is perhaps the most beneficial outcome, given that the root cause of approximately 70% of medical errors can be attributed to poor communication and problems with coordination between team members.

In fact, the 2002 Institute of Medicine (IOM) Committee on the Health Professions Education recommended that "all health professionals should be educated to deliver *patient-centered care* as members of an *interdisciplinary team*, emphasizing *evidence-based practice*, *quality improvement* approaches, and *informatics*." These five core competencies are applicable to all health professionals in all areas of practice. In an effort to improve care for the aging population, the American Society of Geriatrics has also identified competencies for health profession disciplines participating in the care of older adults.

### **Conclusions and Recommendations**

Nebraska has a number of existing programs that can help address the workforce shortages. The federal health reform law offers the opportunity to expand some of these programs. We also anticipate that there may be opportunities for pilot programs and demonstration programs that could benefit Nebraska. As the opportunities for pilots and demonstration programs are announced UNMC anticipates exploring new alternatives which may include state participation.

Interprofessional Education holds considerable promise and should be a required part of health professional education. UNMC is currently developing and assessing IPE curricula and educational delivery methodology. Questions remain about IPE however, and there has been little, if any, federal funding currently available for educational outcomes research. It must also be recognized that the intended outcomes of IPE will likely challenge existing supervisory requirements and reimbursement patterns and these will need to be examined to keep pace with newly developed delivery models.

The ACA provides for the establishment of community-based interdisciplinary, interprofessional teams to support primary care practices within hospital service areas, as well as establishes the Independence at Home Medical Practice Demonstration Program, to test models of care that use physician and nurse practitioner directed teams to reduce expenditures and improve health outcomes. A nurse practitioner or physician assistant may participate in, or lead, a home-based primary care team. Nebraska will need to develop and evaluate new models of care to determine if they deliver lower cost, high quality care. Demonstration projects could not only evaluate the effectiveness of various team composition and delivery models, but more clearly delineate the roles of PAs and NPs in the delivery and management of primary care.

The Rural Health Opportunities Program (RHOP) which offers early admission to health profession programs for students interested in returning to rural practice has been shown to be successful model for increasing the rural health workforce. RHOP began in 1990 and has produced 323 graduates; 145 or 40% have been allied health graduates from UNMC. The range for graduates staying in Nebraska varies by program, but has been generally high (Physician Assistant-78%; Physical Therapist -73%; Clinical Laboratory Scientist-62%; Radiography-73%). Last year the UNMC School of Allied Health increased RHOP slots by 70%, but the pipeline is long for these students and the total numbers of participants remains relatively small.

Utilizing rural training sites has also proven to be an effective model for keeping health professions graduates in rural communities. For example, the Clinical Laboratory Science program has been training students in five Nebraska communities since 1992. Ninety percent of these graduates have taken a first position in a rural community. While effective, the number of students placed in rural training sites is small. Exploring incentives to increase the number of rural training sites for all health profession students is critical to expanding our workforce shortage issues.

Increasing enrollment in allied health professions programs is another strategy for addressing workforce shortages. Indeed, in 2010 UNMC increased enrollment by 25% in both its physical therapy and physician assistant education programs. Recently, the UNMC PA Program received \$924,000.00 in federal funding to support students pursuing careers as physician assistants from the \$30.1 million allocated for the expansion of physician assistant training under the ACA. These funds provide student scholarships and educational support. Scholarship and/or loan forgiveness programs for students entering other allied health professions, and/or choosing to practice in selected geographic areas of Nebraska may also prove valuable in the development of an allied health workforce to serve Nebraska.

Incentives that support increases in enrollment must be accompanied by commensurate increases in clinical training sites as previously noted, as well as faculty. Faculty shortages in the allied health professions parallel those in nursing. To effectively increase health care professionals, Nebraska will need to examine strategies to increase health professions faculty and retain them in Nebraska.

Degree completion programs are aimed at improving and expanding the skills of the existing workforce, and not primarily at expanding the numbers of workers. Such programs, allow health professionals to remain working in their home communities during their education. UNMC currently offers four such distance education programs. Expanding these programs, and/or adding programs that facilitate retraining of individuals who have left active practice may present an opportunity for workforce development. Section 5205 of ACA does provide scholarships for mid-career allied health professionals to receive additional education.

Finally, the UNMC School of Allied Health Professions, particularly Physical Therapy Education, has had success in recruiting non-traditional students from rural communities; those seeking a second career in health care. These students are generally well-established in their communities and highly motive to return to practice. Loan forgiveness and stipends, or other novel incentives could expand this pool of future applicants.

Thank you for the opportunity to comment and provide some perspective on the allied health professions. The School of Allied Health Professions at UNMC remains highly committed to its primary mission of developing an allied health workforce that provides accessible, high quality, affordable care for Nebraska.

LR 467 Select Committee  
Interim Hearing- Patient Protection & Affordable Care Act (ACA)  
October 7, 2010

Comments on Rural Workforce Issues  
Jeffrey D. Harrison, MD, Assistant Dean for Admissions  
Program Director, Family Medicine Residency  
University of Nebraska Medical Center (UNMC)

A multi-disciplinary team approach will be needed to provide optimal care for the citizens of the state as we look to the next 10-20 years. This report will focus only on the physician workforce issues, programs in place and potential solutions facing rural Nebraska.

**Issues facing rural Nebraska**

Nebraska's rural population is facing an inevitable shortage of healthcare professionals as delineated in the Nebraska Health Workforce Planning Project. While Nebraska's current overall provider to population ratio is at the national average, little solace should be taken from that fact. The current distribution and demographic of the states rural workforce portend a worsening of an already inadequate supply of providers. Facts supporting this assertion include:

- 50 of 93 Nebraska counties are primary care designated Health Profession Shortage Areas
- 15 of 38 frontier counties have no health provider
- 42% of Nebraska's population lives rural; yet only 28% of MD's, 33% of DO's, 38% of PA's, 32% NP's, and 32% of RN's are practicing rural
- One third of rural physicians are pre-retirement age (32%) and have indicated plans to retire or leave their current practice in the next 5-10 years.

The vast majority of Nebraska's practicing physicians are MD's (3402). Given that 28% of those are rural providers (952) and that 32% plan to leave practice in the next 10 years we are facing a need of 305 physicians just to maintain our current status.

This projected need for rural physicians comes at a time when it is becoming more difficult to produce a rural workforce. There are a number of factors that shape this difficulty. Demographic data have consistently shown that the most likely person to practice rural is from a rural background, has attended a public institution within the state and has a service orientation. The most rapidly declining age demographic in Nebraska's 63 rural counties is the 19-30 year old age group, the very group that would be replacing the current group of providers. This decline in potential rural physicians also occurs at a time when the cost of medical education (average graduate has > \$150,000) is driving many medical students away from primary care and towards the medical specialties where typical compensation is more than double that of a primary care provider.

Why is a primary care based workforce critical for the state of Nebraska? The population density and distances between population centers mandates such a workforce. A typical family physician needs a population of 2500 patients per full time practice to be financially viable. A

typical general internist would need 3500 patients, a typical obstetrician 10,000 patients, and a typical orthopedist 16,000 patients. Those patient population needs coupled with the fact that Nebraska has 19 counties with fewer than 2500 people exemplify the financial impracticality of a specialty based rural workforce.

In summary, Nebraska must replace more than 300 rural physicians in the next ten years to maintain the current physician workforce. This need comes at a time when young adults, who are statistically the most likely to practice rural, are the most rapidly declining age demographic in the 63 rural counties of the state. This is occurring at a time over rising educational debt load and the inevitable movement into higher paying specialties that are not financially sustainable in Nebraska's rural areas.

### **University of Nebraska Medical Center Programs**

The University of Nebraska Medical Center is addressing these issues.. A number of programs exist both with UNMC and in collaboration with Chadron State College, Wayne State College and the University of Nebraska-Kearney. These programs and their successes will be briefly outlined below.

#### **Rural Health Opportunities Program (RHOP)**

RHOP is a jointly sponsored program between UNMC, Chadron State College and Wayne State College that began in 1990. Selection into the program guarantees admission to UNMC pending completion of the required undergraduate curriculum and maintenance of academic and professional standards. Applicants are selected while still seniors in high school with strong preference given to those from rural communities who express a desire to return to those communities as well as demonstrating the academic ability to be successful in the program. The participants in this program are granted full tuition scholarships to ease the educational burden of medical education. Wayne State and Chadron State both offer 5 positions each year.

The medicine RHOP program has graduated 81 physicians since its inception with 54% practicing in rural Nebraska and 75% practicing in Nebraska overall. The only programs demonstrating this level of success are those accepting students after matriculation into medical school. RHOP also has programs in the allied health professions, pharmacy and dentistry with similar results.

#### **Kearney Health Opportunities Program (KHOP)**

KHOP is a jointly sponsored program between the University of Nebraska Medical Center and University of Nebraska Kearney that began in 2008. The impetus for this program was based on the success of the RHOP program and the large number of applicants to RHOP from central Nebraska. Selection into the program guarantees admission to UNMC pending completion of the required undergraduate curriculum and maintenance of academic and professional standards. This program has two distinct tracks; a traditional program modeled after RHOP and a non-traditional program designed for non-traditional students.

The traditional track offers 5 positions yearly with the first class starting at Kearney in August 2010. Like RHOP, the program attempts to select applicants who express a desire to practice

in a rural location and have demonstrated the academic ability to achieve success. Selected students are granted a full tuition scholarship to ease their educational burden.

The non-traditional track was implemented in 2008 to address a growing number of applicants to the College of Medicine who were already degree holders in a science of healthcare related field. This program targets individuals living in rural Nebraska who express the desire to earn a medical degree and return to practice in a rural setting. Once selected the student spends one to two years at UNK completed an individualized course of pre-requisites that allow them to enter the College of Medicine. The overall goal is to shorten the typical 11 years process it takes to produce a residency trained physician to 8 years.

The ACA offers potential funding opportunities that could benefit the RHOP and KHOP programs.

#### Advanced Rural Training Program (ARTP) and Primary Care Program (PC)

The Department of Family Medicine and Department of Internal Medicine have sponsored graduated training programs for UNMC senior medical students since 1991. Each program is designed to attract senior students interested in rural primary care to use their senior year in medical school to gain additional skills and training inside highly regarded residency programs. The four year curriculum is designed to provide participants the knowledge, skills and confidence needed to be a successful rural primary care physician.

This program is open to 10 senior students per year. Those selected are granted a tuition waiver for the senior year of medical school and given a forgivable loan for living. Completion of the program waives the tuition cost and practicing two years as a primary care provider in underserved Nebraska forgives the loan. To date there have been 180 program participants with 75% practicing in underserved Nebraska communities.

#### Rural Training Tracks (RTT)

In 1992 Nebraska became only the third state in the nation to offer a Rural Training Track in Family Medicine. This program, called a 1-2 model, is based on the first year of residency education at a core site (Omaha) and the final two years in a rural community. The rationale for this type of training is based on the fact that 50% of family physicians practice within 50 miles of where they do their residency training. The initial Nebraska sites were located in Grand Island Kearney. Their success led to the expansion of sites into Scottsbluff and North Platte in 1996 and eventually Norfolk in 2000.

Nebraska's RTT's are the largest network in the nation and recognized as one of the most successful. There have been over 72 graduates of the program with 80% practicing in rural Nebraska. This program offers 2 positions per year at each site.

The University of Nebraska Medical Center is recognized as an innovative leader in rural medical education. This recognition comes in part from the programs noted previously. Should each of these programs be 100% successful in putting physicians into rural Nebraska practices, there will still be a shortage based on expected retirements over the next 10 years. As such, Nebraska will need to be proactive in addressing that expected shortfall.

### **Recommendations to meet the long term needs of the state**

The concept of recruiting students while still in high school, then offering a continuum of undergraduate, graduate and post graduate training opportunities is known as a pipeline program. Faced with the reality of a shrinking rural population, this type of program offers the best hope in maintaining a viable and adequately trained rural workforce as outlined in the Nebraska Health Workforce Planning Project (issued by University of Nebraska Medical Center in September, 2009). To achieve success in such a program the following factors will need to be in place.

- Continued collaboration between UNMC, Chadron State College, Wayne State College and the University of Nebraska Kearney.
- Targeted scholarships at UNMC, UNK, Chadron State College and Wayne State College that support the education of pre health profession students wishing to practice in rural Nebraska.
- Strong undergraduate science programs at UNK, Chadron State and Wayne State that not only prepares the student for success at UNMC, but also attracts the best and brightest rural students in the state to those campuses.
- The continued support for all RHOP and nursing disciplines at all University and state college campuses. This report has not focused on the interdisciplinary aspect of training; however the likelihood of pre-health profession students returning to a rural setting increases when they marry others of a like background.
- The financial ability of the College of Medicine to offer advanced programs that help ease the burden of medical education for those students interested in rural practice.
- Continued support of loan forgiveness programs for those health providers choosing rural and underserved practice locations.
- Continued support for family medicine residency positions that focus on production of rural providers.
- State support for pilot programs that clarify roles within a multi-disciplinary health team and seek to define the best practice models in a rural setting for those teams.



October 7, 2010

Senator Tim Gay  
Chair, Health and Human Services Committee  
Nebraska Legislature  
Room 1402, State Capitol  
Lincoln, NE 68509

***Re: LR 467 – Implementation of the Affordable Care Act***

Dear Chairman Gay and LR 467 Committee Members:

My name is Jennifer Carter and I am the Director of Public Policy and the Health Care Access Program at Nebraska Appleseed. Appleseed is a non-profit, non-partisan legal advocacy organization that works for equal justice and full opportunity for all Nebraskans. Our Health Care Access Program is dedicated to ensuring access to quality, affordable health care for all Nebraskans. For the last two years we have had the opportunity to work on the passage of the Patient Protection and Affordable Care Act and now its implementation.

We are very grateful to this Committee for dedicating so much time to this interim study and for the careful and serious examination of what implementation of the Affordable Care Act will entail. The testimony this Committee has received thus far makes clear that there is much work to be done and many serious decisions to be made that will significantly impact how Nebraskans access coverage, the quality of information they received about coverage, and how they will be able to afford coverage. We agree with many previous testifiers that the creation and implementation of an Exchange is the key part of implementation. For Appleseed and its low-income constituents, the expansion of Medicaid and its seamless operation with the Exchange is equally important. But, for either of those endeavors to be successful, it is critical that stakeholders from across the state and from a variety of perspectives help to lead and inform the implementation of reform.

Stakeholder Input

The goal of the Affordable Care Act was to provide more accessible and affordable health care coverage. It does this in a variety of ways and with a variety of approaches, but the ultimate goal was to create a better and more just health care system for every American as patient and consumer. That goal can be easily thwarted if not all the stakeholders have an equal seat at the table. It is imperative that ample and consistent consumer input be part of this process.

For example, the Exchange has been referred to as an on-line market, compared occasionally to Travelocity. But that is only one way to structure and exchange and there needs to be an examination of whether that is the best Exchange structure for Nebraskans. Many rural and low-income Nebraskans may not have easy access to the internet and persons with disabilities may have even more significant challenges using an on-line system. Moreover, any Nebraskan might need help navigating this new system and understanding the information presented, so

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CORE VALUES

COMMON GROUND

EQUAL JUSTICE

deciding if and how a person might find assistance will be important. Consumers and advocates can be helpful in finding creative ways to address these concerns.

These LR 467 hearings have demonstrated that there is a clear need for an ongoing working group or task force that brings together representatives from as many key stakeholder groups as possible and ensures that there is consumer input into the implementation process. Any task force should represent the Legislature, the relevant state agencies, businesses (large and small from varying viewpoints), the insurance industry, rural Nebraskans, and a variety of consumers and their advocates – low-income Nebraskans, persons with disabilities, and seniors for example. While we are pleased that the Department of Insurance included in its state planning grant the opportunity for public hearings, there needs to be more consistent input from stakeholders over the course of the next several years as decisions are made, both large and small, that will have a significant impact on consumer access. The law provides the opportunity for us to work together, plan to get this right and implement this law in a way that works best for Nebraskans. That cannot be done with a few public hearings, state agencies working separately, and consumers rarely being heard. A central hub for collaboration will offer the best way to maximize the opportunities under implementation and craft a system that works as well for someone in Alliance as it does in Omaha, and is as accessible to someone with means as it is for a person with low-income or a disability.

Eighteen other states and the Virgin Islands have created task forces or working groups to lead the implementation. Some states have already issued preliminary reports outlining the goals of implementation. We strongly encourage the members of this Committee to bring legislation to create such a working group with meaningful consumer representation that will work together over the course of the next several years while reform is implemented.

#### Medicaid

Medicaid provides critical access to health care for our most vulnerable families and has been designed to deal with a population that can have particular needs and challenges in a way that is more cost effective than serving those families through the Exchange or private market. It makes sense then that the Affordable Care Act uses that existing infrastructure as the foundation of coverage for our lowest income individuals and families.

The ACA expands coverage to individuals up to 133% of the Federal Poverty level and most significantly, will make childless adults eligible for coverage. This expansion will help thousands of Nebraskans, including parents who are not eligible today because Nebraska's eligibility level for adults is so low (approximately 47% FPL). Education and accessibility will be the cornerstones of a successful expansion. Nebraskans will need to know this program is available and how to apply. The Exchange will be one of the best places for this information as states will be required to determine Medicaid eligibility through the Exchange.

Much has been made of the potential costs of the Medicaid expansion. The numerous flaws in the analysis by Milliman have been detailed repeatedly, including vastly overestimating the number of newly eligible Nebraskans who will participate in the program, overestimating costs per enrollee, assigning costs for provisions that are not in the law, and failing to account for the significant savings that will result to the state. We understand that Director Chaumont has indicated that the report is in part a "worst case scenario." But even the mid-range estimates are unrealistic. More importantly, the Administration and the Department are not using these numbers as outside estimates, but are asking Legislators and others to accept these significantly flawed numbers wholesale and use them as a basis for serious policy decisions.

More realistic estimates approximate the cost to be 1.5 – 2.2% more than the state would *otherwise have spent on Medicaid in the absence of reform*. This is an important point to remember. Regardless of reform, the Medicaid program would have continued to cover our lowest income parents and children and aged, blind, and disabled Nebraskans. It is likely that without reform, the number of participants would have increased due to increasing numbers of uninsured.

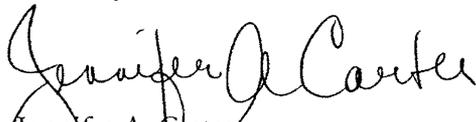
With reform, the state gets a host of benefits in return for the expansion. The expansion is fully funded until 2017 and will not cost the state more than 5% over the next 10 years. For this small investment, the state receives over \$2 billion (by the state's own estimates from December 2009) of federal dollars into our local economies. Over 80,000 Nebraskans are estimated to gain access to health care. And the amount of uncompensated care will go down, relieving both providers and consumers who bear the burden of that cost shift.

The Affordable Care Act also provides opportunities to reorganize our program to be more efficient. Next year the state will have the opportunity to receive a 90% match rate for implementing a medical home model and chronic care management for enrollees with at least two chronic conditions. Several new demonstration projects are also available to the states, most starting in 2012.

We recognize that the Affordable Care Act is not perfect and we can work to improve it. But, it is a good law that will provide needed access to health care to thousands of Nebraskans. It is an opportunity, if done right, to strengthen, literally and figuratively, our communities and our state's greatest resource, its people.

Once again, we thank the LR 467 Committee for their careful attention to this matter. We hope this is just the beginning of a long and productive dialogue.

Sincerely,



Jennifer A. Carter  
Director, Public Policy and the Health Care Access Program

Health and Human Service Committee  
Nebraska Legislature  
Hearing on Healthcare Reform  
October 7, 2010

Members of the Health and Human Services Committee:

My name is Topher Hansen. I am the Executive Director of CenterPointe and a member of the Nebraska Association of Behavioral Healthcare Organizations (NABHO). I am here today to talk about the impact healthcare reform will have on behavioral healthcare issues in Nebraska.

Healthcare reform will help coverage for mental health and substance use issues achieve parity with coverage for other healthcare issues. This will be achieved in a number of ways.

- 1) Insurance policies cannot be denied based on pre-existing conditions;
- 2) Mandatory renewal of policies;
- 3) The elimination of annual and lifetime limits;

All of these changes should benefit people with any chronic illness, not just mental health or substance issues.

Because it is not unusual for people with chronic, untreated behavioral health issues to be uninsured, there are two ways the law will make insurance available to people that are currently uninsured.

- 1) Medicaid will expand to 133% of poverty;
- 2) State-based purchasing pools known as insurance exchanges. These insurance products must meet certain requirements and offer “essential health benefits.” Here, the legislation stipulates that for both Medicaid and the “essential health benefits”, that services for mental health and substance use conditions must be included and further, that the requirements of the federal Mental Health Parity and Addiction Equity Act must be met.

Giving care to any chronic condition as early as possible helps improve long term outcomes and reduces unnecessary costs from lack of care. This should be true for individuals needing behavioral health services as well as those individuals with other chronic health conditions.

Thank you.

Respectfully submitted,

Topher Hansen, JD



Nebraska Pharmacists Association

**Nebraska Pharmacists Association  
Testimony ~ LR 467  
October 7, 2010**

Senator Gay and members of the Committee, I am Joni Cover, Executive Vice President of the Nebraska Pharmacists Association. Thank you for allowing me to share with you information from the pharmacists perspective about Health Care Reform and the Affordable Care Act.

Over the past few weeks, you have been given an enormous amount of information about various aspects of the health care reform legislation. In addition, you've heard that much of the detail of the reform legislation is yet to be determined. Pharmacy is no exception to that "to be determined" category. Much of what I want to share with you today is about the opportunities for pharmacy in the legislation, and opportunities the Nebraska Legislature should consider for programs to improve health outcomes and increase cost savings.

According to an article published in the *Journal of the American Pharmacists Association*, improper medication use costs our nation approximately \$177 billion a year. Pharmacists-provided MTM services ~ where pharmacists coach patient to help them get the maximum benefit from their medications ~ can improve health outcomes and reduce overall health care costs.

In the Health Care Reform legislation, several bipartisan provisions were included to establish pilot programs focusing on disease state management, including medication therapy management or MTM. Pharmacists are uniquely positioned to advance the two central health care goals of *improving quality care* and *reducing costs*. While most people's experience at the pharmacy consists of simply receiving their medicines and occasionally asking questions, pharmacists are trained to do far more for patients, particularly regarding MTM and Medication Reconciliation.

**MTM Services include:**

- Formulating a medication treatment plan
- Monitoring and evaluating the patient's response to therapy
- Performing a comprehensive medication review to identify, resolve and prevent medication related problems, and
- Coordinating and integrating MTM services within the broader health care management services being provided to the patient.

**Medication Reconciliation:** Patients admitted to a hospital commonly receive new or have changes made to their existing medications. As a result, the new medication regimen prescribed at the time of discharge may inadvertently omit needed medications that patients have been receiving for some time. Alternatively, new medications may

unintentionally duplicate existing medications. For example, a physician might prescribe a calcium channel blocker to a patient who has hypertension but is already taking another

medication from the same drug class. **Medication reconciliation** refers to the process of avoiding such inadvertent inconsistencies across transitions in care by reviewing the patient's complete medication regimen at the time of admission, transfer, and discharge and comparing it with the regimen being considered for the new setting of care.

MTM keeps patients with chronic illnesses out of the hospital, keeps the elderly out of the nursing homes, and keeps employees productive ~ results that reduce the highest costs in the system while greatly expanding access to care and improving the quality of life for patients. Opening up the system by removing impediments to MTM by pharmacists accomplishes both goals at the same time. There are several examples of successful public and private sector programs have demonstrated the improved health outcomes and reduced overall health care costs from MTM services ~ such as the Ashville Project and the Diabetes Ten City Challenge. The Affordable Care Act included the following provisions:

- Medication Therapy Management(MTM) Delivery Programs
  - Establish grant programs for pharmacist-provided MTM services to increase patient access to pharmacist clinical services thereby improving the quality of care and reducing overall costs in the treatment of individuals with chronic illness.
- Improving Current MTM Programs in Medicare Part D
  - Improve current MTM programs that were established in the Medicare Modernization Act of 2003. The ACA requires Medicare Part D plans to offer a minimum set of MTM services to certain targeted beneficiaries.
  - Establish a care coordination and management performance bonus program for Medicare Advantage plans that includes programs with a focus on patient education and self-management of health conditions. MTM programs more robust than Medicare Part D MTM programs are eligible.
- Including Pharmacists and Pharmacist-Related Services in Integrated Care Models
  - Establish an Independence at Home demonstration program that includes pharmacists on the team of health care providers.
  - Establish a program to provide grants to establish community-based interdisciplinary teams that support pharmacy care provider access to pharmacist-delivered medication management services, including medication reconciliation. ie: Medical Home
- Including Pharmacists and/or Pharmacist-Related Services in Transitional Care Models
  - Establish a community-based care transition program to provide high-risk Medicare beneficiaries transitional care interventions, which may include conducting comprehensive medication review and management.
  - Establish a national pilot program for integrated care during an episode of care provided to a beneficiary around a hospitalization. A payment methodology tested under this program shall include compensation for providing applicable services such as medication reconciliation.

Each of these provisions highlights the importance of including pharmacists in the health care team and the valuable medication expertise pharmacists provide to patients in various point of care settings. We know because of the studies, pilot programs, and MTM successes that when patients utilize their medications properly, managed by pharmacists working collaboratively with physicians, health outcomes are improved. And, paying pharmacists for their expertise in medication management saves money.

Currently, there are several state Medicaid programs that have initiated pharmacist disease management programs which pay pharmacists for their MTM services which has ultimately saved money for the Medicaid programs. Many private payors, self-funded insurance plans and state-employee plans have initiated successful programs similar to those outlined in the Affordable Care Act.

Health Information Technology will also have a huge impact on care coordination in the Health Care Reform implementation. ePrescribing has been touted as a way to streamline prescribing, reduce errors, and save the prescribers and pharmacists time in their daily work-flow. The reality is that it has created new errors, is costly for pharmacies to adopt (pharmacies pay for the transaction fees for receiving electronic prescriptions while physicians are incentivized to adopt eprescribing), and often frustrating for physicians when the process does not work seamlessly. Additionally, pharmacists must be able to access patient electronic medical records to properly and safely implement MTM programs, provide medication reconciliation services, and to manage medication adherence and disease management for their patients.

Pharmacists in Nebraska are perfectly situated as the most accessible healthcare provider to improve the health of their patients with the implementation of MTM and disease management programs. Saving money and improving health outcomes ~ meeting the goal of health care reform.

Thank you for the opportunity to comment.

# Our Nation's Medication Use Problem

Medications are the first line of defense and have been proven to be our most important weapon in the fight against all disease, including chronic diseases such as diabetes and coronary heart disease. Unfortunately, improper medication use has been estimated to cost our nation \$177 billion annually in total direct and indirect healthcare costs.<sup>1</sup> Poor adherence to medications causes approximately 125,000 deaths each year, and costs at least \$75.6 billion annually.<sup>2</sup>

Pharmacists' medication expertise is often required for patients to fully optimize their medication therapy. Several public and private sector programs such as the Asheville Project, the Diabetes Ten City Challenge, and the Veterans Administration have effectively utilized pharmacist clinical services in collaborative care models.

## Every dollar spent on pharmacists' patient care services realizes health care savings of \$16.70.<sup>3</sup>

**Minnesota MTM Care Program:** estimated annual cost savings amount of \$403.30 per patient for MN adults achieving the "optimal care" benchmark for diabetes. Even though a cause and effect relationship cannot be firmly established, potential annual cost savings among the 41 medication therapy management services (MTMS) recipients with diabetes achieving optimal care would be \$15,325.<sup>4</sup> Pharmacist-provided MTMS decreased health care costs from \$11,965 to \$8,197 per patient per year.<sup>5</sup>

**Diabetes Ten City Challenge (DTCC):** average total health care costs were reduced annually by \$1,079 per patient compared to projected costs if the DTCC had not been implemented; improvements in key clinical measures, including A1C, cholesterol and blood pressure; increases in preventive care measures, including the number of people with current influenza vaccinations, eye exams and foot exams.<sup>6</sup>

**Department of Veterans Affairs (VA):** by extrapolating the average salary data for pharmacist, the VA expects to see an annual \$368,000 in savings from each pharmacist by providing clinical pharmacy services.<sup>7</sup>

**Ambulatory Care Settings:** annual savings attributable to pharmacists include \$3.5 billion in hospital cost avoidance by coordinating medications from multiple prescribers.<sup>8</sup>

**Anticoagulation Clinic:** annual savings attributable to pharmacists include more than \$1,600 in direct health care costs per patient at a pharmacist-run anticoagulation clinic, compared to usual medical care.<sup>9</sup>

**Benefit-to-Cost Ratio:** a systematic literature search was conducted to identify published economic evaluations of pharmacist clinical services. Among studies reporting data necessary to determine a benefit-to-cost ratio (n=15), the pooled median value was 4.81:1—meaning that for every \$1 invested in pharmacist clinical services, \$4.81 was achieved in reduced costs or other economic benefits.<sup>10</sup>

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9. Persell SD, Osborn CY, Richard R, et al. Limited health literacy is a barrier to medication reconciliation in ambulatory care. *J Gen Intern Med.* 2007; 22:1523-6

10. Chiquette E, Amato MB, Bussey HI. Comparison of an anticoagulation clinic with usual medical care: anticoagulation control, patient outcomes, and health care costs. *Arch Intern Med.* 1998;158:1641-77

**Institute of Medicine (IOM):** "...because of the immense variety and complexity of medications now available...the pharmacist has become an essential resource...and thus access to his or her expertise must be possible at all times."<sup>1</sup>

**Centers for Medicare and Medicaid Services (CMS):** "... we believe that MTMP [medication therapy management programs] must evolve and become a cornerstone of the Medicare Prescription Drug Benefit."<sup>2</sup> More recently, CMS stated that in their ongoing attempt "to maximize access to MTM", that the Agency wants to "raise the level of the MTM interventions offered to positively impact medication use."<sup>3</sup>

**Agency for Healthcare Research and Quality (AHRQ):** Agency for Healthcare Research and Quality (AHRQ): "...pharmacists were most likely to prevent the errors from reaching the patients (40 percent of intercepted medication errors), while physicians and patients were almost equally likely to intercept the medication error (19 percent and 17 percent of intercepted errors, respectively)."<sup>4</sup>

**Medicare Payment Advisory Commission (MedPAC):** Medicare Payment Advisory Commission (MedPAC): "...a Medicare medical home would be responsible for monitoring its patients' medications. Medical homes should conduct periodic reviews of a patient's regular medications in addition to reviews immediately after an acute event, such as a hospitalization... Ideally, these medication reviews would be coordinated with a pharmacist."<sup>5</sup>

**George Halverson, Chairman and CEO of Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals:** "We ... had teams of nurses, caregivers, and pharmacists actually, because pharmacists are the most underutilized resource in health care; use[d] pharmacists to help advise if patients were not taking the drug, what the right drug would be, and the result of that was 73% reduction in deaths for heart disease and coronary heart disease for the entire heart population that we have in Colorado."<sup>6</sup>

**Kendall Powell, Chairman and CEO of General Mills:** "No one understands these medications. They are too complex. We have white collar, professional, highly educated people at General Mills who do not know how to follow their meds. And so what we're doing now – again on this prevention tact – is we're sitting them down with a pharmacist. For as long as they need to, to understand what they're taking, why, the consequences of withdrawal, all the interactions. And again it makes a huge difference in the management of chronic disease."<sup>7</sup>

**New York Times:** "At this point in the health reform process, it's all about the numbers. While the Congressional Budget Office has begun to score health reform proposals to help calculate the price tag for reform, it hasn't scored the potential savings to the federal government of chronic disease prevention and management programs. It's admittedly difficult to quantify the long-term impact of prevention initiatives, but we are seeing more and more evidence from smaller-scale programs like the Ten City Challenge of the potential economic impact of such coordinated approaches. We believe such programs are critical long-term investments that will help bend the curve and also improve and save lives."<sup>8</sup>

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6. HIMSS09 Keynote Address, accessed May 18, 2009 at <http://www.himssconference.org/general/videos.aspx>

7. During a breakout session of the White House Forum on Health Reform on March 5, 2009.

8. June 23, 2009

## State Medicaid Programs Utilizing the Services of Pharmacists

### Missouri Medicaid Pharmacy-Assisted Collaborative Disease Management Program.

In Missouri, pharmacists and primary care providers work collaboratively to improve health outcomes and reduce unnecessary healthcare utilization for certain Medicaid recipients. It is estimated that the program has helped reduce per capita annual program expenditures by \$6,804 and has generated annualized program savings of \$2.4 million.<sup>1</sup>

### Minnesota Medication Therapy Management Care Program

A year-long evaluation of Minnesota's MTM program found that pharmacists identified and resolved 789 drug therapy problems in 259 recipients (3.1 drug therapy problems per recipient). Inadequate therapy (e.g. dose too low for effectiveness, needs additional preventive therapy, and noncompliance) represented 73% of resolved drug therapy problems.<sup>2</sup>

Importantly, the most successful pharmacists in the first year of the MTMS program were those with established collaborative practice relationships with physicians and other primary care providers and were also part of an integrated health delivery system. This finding is consistent with health care delivery improvements advanced in chronic care and the medical home model.

### Iowa Medicaid Pharmaceutical Case Management (PCM)

The Iowa PCM program provides an opportunity for physicians and pharmacists to closely manage the total medication regimens of their most complex patients.

Importantly, Iowa Medicaid compensates pharmacists and physicians for the additional care associated with drug therapy management services.

The PCM program significantly improved medication safety and did not measurably affect Medicaid expenditures. Data suggested that emergency room and outpatient facility utilization may have decreased for patients of pharmacies who adopted PCM most intensely.<sup>3</sup>

### Other State MTM Programs

The following states have implemented MTM programs and pharmacy-assisted disease management programs for Medicaid beneficiaries.

- Florida (*Medicaid Drug Therapy Management for Behavioral Health*)
- Iowa (*Medicaid Pharmaceutical Case Management Program*)
- Maryland (*P3 Diabetes Disease Management Program*)
- Minnesota (*Medicaid Medication Therapy Management Program*)
- Missouri (*Medicaid Pharmacy-Assisted Collaborative Disease Management Program*)
- Mississippi (*Medicaid MTM*)
- Ohio (*RxEase, Pilot Program, pharmacists provide MTM to patients with chronic diseases such as diabetes, asthma, and cardiovascular disease*)
- Virginia (*Virginia Healthy Returns*)

States who utilize the services of pharmacists beyond Medicaid:

- Wyoming Pharm Assist Program
- Montana Pharm Assist Program (has not yet implemented)

1 2006 Disease Management Directory & Guidebook, "Pharmacist-Led DM Delivers Clinical, Financial Dividends, pp.7-10, and Missouri Medicaid DM Program Shows Positive First-Year Outcomes, pp.583-84.

2 Evaluating Effectiveness of the Minnesota Medication Therapy Management Care Program. Final Report. Submitted December 14, 2007. (Available at: [http://www.dhs.state.mn.us/main/groups/business\\_partners/documents/pub/dhs16\\_140283.pdf](http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_140283.pdf) (Page 4))

3 Iowa Medicaid Pharmaceutical Case Management (PCM), Report of the Program evaluation, December 2002, available at: <http://www.iarx.org/Documents/PCM%20Final%20Report%20Executive%20Summary.pdf>



Prevention: Fitness, Immunizations  
and Smoking Cessation

Prevention: Partnering with the  
Washington Redskins

Intervention: The Asheville Project

Intervention: The Diabetes Ten City  
Challenge

Innovation: Cancer and Alzheimer's  
Disease

Innovation: Adult Immunization

A pharmacy care intervention program for employees with type 2 diabetes and asthma achieved dramatic results for the City of Asheville.



## Intervention: The Asheville Project

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### Triple Solution

Invest in health and save  
our healthcare.

The second key to lowering healthcare costs is to help people get the right care when they do get sick. **Early and consistent treatment** can help people better manage their chronic diseases. It can also prevent them from getting sicker.

### Intervention: The Pharmacy Care Program

The City of Asheville partnered with the North Carolina Association of Pharmacists (NCAP) to provide a pharmacy care program to demonstrate the value of pharmacist-directed case management.

The City offered a wellness program to its employees with diabetes or asthma. For employees with diabetes, copays were waived for disease-related medications and supplies for patients who agreed to:

- Attend diabetes classes.
- Get lab work every 6 months.
- Meet with a participating pharmacist once a month for 30 minutes.

The City paid for all services, including the counseling time of community pharmacists.

### Intervention Can Bring Real-Life Results.

#### John: A Real Story of Results

John is a 54-year-old business manager who suffers from type 2 diabetes and asthma. This is a typical day in John's life:

- He works hard for the City of Asheville.
- When he isn't managing people at work, he's managing his own chronic diseases.
- He is tired of living two detail-oriented lives.
- He knows he can take time off from work. But he can't take time off from diabetes or asthma.
- With so many responsibilities, he wishes he knew how to handle them more effectively.
- He's tempted to give up. He's tempted to let the diabetes and asthma take their courses.
- Maybe giving up would be easier. But John is not a quitter. He decides to enroll in the pharmacy care program to see if maybe there is hope.



Now, 6 months after committing to better lifestyle choices, John is still in the pharmacy program. He's a changed man:

- He attends diabetes education classes. He is relieved that somebody is finally managing him for a change.
- He visits with a pharmacist in the program once a month during his lunch break. He receives counseling on how to better deal with his diabetes and asthma.
- He does his part to take care of himself with the education he receives.
- He regularly checks his blood sugar at home.
- He has a foot exam every 6 months.
- His cholesterol has improved.
- His medical claims have decreased.
- He feels better. And he uses more of his paid time off for vacations instead of sickness.

Because John is doing his part, the City of Asheville is paying for his medications. He's a believer in better health.

### A Partnership of Success

Promoting an active partnership with the pharmacist achieved dramatic results for the

### What You Can Do

Make your voice  
and opinions  
heard.

[Learn more](#)

### Sites For Your Health

[GSKforYou.com >>](#)

Find help with prescription  
costs.

[TakingMeds.com >>](#)

Get the most from  
medicines.

[1on1Health.com >>](#)

Learn to manage health.

## City of Asheville:

- Direct costs went down by \$2,431 per patient over 5 years.
- The town realized about \$18,000 per patient in annual productivity gains as the number of missed work days dropped by half.<sup>1</sup>
- While some costs increased, total healthcare costs decreased. This demonstrated the power of effective health management.
- [Watch a video](#) to learn more about the City of Asheville and diabetes management.
- Read about how the [Ten City Challenge](#) and [Pitney Bowes](#) case studies address the importance of intervention.

## References:

1. Cranor C, Bunting BA, Christenson DB. The Asheville Project: long-term clinical and economic outcomes of a community pharmacy diabetes care program. *J Am Pharm Assoc* 2003; 43:173-184.

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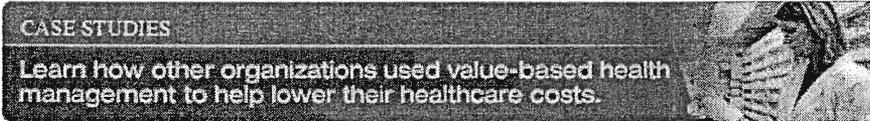
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- [Pitney Bowes](#)
- [The Diabetes Ten City Challenge](#)
- [The Lancaster County BRIDGE Project](#)



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## Case Study: The Diabetes Ten City Challenge

The Diabetes Ten City Challenge (DTCC) supports participating employers within 10 cities to help manage diabetes within their covered populations. The DTCC uses community pharmacists, financial incentives, and a self-management tool to help participants with their care plan.

### Economic Evaluation of First-Year Data

#### Results of the DTCC have shown the following cost savings:

- Average total healthcare costs were reduced annually by \$1,080 per patient (compared with projected costs).
- Average savings of \$593 per patient per year through employer incentives like waived copays on diabetes medications and supplies.

#### Percent improvement in patients achieving national HEDIS goals:

- 23% blood glucose (HbA1c <7%).
- 39% blood pressure (<130/80 mmHg).
- 11% cholesterol (LDL-C <100 mg/dL).

#### Prevention increased:

- Flu vaccinations from 32% to 65%.
- Eye exams from 57% to 81%.
- Foot exams from 34% to 74%.

### Program Components

- Employers established a voluntary health benefit for employees, dependents, and retirees with diabetes.
- Thirty employers in 10 cities waived copayments for diabetes medications and supplies if participants met regularly with a specially trained pharmacist "coach".
- Pharmacists communicated with physicians after every visit and referred patients to other healthcare providers for additional care or education as needed.

### DTCC Personal Triumphs

—TAMPA BAY, FL. In the first year of implementing the DTCC as part of the comprehensive health management and support programs for employees of the Manatee County Government and the Pinellas County Sheriff's Office, the county's cost for diabetes-related hospital admissions dropped from \$500,000 to around \$70,000 and has stayed in that range for three years.

—DALTON, GA. This city represents a smaller market with a high percentage of manufacturing jobs. The results have been positive with patients receiving one-on-one guidance from health professionals. In fact, one participant lost 20 pounds and reduced his HbA1c to 5.8 from an original level over 7 during the program. He also used his employer's health club membership to swim more, and won six medals at the state senior competition.

—HONOLULU, HI. Personal health and dietary coaching have made a difference in the lives of patients in Hawaii. One man in the study noted that "A lot of times you only see a doctor for five minutes, you talk briefly and you're out of there. With my pharmacist coach, I am able to sit down, talk about what's going on and not feel rushed." After sitting with his coach and learning about the high glycemic levels of many traditional Hawaiian foods, this participant lowered his HbA1c level from 11 to 6.9 over two years.

—CUMBERLAND, MD. Western Maryland Health System, a large employer and the only hospital in

*Allegany County, Maryland, immediately recognized the benefit of joining the DTCC. They welcomed the potential savings of the proactive approach. Cumberland-area study participants appreciated the plan as well. A local pastor and his wife learned how to manage their diabetes together, using blood monitoring and exercise. The pastor dropped 36 pounds and his wife lost 11. And now they're enthusiastically spreading the good news of proactive health management to their entire congregation.*

To learn more, go to [www.DiabetesTenCityChallenge.com](http://www.DiabetesTenCityChallenge.com)

The DTCC program was sponsored by the American Pharmacists Association with support from GlaxoSmithKline.

Reference: Journal of the American Pharmacists Association, May/June 2009. Diabetes Ten City Challenge: Final economic and clinical results.

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# CENTER *for* RURAL AFFAIRS



**Testimony from Melissa Florell**  
2148 20 Rd  
Kearney, Nebraska  
(308) 237-2026  
LR 467, October 7, 2010

Good Afternoon and thank you to the members of this interim committee for the opportunity to speak today. My name is Melissa Florell. I have lived in rural Nebraska my entire life. I grew up on a farm in northeast Nebraska and now my husband, children, and I farm near Kearney. My perspective on health care reform is both personal and professional as I practice as a registered nurse. Through talking to friends, family, and my patients, I've realized that our nation's health care system is inaccessible to many people, especially those living in rural areas. The high cost of health care inhibits economic growth and reinvestment in small businesses, including family farms. Farm families are more likely to be uninsured or underinsured than non-farm families and a staggering number carry medical debt.

The cost of health insurance continues to rise while benefits decrease, causing hardships for many families, including my own. Because I choose to work part-time as a nurse in order to complete an advanced nursing degree and play a more active role in our farm operation, I am not eligible for health care benefits through my employer. For this reason we purchase insurance on the private market. Our family's health insurance (we are a healthy family of 5) with a \$3000 deductible has a monthly premium of over \$750. When we reapplied to our insurance company a year ago in order to attempt to qualify for a lower premium, my sons who have no chronic illnesses were excluded. Health care costs are a monthly conversation in our home, and the saddest part is that many farm families struggle even more with health care costs than we do.

A 2007 survey conducted by The Access Project found that families purchasing health insurance on the private market spend \$4359 more annually than those receiving insurance coverage through their employers. These individual insurance plans only cover an average of 63% of medical costs, compared to group insurance which covers an average of 75% of costs.

Agriculture continues to be an integral part of the rural economy and for this economy to remain strong quality health insurance must be accessible. These are personal stories, but they are not isolated incidents. They are examples of why the current insurance market does not provide adequate options for rural residents, especially those who are self-employed. So many people I know wait too long to seek care, because they feel they can't afford it, or fear becoming uninsurable.

The Patient Protection and Affordable Care Act supports initial steps to improve access to and the availability of health care in our country, including rural Nebraska. In addition to the challenge of obtaining adequate and affordable health insurance, rural residents also face a critical shortage of primary care providers. Primary care providers offer routine primary care,

health promotion and disease prevention, and treat chronic health care conditions— fundamental needs of the rural population who are consistently found to have higher incidence of chronic illnesses such as arthritis, asthma, heart disease and untreated mental disorders than urban residents. The shortage leads to diminished health status and quality of life for rural residents. The primary care workforce is composed of physicians, nurse practitioners, physician assistants and registered nurses, and shortages exist in all areas of this workforce. In order to build strong rural communities we must invest in all parts of the health care workforce.

Title V of the PPACA contains provisions with the potential to positively impact the rural health care workforce. Rural physician training grant and interdisciplinary community based linkages programs are both intended to recruit prospective primary care providers from rural areas and support them, financially and academically, in their preparation. Both programs contain support for Area Health Education Centers (AHECs). AHECs work to adapt national initiatives to address local and regional health care issues. They also use community-based training to recruit, train, and retain rural health care providers. The health reform law also contains provisions supporting the recruitment and retention of registered nurses and advanced practice nurses. Registered nurses make up the largest sector of the health care workforce and are facing severe, increasing shortages. The law authorizes \$338 million dollars for FY 2010 for existing and revised title VIII nursing workforce development programs. including advanced education grants, nursing workforce diversity grants, and nurse education, quality and retention programs. Faculty nurse education is also supported through loan repayment and scholarship programs to support increasing capacity for registered nurse programs. Grant programs for Nurse Managed Health Clinics, Family Nurse Practitioner training program, and a demonstration project to reimburse hospitals for costs associated with training advance practice nurses recognize and support the important contribution these practitioners play in primary care.

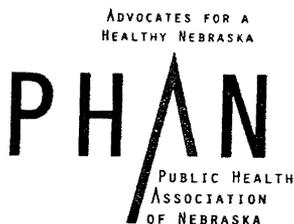
Nebraska's effective implementation of national health care reform can help to ensure vibrant, healthy rural communities and the new state-level health insurance Exchange that will be created under the Affordable Care Act will serve as a major insurance marketplace when it begins 2014. The Exchange will provide many currently un and underinsured Nebraskans with a simple way to obtain quality, affordable coverage. This is especially true for rural Nebraskans who are less likely to have access to health insurance than those in non rural areas. As Nebraska policy makers decide how to structure the Health Insurance Exchange, they must consider the unique circumstances of rural residents.

Rural places and their residents are more isolated and this is particularly true of low-income rural residents who need access to affordable health insurance most. Information about the Exchange will be difficult to spread to these populations without a specific emphasis and significant resources.

I am concerned about what seems like the conventional wisdom that the Exchange must

be web-based to be effective and efficient. This may be true for the largest number of people across the nation, but it is not necessarily true for many rural people in our state. Generally, rural people have less access to high speed telecommunications technology. Again, that is particularly true for low-income rural residents. A web-based Exchange will leave out a significant portion of the rural population and provide less than optimum service for a larger share of the rural population. If that is the case, health care reform will accomplish little to address the health insurance disparities currently endured by many rural people.

Small businesses and self-employed individuals make up a substantial percentage of the Nebraska's rural population compared to urban areas. Historically these workers have the highest likelihood of being uninsured due to the high cost resulting from very small risk pools. The Exchange must be structured to insure that rural small businesses can pool their employees with other small businesses in order to spread the risk and lower insurance costs. It would also be most optimum to create one insurance pool with both small business and individual consumers. Regulations should create incentives for states to create one insurance pool, and allow people buying in both the individual and the small business pool to be captured in that one insurance pool. Such a structure will be extremely beneficial to rural small businesses and their employees and families. The opportunity for broader pools will address many of the issues that lead to high rates of uninsurance and underinsurance in rural areas.



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**TO:** Senator Tim Gay, Co-chair  
Senator Lavon Heidemann, Co-chair  
Senator Rich Pahls, Co-chair  
Senator Mike Gloor  
Senator Galen Hadley  
Senator Kathy Campbell  
Senator Keith Mello  
Senator Tanya Cook  
Senator Jeremy Nordquist

**From:** Kay Oestmann, President  
Public Health Association of Nebraska

**Date:** October 7, 2010

**Subject:** Patient Protection and Affordable Care Act-Public Health

### **Opportunities for Public Health**

The Act provides for expanded and sustained national investment in prevention and public health programs authorized by the Public Health Service Act for prevention, wellness, and public health activities, including prevention research and health screenings

Competitive grants will be available for state and local governmental agencies as well as community-based organizations. The purpose of the funding will be to reduce chronic disease rates, address health disparities, and develop a stronger evidence-base of effective prevention programming.

### **Fiscal Year 2010 Appropriation-\$250 million for public health and prevention:**

\$44 million for approved but not funded ARRA grants  
\$16 million for tobacco cessation activities  
\$20 million for primary and behavioral health integration  
\$16 million for obesity prevention and fitness  
\$20 million for Epidemiology and Lab Capacity state grants  
\$50 million for state public health infrastructure  
\$15 million for public health training centers  
\$30 million for HIV/AIDS  
\$8 million for public health workforce  
\$10 million for Community and clinical preventive services task forces  
\$20 million for surveillance

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**Community Transformation Grants (CPPW):**

Reduce chronic disease rates, address health disparities, and develop a stronger evidence base of effective prevention programming

20% of the grants are targeting to rural and frontier areas

Expand The Communities Putting Prevention to Work (CPPW) program

Omaha is currently receive funding through this provision

**Healthy Living, Living Well**

Community-based public health interventions include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health and promote healthy lifestyles.

**Major Opportunities:**

Build a system of care that focuses on prevention and primary care

Develop and expand the field of public health systems and services research.

**Current Health Statistics**

One in 4 Americans has heart disease; one in 3 has high blood pressure.

Twenty-four million Americans have type 2 diabetes, and another 54 million are pre-diabetic, at high risk for developing type 2 diabetes. An estimated 2 million adolescents have pre-diabetes.

**Financial Burden of Specific Diseases**

Percent of US Health Care Costs by Top Diseases that Can Be Impacted by Physical Activity, Nutrition, and Smoking

*Health Conditions*

*Percent of Health Care Costs in the U.S.*

Diabetes, high blood pressure, or Combination of the 2 diseases	9.4 percent
Diabetes or high blood pressure who also have Heart disease or stroke and/or kidney disease	16.0 percent
Heart disease or stroke and/or kidney disease who Do not have diabetes or high blood pressure	6.2 percent
Cancer	3.1 percent
Arthritis	1.1 percent
COPD	2.0 percent

Source: Urban Institute calculations using data from the 2003-2005 Medical Expenditure Panel Survey (MEPS)

**Impact of funding prevention activities**

(Prevention for a Healthier America- Trust for America Report)

Annual Intervention cost on Investment at \$10 per person: \$17,470,000

**Savings in medical care costs:**

1-2 years: \$35,500,000

5 years: \$18,100,000

This return on investment represents medical cost savings only and does not include the significant gains that could be achieved in worker productivity, reduced absenteeism at work and school, and enhanced quality of life.

**Nebraska**

Total Annual Intervention Costs (at \$10 per person): \$17,470,000

Nebraska Return on Investment of \$10 per person:

	1-2 years	5 years	10-20 years
Total State Savings	\$35,500,000	\$119,700,000	\$131,500,000
State Net Savings			
ROI for State	1.04:1	5.86:1	6.53:1

\*In 2004 dollars

Indicative Estimates of State-level Savings by Payer: Proportion of Net Savings for an Investment of \$10 Per Person

	1-2 years	5 years	10-20 years
Medicare Net Savings (Proportion of net savings)	\$4,880,000	\$27,600,000	\$30,700,000
Medicaid Net Savings (Federal share) (Proportion of net savings)	\$1,040,000	\$5,920,000	\$6,600,000
Medicaid Net Savings (State share) (Proportion of net savings)	\$707,000	\$3,990,000	\$4,450,000
Private Payer and Out of Pocket Net Savings (proportion of net savings)	\$11,400,000	\$64,700,000	\$72,100,000

\* In 2004 Dollars

\*Source: TFAH calculations from preliminary Urban Institute estimates, based on national parameters applied to state spending data.

**Conclusion**

Health reform is a journey and not a destination.

**Chaffee, Michelle**

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**From:** Kay Oestmann [kay@sedhd.org]  
**Sent:** Wednesday, October 27, 2010 6:23 PM  
**To:** Sen. Gay, Tim; Sen. Heidemann, Lavon; Sen. Pahls, Rich; Sen. Gloor, Mike; Sen. Hadley, Galen; Sen. Campbell, Kathy; Sen. Mello, Heath; Sen. Cook, Tanya; Sen. Nordquist, Jeremy  
**Cc:** Chaffee, Michelle  
**Subject:** Info from LR 467

Senators:

Reflecting on my comments to the committee during the LR 467 Hearing, I realized some of your questions may not have been answered adequately. I have included additional information below.

**Number of local health departments:**

Currently there are 21 Local Health Departments of which 4 represent a single county. (Douglas, Lincoln/Lancaster, Scottsbluff, and Dakota)

A map of the local health departments/ districts is attached.

**Local Health Districts receiving funding from their counties:**

Eight of the departments receive some level of funding from their counties, seven of the departments received county funding prior to the implementation of LB 692 (Health Care Cash Fund).

The legislation (LB 692) stipulated that current funding received by existing health departments could not be supplanted.

**Funding received from State General Funds:**

The local health departments/districts receive a total of 1.8 million from the state budget for surveillance activities which includes communicable disease investigations such as pertussis (whooping cough), TB, rabies. Weekly contacts with schools, hospitals, nursing homes, day cares, and Doctor's offices check on influenza like illness. In this way departments are able to predict when the flu is entering their districts enabling them to respond and educate their citizens. This funding also assists in follow up of food borne illness and environmental illnesses associated with water quality or vectors. Part of the funding assists districts in identifying those factors that put their counties at risk so they may approach them through community coalitions and response.

No other funding is received from state general funds.

**Health Care Cash Fund (Tobacco Settlement):**

The Health Care Funding Act allocates \$5.6 million each year for state wide local public health.

The funds received are separated into two categories: infrastructure and population base. For example, the total amount of funding may range from \$1,116,935 for the state's largest health district to \$168,780 for the smallest district. The infrastructure funding assists departments in day to day expenses: such as rent, utilities, and basic staffing. Per capita funding is used to assist in the development of programs identified as needs in the community assessment. In addition the health departments work in partnership with their local communities to seek other funding sources to meet identified public health needs.

10/28/2010

By statute all health districts report annually on use of the funding to DHHS. A report is compiled by the Division of Public Health and submitted to the Legislature. It is available for all Senators on January 1 of each year.

### **Patient Protection and Affordable Care Act - Public Health Funding**

At this time none of the funds identified for public health have been specifically designated for local public health.

The funds that have been released to date have designated the state as the only qualified applicant.

The health directors have met with Dr. Schaefer to offer assistance with grant applications.

The health directors have also requested the local health departments be allowed to apply for funds in the event the state chooses not to pursue a funding opportunity.

Thank you for your interest in Public Health.

Please feel free to contact me at any time for additional information.

Kay Oestmann, President  
Public Health Association of NE (PHAN)

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## LOCAL HEALTH DEPARTMENT FACT SHEET

### Background

- Prior to 2001, the local public health system in Nebraska was weak, fragmented, and severely underfunded. Local public health departments covered only 22 of the state's 93 counties.
- In January 2001, when the Tobacco Master Settlement Agreement was issued, Nebraska's Legislature passed the Health Care Funding Act, LB 692. This legislation assures a minimum of \$50 million in interest per year in *perpetuity* for use in health-related activities. Local public health currently receives only 10% of the funds allocated from the Health Care Funding Act.
- By law, the Health Care Funding Act allocates \$5.6 million each year for statewide local public health. This translates into just \$3.14 for each person living in Nebraska.
- Based on public health need, LB 1060 was passed in 2006. This legislation provides funding for ongoing disease surveillance, communicable disease investigation and control, and the development of statewide standards for data collection and measurement.

### What Local Health Departments Do

Local health departments use a systematic approach to public health programs and services. By Nebraska State Statute local public health departments provide:

- Assessment of Community Health Status
- Prevention
- Public Health Education
- Environmental Health
- Public Health Nursing
- Screening and Immunizations
- Surveillance and Communicable Disease Control
- Preparedness Against Public Health Threats
- Public Health Policy

### Operation

Local health departments are as necessary as police, firefighters and medical personnel to respond to emergencies and protect the community's health and safety. The departments are staffed by qualified health professionals who apply proven, cost-effective methods to prevent disease, promote health and prevent public health threats.

The local health department is the foundation of the local public health system that also includes local physicians, hospitals, academia, business, media, and other local and state governmental agencies.

Local public health priorities are identified as a result of each local health department's assessment of the community. The departments mobilize community partnerships and resources to solve health problems.

### Funding Leveraged into Nebraska

All local health departments are successful in leveraging other funds. Federal grant funds are being used by local health departments for bioterrorism planning, public education efforts related to West Nile Virus and the Clean Indoor Act, Preventive and Maternal and Child Health block grants, and Radon testing. Some departments also receive funds from private foundations and directly from the Federal government.

### Going Forward

Nebraska's economy is tied to the health of everyone in the state. Public health issues such as rising obesity rates, cancer, substance abuse, infectious diseases and exposure to environmental hazards can affect young and old alike. Nebraska needs strong, effective local public health to make positive changes in the health of all people in Nebraska.

FRIENDS OF PUBLIC HEALTH IN NEBRASKA

4521 Hill Drive Lincoln, NE 68510 402-489-5097

*Friends of Public Health in Nebraska is the advocacy affiliate of the following organizations: The Public Health Association of Nebraska and the Nebraska Association of Local Health Directors*

# Nebraska's Network of Local Public Health Departments

Working Together to Advance the Health of All Nebraskans

Prevent. Promote. Protect.

In 2001, Nebraska's Legislature passed LB 692, a historic law that created a statewide local public health infrastructure to ensure all people in Nebraska would have access to a local public health department. The LB 692 funds were critical in building a local public health system across the state and remain vital to addressing ongoing public health needs in local communities.



LR 467 Select Committee  
Interim Hearing – Patient Protection & Affordable Care Act  
October 7, 2010

**Necessary Steps to Correct the Primary Care Workforce Shortage**

Bob Rauner, MD, MPH, FAAFP  
Nebraska Academy of Family Physicians

One of the most overlooked areas of the Patient Protection and Affordable Care Act is the necessity for reducing long term health care costs. There are three initiatives available that have the best evidence for both improving health and saving money in the long term:

1. Improvements in health information technology.
2. The patient-centered medical home.
3. Efforts to decrease the prevalence of obesity and increase physical activity.

Improvements in health information technology are already in the implementation phase with programs and incentives created by the HITECH Act.

The evidence for the benefit of the patient-centered medical home was already discussed in detail by Dr. Tom Tape; however it currently has two major obstacles: a decline in the number of medical students entering primary care and a payment system that does not provide the incentives necessary to encourage the patient-centered medical home.

The primary care workforce is already below Nebraska's current needs (see attached shortage area map) and likely to get worse in the next 10 years given the current age distribution of primary care physicians in Nebraska (see attached age distribution). There are several current trends which will continue to make this worse:

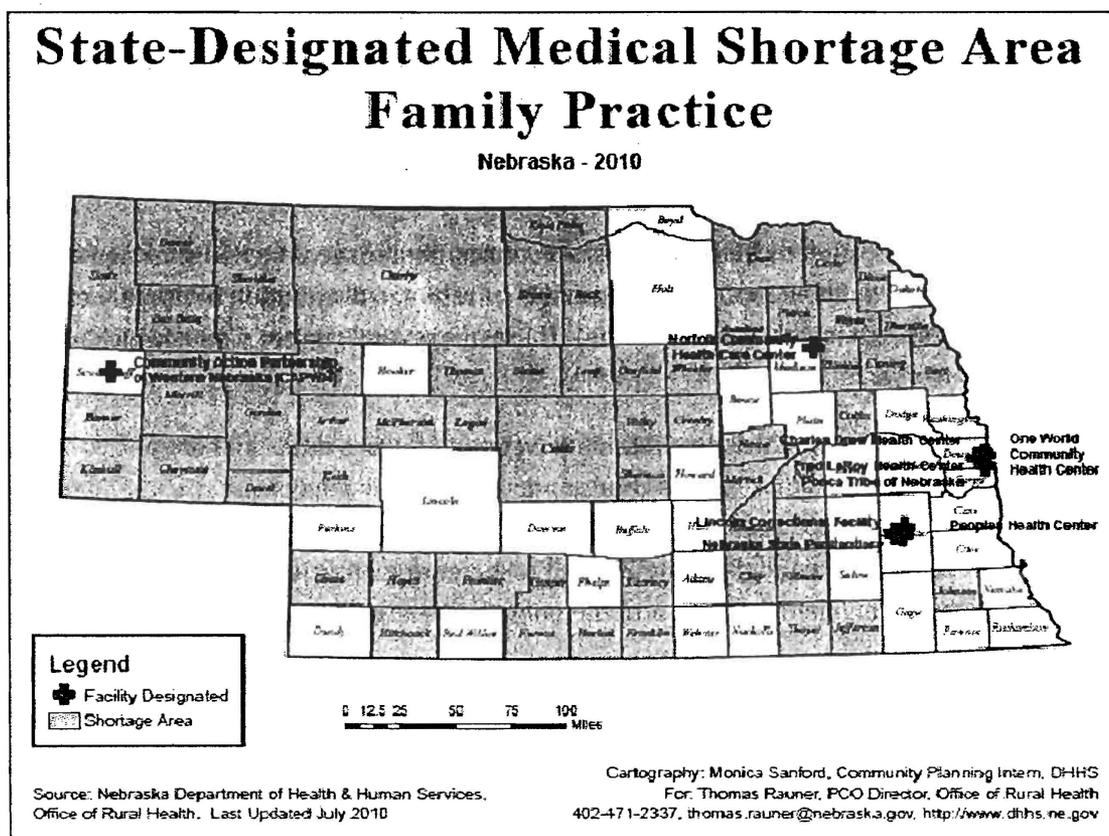
1. Current age of the family physician workforce is weighted toward those in their 50's.
2. Declining numbers of medical students choosing to enter family medicine.
3. Ageing of the population.
4. Increasing disease burden of the population due to increasing prevalence of obesity.
5. Potential expansion of health insurance to the uninsured thereby increasing demand.

Potential solutions:

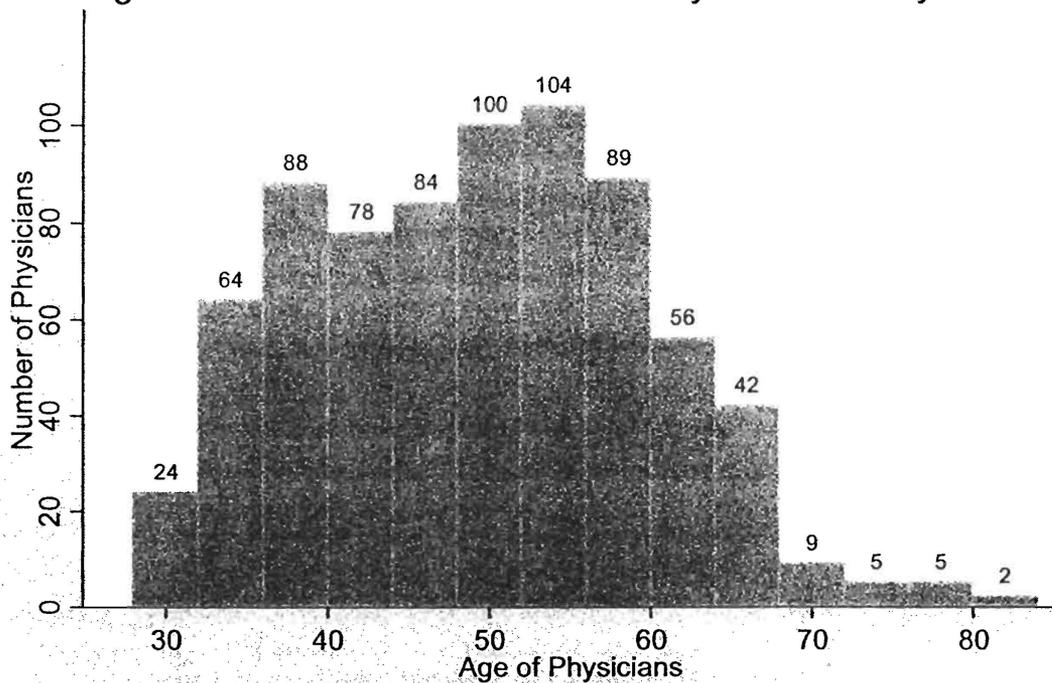
1. Expanded options for loan repayment/tuition forgiveness.
2. Preferential admission of to medical student based on proven demographic characteristics that predict entering primary care.
3. Set expectations with accountability for UNMC in training an adequate number of primary care physicians.
4. Change the payment structure from flat fee for service to a blended payment model.

Blended payment is the key for providing the correct incentives to expand the patient-centered medical home. This is an essential component of the Nebraska Medicaid Medical Home bill that was passed last year. Unfortunately, this will not provide wide spread change until multiple payers become involved. At the present time this will only happen in the 2 pilot Medicaid sites because the only payer that has shown an interest in being involved is Blue Cross Blue Shield of Nebraska. There is no opportunity for this to happen currently because other payers (including the 2 Medicaid managed care providers) have so far shown no interest in cooperation with patient-centered medical home efforts. Until this is fixed, it will be very difficult to create a market based incentive to encourage a stronger primary care workforce.

The third potential initiative to both improve health and lower costs are efforts to reduce the prevalence of obesity and increase physical activity. Nebraska is ripe for expanded efforts in this area. There are numerous promising models that have started in other states. There is also widespread interest at the community level. The next necessary ingredient is leadership from the top. The Nebraska Medical Association's Public Health Committee is working on a state plan that we will be pushing in the next few months.

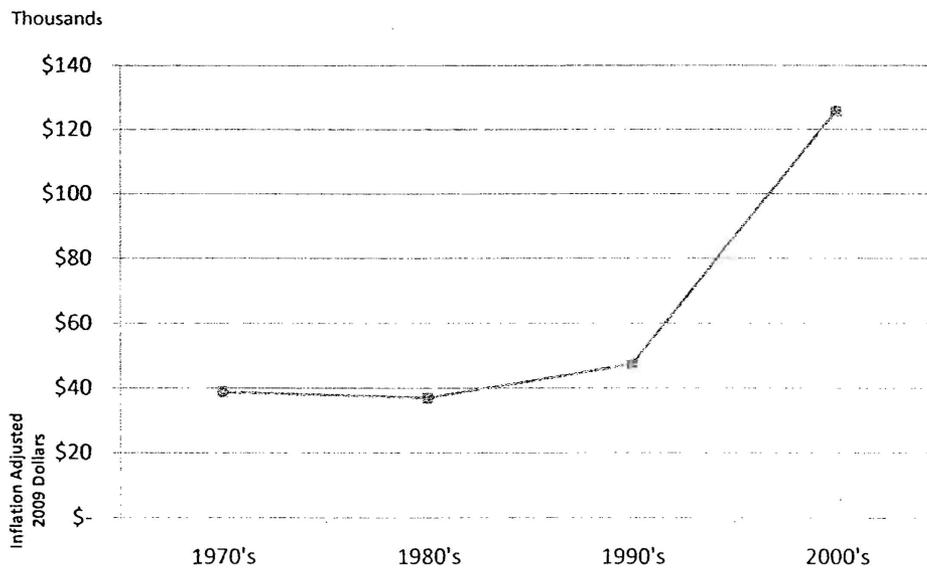


## Age Distribution of Nebraska Family/General Physicians



Source: UNMC Health Professions Tracking Center 2009

## Nebraska Family Physician Inflation Adjusted Student Debt



Source: Office of Rural Health, Nebraska HHS, 2009

## Issue Brief:

# Medical Home 2.0: *The Present, the Future*

### Foreword

In the Patient Protection and Affordable Care Act of 2010, the expansion of patient-centered medical home pilot programs is among delivery system reforms intended to reduce costs and improve population-based health by leveraging clinical information technologies, care teams and evidence-based medical guidelines.

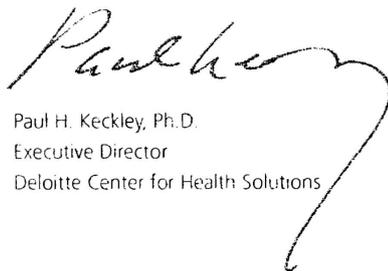
Conceptually, a medical home model makes sense: Improved consumer access to primary care health services and increased accountability for healthy lifestyles are foundational to a reformed health system. For primary care clinicians, the current system of volume-based incentives limits their ability to appropriately diagnose and adequately manage patient care. For consumers, lack of access to effective and clinically accurate diagnostics and therapeutics via primary care is a formula for delayed treatment, overall poor health and higher costs. The medical home model is designed to address these issues.

*Primary care is the front door to a transformed system of care in which multi-disciplinary care teams share responsibility and risk with consumers in managing outcomes and costs.*

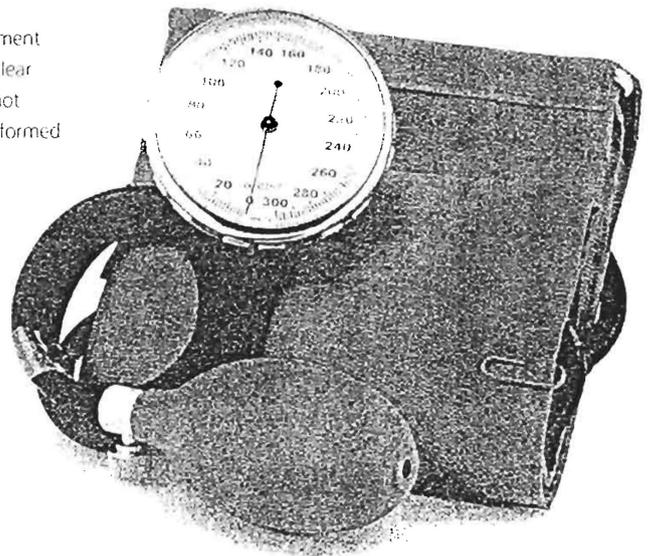
This is the Deloitte Center for Health Solutions' second look at the medical home. We maintain our support for this health care innovation and encourage the continued exploration of operating models and payment mechanisms that optimize its results and provide a clear path to widespread deployment. The status quo is not sustainable; primary care is the front door to a transformed

system of care in which multi-disciplinary care teams share responsibility and risk with consumers in managing outcomes and costs. The "medical home 2.0" is an advancement in the design, delivery and payment for health care services that leverages emergent characteristics of a transformed health system -- shared decision-making with patients, multidisciplinary teams where all participate actively in the continuum of care, incentives for adherence to evidence-based practices and cost efficiency and health information technologies that equip members of the care team and consumers to make appropriate decisions and monitor results.

The medical home 2.0 is a promising and necessary improvement to the U.S. system of health care. It is more than a new way to pay primary care physicians; it is a new way to deliver improved health care in the U.S.



Paul H. Keckley, Ph.D.  
Executive Director  
Deloitte Center for Health Solutions



In 2007, the four societies released the *Joint Principles of the Patient-centered Medical Home*, which are summarized in Figure 1.

**Figure 1: Summary of Joint Principles of the Patient-centered Medical Home**

Principle	Description
Personal physician	Patients are assigned to a personal physician who provides "first contact, continuous and comprehensive care"
Physician-directed medical practice	Personal physician leads all other health care providers in the patient's care
"Whole person" orientation	Personal physician is responsible for all of the patient's care, including acute, chronic, preventive and end-of-life care
Integrated and coordinated care	Care is coordinated across all facilities through health care technology
Quality and safety	<ul style="list-style-type: none"> <li>Practice collaborates with patient and family to define a patient-centered care plan</li> <li>Practice uses evidence-based medicine and care pathways</li> <li>Practice performs continuous quality improvement by measuring and reporting performance metrics</li> <li>Patient feedback is incorporated into performance measurement</li> <li>Patients and families participate in practice quality improvement</li> <li>Information technology is a foundation of patient care, performance measurement, communication and patient education</li> <li>Practices are certified as patient-centered by non-governmental entities</li> <li>Physicians share in savings from reduced hospitalizations</li> <li>Physicians receive bonus payments for attaining predetermined quality metrics</li> </ul>
Enhanced access to care	Patients can take advantage of open scheduling, expanded hours and new communication options with the physician practice
Payments that recognize primary care added value	Payments should reflect both physician and non-physician value and encompass payments for all services, including non-face-to-face visits and care management

## Introduction

The patient-centered medical home (PCMH) is a way of organizing primary care so that patients receive care that is coordinated by a primary care physician (PCP), supported by information technologies for self-care management, delivered by a multi-disciplinary team of allied health professionals and adherent to evidence-based practice guidelines. The goal of the PCMH is to deliver continuous, accessible, high-quality, patient-oriented primary care.

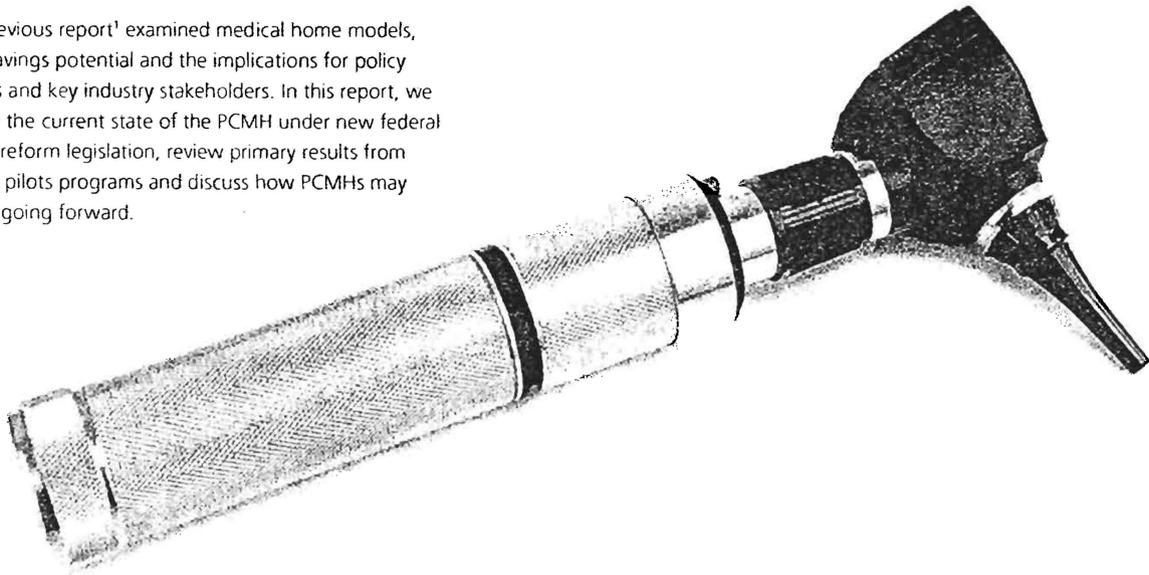
The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967; more recently (2006), it was used in pilot programs for Medicare enrollees. PCMH's potential to improve population-based outcomes and reduce long-term health care costs has its underpinning in the 2010 Patient Protection and Affordable Health Care Act (PPACA), where new pilot programs are funded.

Our previous report<sup>1</sup> examined medical home models, their savings potential and the implications for policy makers and key industry stakeholders. In this report, we outline the current state of the PCMH under new federal health reform legislation, review primary results from several pilots programs and discuss how PCMHs may evolve going forward.

## The medical home, pre- and post-reform

The PCMH is an innovative model of primary care delivery that espouses coordination of care as a necessary replacement for volume-based incentives that limit PCP effectiveness. It is widely touted by American Academy of Family Physicians (AAFP), AAP, American Osteopathic Association (AOA) and the American College of Physicians (ACP) as a means of reducing long-term health care costs associated with chronic diseases.<sup>2</sup>

The goal of the PCMH is to deliver continuous, accessible, high-quality, patient-oriented primary care.



<sup>1</sup> *The Medical Home: Disruptive Innovation for a New Primary Care Model*, Deloitte Center for Health Solutions. Available at <http://www.deloitte.com/us/medicalhome>

<sup>2</sup> *Joint Principles of the Patient-centered Medical Home*, American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association, March 2007, [http://www.acponline.org/advocacy/where\\_we\\_stand/medical\\_home/approve\\_ip.pdf](http://www.acponline.org/advocacy/where_we_stand/medical_home/approve_ip.pdf). Accessed June 2010.

The "patient-centered medical home" is referenced 19 times in PPACA<sup>3</sup> in the context of five major initiatives, which are detailed in Figure 2.<sup>4</sup>

Figure 2: PCMH References in the PPACA

PCMH Initiative	Description
Innovation Center	The Center for Medicare and Medicaid Innovation will be testing and evaluating models that include medical homes as a way of addressing defined populations with either: (1) poor clinical outcomes or (2) avoidable expenditures.
Health Plan Performance	Medical homes are identified as one performance indicator for health plans. Additionally, the state health insurance exchanges are designing incentives to encourage high-performance plans, including those with medical homes.
Chronic Medicaid Enrollee Care	Starting in 2011, the federal government will match state funds up to 90 percent for two years to those states that provide options for Medicaid enrollees with chronic conditions to receive their care under a medical home model.
Community Care	To encourage the establishment of medical homes in community health systems, PPACA is providing grants to community care teams that organize themselves under the medical home model.
New Model for Training	In conjunction with the Agency for Health Research & Quality (AHRQ), PPACA creates the Primary Care Extension Program, which provides primary care training and implementation of medical home quality improvement and processes.

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3 Lowes, Robert "Lack of Adequate Pay Reduces Effectiveness of Medical Home," *Medscape Medical News*, June 7, 2010.

4 Bernstein J, Chollet D, Peikes D, and Peterson GG "Medical Homes: Will they Improve Primary Care?" Issue Briefs, *Mathematica*, June 2010.

**Pilot programs and peer-reviewed literature**

While trade and peer-reviewed literature reference more than 100 planned or established PCMH pilot programs, results reporting (e.g., cost savings, population health

improvements) is scarce. The referenced programs (a few of which are listed in Figure 3) vary widely in structural characteristics, scope of patient enrollment, disease mix, operating models and sponsorship.

**Figure 3: Pilot Medical Home Programs in the U.S.<sup>5</sup>**

Program	State	Start	# Physicians
TransformMED National Demonstration Project: 36 family practices	Multiple	2006	TBD
Guided Care	MD	2006	49
Greater New Orleans Primary Care Access and Stabilization Grant	LA	2007	324
Louisiana Health Care Quality Forum Medical Home Initiative	LA	2007	500
Colorado Family Medicine Residency PCMH Project	CO	2008	320
Metcare of Florida/Humana Patient-centered Medical Home	FL	2008	17
National Naval Medical Center Medical Home Program	MD	2008	25
Blue Cross Blue Shield of Michigan: Patient-centered Medical Home Program	MI	2008	8,147
Priority Health PCMH Grant Program	MI	2008	108
CIGNA and Dartmouth-Hitchcock Patient-centered Medical Home Pilot	NH	2008	253
EmblemHealth Medical Home High Value Network Project	NY	2008	159
CDPHP Patient-centered Medical Home Pilot	NY	2008	18
Hudson Valley P4P-Medical Home Project	NY	2008	500
Queen City Physicians/Humana Patient-Centered Medical Home	OH	2008	18
TriHealth Physician Practices/Humana Patient-centered Medical Home	OH	2008	8
OU School of Community Medicine – Patient-centered Medical Home Project	OH	2008	TBD
Pennsylvania Chronic Care Initiative	PA	2008	780

continues on next page

5. Pilots and Demonstrations, The Patient-Centered Primary Care Collaborative Website, <http://www.pccpcc.net/pccpcc-pilot-projects>. Accessed June 2010

continued from previous page

Program	State	Start	# Physicians
Rhode Island Chronic Care Sustainability Initiative	RI	2008	28
Vermont Blueprint Integrated Pilot Program	VT	2008	44
Alabama Health Improvement Initiative—Medical Home Pilot	AL	2009	70
UnitedHealth Group PCMH Demonstration Program	AZ	2009	25
The Colorado Multi-Payer, Multi-State Patient-centered Medical Home Pilot	CO	2009	51
CareFirst BlueCross BlueShield Patient-centered Medical Home Demonstration Program	MD	2009	84
Maine Patient-centered Medical Home Pilot	ME	2009	221
IB PCMH Academic Collaborative	NC	2009	753
NH Multi-Stakeholder Medical Home Pilot	NH	2009	63
NJ Academy of Family Physicians/Horizon Blue Cross Blue Shield of NJ	NJ	2009	165
Greater Cincinnati Aligning Forces for Quality Medical Home Pilot	OH	2009	35
IB PCMH Academic Collaborative	SC	2009	753
Washington Patient-centered Medical Home Collaborative	WA	2009	755
West Virginia Medical Home Pilot	WV	2009	50
CIGNA/Piedmont Physician Group Collaborative Accountable Patient-centered Medical Home	GA	2010	93
WellStar Health System/Humana Patient-centered Medical Home	GA	2010	12
CIGNA/Eastern Maine Health Systems	ME	2010	30
NJ IQHC Medical Home Pilot	NJ	2010	17
D'icic PCMH pilot	OR	2010	1
Texas Medical Home Initiative	TX	2010	30
Medicare-Medicaid Advanced Primary Care Demonstration Initiative	Up to 6 states	2011	TBD

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*Academic research: Systematic review of results*

Of the few substantive, academically rigorous studies conducted on PCMHs, three of the more robust are summarized below:

**Study #1** – Researchers at Harvard Medical School, Brigham and Women’s Hospital and Beth Israel Deaconess Medical Center identified 26 ongoing PCMH pilots,<sup>6</sup>

encompassing 14,494 physicians in 4,707 practices and five million patients. The team’s analysis spotlighted the highly variable structural, financial and operational features of these PCMHs (Figure 4). In addition, the team observed that PCMHs employ one of two basic practice models: (1) a collaborative learning chronic care management model or (2) an external consultant-facilitated model.

**Figure 4: Variability of 26 Ongoing PCMH Pilots<sup>7</sup>**

Approach	Characteristic	Frequency*
Transformation Model	Consultative	35%
	Chronic care model-based learning collaborative	23%
	Combination	15%
	None	27%
Use of Facilitator	Internal	27%
	External	42%
	None	31%
Focus of Improvement	General	46%
	Disease-specific	54%
Information Technology*	EMR	69%
	Registry	81%
	Neither are required nor encouraged	8%
Payment Model*	Single payor	69%
	Multi-payors that have Safe Harbors	44%
	Use FFS Payments	100%
	Typical FFS payments	96%
	Enhanced FFS payments	4%
	Use some form of per-person, per-month payments (PPPM)	96%
Incorporate bonus payments (Either existing P4P programs or new programs)	77%	

Adapted from Bitton, A, Martin C, and Landon B. "A nationwide survey of patient centered medical home demonstration projects," *J Gen Intern Med*, June 2010, 25(6) 584-92

\* Respondents are able to choose more than one response, therefore, frequencies may total more than 100 percent

6 Bitton A, Martin C, Landon BE "A nationwide survey of patient-centered medical home demonstration projects," *J Gen Intern Med*, June 2010, 25(6) 584-92

7 Ibid

**Study #2** – A 2010 study led by researchers at Harvard Medical School analyzed seven medical home programs (Figure 5) to assess features of those deemed successful.<sup>8</sup> Sponsors of these programs included prominent commercial health plans, integrated health systems and government-sponsored programs: Colorado Medical Homes for Children, Community Care of North Carolina,

Geisinger Health System, Group Health Cooperative, Intermountain Health Care, MeritCare Health System and Blue Cross Blue Shield of North Dakota, and Vermont's Blueprint for Health. The selected programs were measured on improvements in the number of hospitalizations and savings per patient.

**Figure 5: Analysis of Seven PCMH Pilot Programs<sup>9</sup>**

Pilot	# of Patients	Population	Incentives	Results		
				Hospitalization reduction (%)	ER visit reduction (%)	Total savings per patient
Colorado Medical Homes for Children	10,781	Medicaid CHP+	Pay for Performance (P4P)	18%	NA	\$169-530
Community Care of North Carolina	> 1 million	Medicaid	Per Member Per Month (PMPM) payment	40%	16%	\$516
Geisinger (ProvenHealthNavigator)	TBD	Medicare Advantage	P4P; PMPM payment; shared savings	15%	NA	NA
Group Health Cooperative	9,200	All	TBD	11%	29%	\$71
Intermountain Health Care (Care Management Plus)	4,700	Chronic disease	P4P	4.8-19.2%	0-7.3%	\$640
MeritCare Health System and Blue Cross Blue Shield of North Dakota	192	Diabetes	PMPM payment; shared savings	6%	24%	\$530
Vermont BluePrint for Health	60,000	All	PMPM payment	11%	12%	\$215

Adapted from Fields D, Leshen E, and Patel K. "Driving quality gains and cost savings through adoption of medical homes," *Health Affairs*, May 2010; 29(5): 819-826. Appendix Exhibit 1

8 Fields D, Leshen E, Patel K. "Driving quality gains and cost savings through adoption of medical homes," *Health Affairs*, May 2010; 29(5): 819-27.

9 Ibid

Despite the sample's heterogeneity, the research team concluded that four common features were salient to the seven programs' success:<sup>10</sup>

- Dedicated care managers
- Expanded access to health practitioners
- Data-driven analytic tools, and
- New incentives.

**Study #3** – The National Demonstration Project (NDP) published its preliminary results in 2010 after examining medical home programs between 2006 and 2008. Designed by TransforMED, a subsidiary of the AAFP, the project was the first systematic test of PMCH effectiveness across 36 family practices in several states.<sup>11</sup> The research team concluded that the PCMH model is potentially effective in reducing costs and improving health status but requires significant investment and operating competencies that might be problematic to traditional practitioners.<sup>12,13,14</sup> Among the study's major takeaways:

- **Change is hard.** Both facilitated and self-directed practices implemented 70 percent of NDP PCMH model components; however, implementation was challenging and disruptive.
- **Some practices are better at changing than others.** The demonstration suggested that facilitation improved practices' ability to change, termed "adaptive reserve." Additionally, the practices' "adaptive reserve" weakly correlated with their ability to put PCMH components in place.

- **Practices that received help had an easier time.** Facilitation also increased adoption of PCMH components.
- **IT implementation is easier than changing care delivery.** While both the facilitated and self-directed groups easily implemented EMRs, practices struggled to implement e-visits, group visits, team-based care, wellness promotion and population management.
- Practices had to shift from physician-centered to patient-centered care – a difficult transition for physicians used to being responsible for the entire patient encounter.
- Care pathways required front- and back-office coordination and significant training efforts.
- **Patients may not be quick to appreciate the change.** On the whole, patients did not perceive the transformation to be beneficial, likely because of disruption in the practice and a lack of communication about the benefits of a medical home – e.g., the accessibility of nurse practitioners as opposed to waiting for a doctor's appointment.

10. Fields D, Leshen E, Patel K. "Driving quality gains and cost savings through adoption of medical homes." *Health Affairs*, May 2010, 29(5): 819-826 doi: 10.1377/hlthaff.2010.0009

11. *Ann Fam Med*, 2010 8: S2-8

12. Nutting PA, Crabtree BF, Miller WL, Stewart EE, Stange KC, Jaen CR. "Journey to the Patient-centered Medical Home: A Qualitative Analysis of the Experiences of Practices in the National Demonstration Project." *Ann Fam Med*, 2010, 8 (Suppl 1):s45-s56.

13. Nutting PA, Crabtree BF, Stewart EE, Miller WL, Palmer RF, Stange KC, Jaen CR. "Effect of Facilitation on Practice Outcomes in the National Demonstration Project Model of the Patient-centered Medical Home." *Ann Fam Med*, 2010 8: S33-44

14. Jaen CR, Ferrer RL, Miller WL, Palmer RF, Wood R, Davila M, Stewart EE, Crabtree BF, Nutting PS, Stange KC. "Patient Outcomes at 26 Months in the Patient-centered Medical Home National Demonstration Project." *Ann Fam Med*, 2010 8: S51-67.

The quest for metrics.

The scarcity of academic and trade industry research on PCMHs is problematic. Similarly, the fact that half of PCMH pilots to date identified metrics for calculating results *a priori* is troublesome.<sup>15</sup> Fortunately, credible organizations are making strides to bridge the gap in the quest for valid and reliable PCMH metrics. For example, the National

Committee for Quality Assurance (NCQA) issued scoring guidelines that are used widely by pilot programs.<sup>16</sup> Its Physician Practice Connections – Patient-centered Medical Home (PPC-PCMH), shown in Figure 6, provides nine “must pass” standards, scored on a scale up to 100 total points, with three levels of recognition.<sup>17</sup>

**Figure 6: PPC-PCMH Content and Scoring Correlated to Seven “Joint Principles”<sup>18</sup>**

Core Principles of the Patient-Centered Medical Home Covered in the Tool					
PCMH Domain	Physician-led Practice	Whole-person Orientation	Team-based Care	Quality and Safety	Physical Access
Access and Communication					Setting and measuring access standards (9 pts)
Patient Tracking and Registry Functions			Clinical data systems, paper or electronic charting tools to organize clinical information (14 pts)	Registries for population management and identification of main conditions in practice (7 pts)	
Care Management	Use of non-physician staff to manage care (3 pts)	Care management (5 pts)	Coordinating care and follow-up (5 pts)	Implementing evidence-based guidelines for three conditions and generating preventive service reminders for clinicians (7 pts)	
Health Self-Management		Supporting self-management (4 pts)			Assessment of communication barriers (2 pts)
Quality Improvement				E-prescribing and cost and safety check functions (8 pts)	
Population Health				Electronic systems to order, retrieve and track tests (13 pts)	
Measurement and Reporting				Automated system (4 pts)	
Performance Reporting				Performance measurement and reporting, quality improvement and seeking patient feedback (15 pts)	
Interoperability			E-communication with DM or CM managers (1 pt)	E-communication to identify patients due for care (2 pts)	Interactive web site that facilitates access (1 pt)
	3 pts	9 pts	20 pts	56 pts	12 pts

Adapted from Landon BE, Gill JM, Antonelli RC, and Rich EC. “Prospects For Rebuilding Primary Care Using The Patient-Centered Medical Home,” *Health Affairs*, May 2010, 29(5) 827-834

15 Bitton A, Martin C, Landon BE. “A nationwide survey of patient-centered medical home demonstration projects,” *J Gen Intern Med*, June 2010; 25(6): 584-92

16 Ibid

17 www.ncqa.org.

18 Landon BE, Gill JM, Antonelli RC and Rich EC. “Prospects For Rebuilding Primary Care Using the Patient-Centered Medical Home,” *Health Affairs*, May 2010, 29(5) 827-834

Other notable measurement efforts include the Primary Care Assessment Survey,<sup>19</sup> the Primary Care Assessment Tool,<sup>20</sup> the Components of Primary Care Instrument,<sup>21</sup> the Patient Enablement Instrument, the Consultation and Relational Empathy measure, the Consultation Quality Index and the Medical Home Intelligence Quotient.<sup>22,23</sup>

The medical home model's clinical and economic potential is promising; however, the precise features of an optimally successful program are somewhat elusive. Our findings:

- **With significant investment, the PCMH yields results.** Pilot data suggest that patient outcomes improve and costs are lower with PCMH implementation, but start-up and maintenance costs are high. In particular, fixed costs for information technologies and a multi-disciplinary care team are substantial.
- **Physician adoption is a major challenge.** Among the core competencies required of PCPs to effectively participate in medical home models are: (1) willingness to develop, update and adhere to evidence-based clinical guidelines; (2) flexibility to incorporate feedback from care team members and patients; (3) willingness to use health information technologies (HITs) in diagnostics and treatment planning and routine patient interaction; and (4) willingness to take risk in contracting with payors (health plans/employers). Notably, these principles were espoused as the basis of the "future of medicine" by the Institute of Medicine (IOM) and are now incorporated in clinicians' medical training. However, established practitioners are prone to discount these principles in favor of an overly simplistic preference that they be paid more and not be exposed to risk.
- **HIT is the essential front-end investment.** For patients to receive appropriate care and care teams to effectively manage and monitor patient behavior,

a robust HIT investment including electronic medical records, broadband transmission, personal health records, decision support and web-based services to facilitate access are necessary. HIT represents a major investment; most practices will require assistance with its purchase and implementation.

- **One size does not fit all.** The pilots and academic research suggest wide disparity in PCMH approaches and operating features. Also, existing data is too inconclusive to define the features and incentives that work best for given patient populations. Conceivably, the medical home 2.0 has the ability to serve consumer needs of across the care continuum – preventive, chronic, acute and long-term.
- **Access to an adequate supply of primary care service providers is an issue.** PCPs account for 35 percent of the U.S. physician workforce, compared to 50 percent in most of the world's developed health systems.<sup>24</sup> By 2025, the U.S. will face a 27 percent shortage of adult generalist physicians. Even with increased supply via the expansion of residency programs, demand for primary care services will exceed the supply of providers.<sup>25</sup> Expanding the scope of practice for advanced practice nurses, mitigating frivolous liability claims, improving respect for the profession among medical peers, increasing e-visits, distance/telemedicine, group visits and changes in clinical processes are essential to bolstering the practice of primary care medicine.
- **Incentives must be aligned and realistic.** The Patient-centered Primary Care Collaborative proposed a clinician payment model (used in a number of pilots) which includes three pragmatic incentive elements:
  - A monthly care coordination payment to support the medical home structure
  - A visit-based, fee-for-service component relying on the current fee-for-service system
  - A performance-based component that recognizes the achievement of quality and efficiency goals<sup>26</sup>

19. Safran DG, Kosinski M, Tarlov AR, Rogers WH, Taira DH, Lieberman N, et al. "The Primary Care Assessment Survey: tests of data quality and measurement performance," *Med Care*, 1998, 36(5): 728-39.

20. Shi L, Starfield B, Xu J. "Validating the adult primary care assessment tool," *J Fam Pract*, 2001, 50(2): 161W-75W

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26. Patient-Centered Primary Care Collaborative. Reimbursement reform: proposed hybrid blended reimbursement model [Internet]. Washington (DC): PCPCC; 2007 May [cited 2010 Apr 15]. Available at <http://www.pcpcc.net/reimbursement-reform>

These elements seem to form a reasonable foundation for payment transformation in primary care. However, one issue could impact the third element: the validity and reliability of metrics used to define “quality” and “efficiency” and the timeframe (in months or years, depending on the patient population) in which they’re captured. As these metrics evolve, the relationships between medical homes and specialty practices will necessarily need refinement; also, metrics will need to be developed that reward appropriate inclusion of specialty medicine in targeted patient populations.

#### Closing thought

The medical home of the future likely will be a refinement of the assorted pilots and programs currently under way. We remain supportive and optimistic about its potential, as well as realistic that answers to its challenges will not be quickly available.

The medical home 2.0 is an innovation whose time has come. The confluence of rising health costs, an aging and less healthy population, payment reforms shifting volume to performance, and increased access to clinical information technologies that enhance coordination and connectivity between care teams and consumers suggest that the medical home will likely be a permanent, near-term fixture on the U.S. health care landscape.

Credible organizations are making strides to bridge the gap in the quest for valid and reliable P4M metrics.



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# Deloitte

## Center for Health Solutions

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# FISCAL NOTE

LEGISLATIVE FISCAL ANALYST ESTIMATE

ESTIMATE OF FISCAL IMPACT – STATE AGENCIES *				
	FY 2009-10		FY 2010-11	
	EXPENDITURES	REVENUE	EXPENDITURES	REVENUE
GENERAL FUNDS	16,579			
CASH FUNDS				
FEDERAL FUNDS	16,579			
OTHER FUNDS				
TOTAL FUNDS	33,158		See below	

\*Does not include any impact on political subdivisions. See narrative for political subdivision estimates.

This bill requires the Department of Health and Human Services to apply for a waiver or an amendment to an existing waiver for the purpose of providing medical assistance for family planning services for persons whose family earned income is at or below 185% of the federal poverty level.

A half-time program specialist would be needed to develop the waiver. The costs would be \$33,158 (\$16,579 GF and FF) in FY 10 and \$13,726 (\$6,863 GF and FF) in FY 11.

The Department of Health and Human Services estimates that it could take up to 15 months from the effective date of the bill to receive federal waiver approval and implementation begins. The department also estimates based on the U. S. Census statistics that approximately 24,725 women who currently do not qualify would become eligible for family planning services at 185% of the federal poverty level. The approximate cost per recipient is \$184. The state match for family planning services is 10% with 90% paid by the federal government. Assuming an implementation date of December 2010, for seven months in FY 11, the cost of family planning services is estimated to be \$2,653,817 (\$265,382 GF and \$2,388,435 FF).

Eligibility would be based on income only. The department estimates that one eligibility worker is needed per 1,000 applicants. The cost would be \$817,946 (\$408,973 GF and FF) in FY 11. Under the current eligibility determination process, this number of workers would be needed. The department is transitioning to a new application process called ACCESSNebraska. This will be an on-line and phone application process with all records filed and stored electronically. Currently, online application is available and by FY 12, the process will be fully automated with the option to apply over the phone. The number of eligibility workers is projected to decrease every year starting in FY 10 with the largest decline in FY 12. With the implementation of the waiver estimated to be December 2010 along with the phased-in implementation of ACCESSNebraska, it is likely fewer than 24 additional workers may be required.

An evaluation of other states family planning waivers was conducted by the CNA Corporation under contract with the federal Centers for Medicare and Medicaid (CMS). The report published in 2003 showed family planning waivers saved millions of dollars in all six state programs that were evaluated. The states were Alabama, Arkansas, California, New Mexico, Oregon and South Carolina. In calculating the potential savings in Nebraska, the department assumes 4% of the women receiving services would have otherwise have had a birth that would be covered by Medicaid. Using this assumption, the savings would be \$11,210,315 (\$4,484,126 GF and \$6,726,189 FF) in FY 12. This is based on the cost of prenatal care and delivery at \$9,360 and medical services for an infant up to one year of age at \$1,975. Prenatal care, delivery and medical care for a newborn is matched at 60% from the federal government with 40% paid by the state.

The net minimum annual savings in FY 12 and beyond is estimated to be \$5,842,969 (\$3,620,213 GF and \$2,222,756 FF).

# STATE MEDICAID FAMILY PLANNING ELIGIBILITY EXPANSIONS

STATE	BASIS FOR ELIGIBILITY			ELIGIBLE CLIENTS INCLUDES		APPLICATION/ REIMBURSEMENT AT FIRST VISIT	ACCESS NECESSARY DOCUMENTS FOR CLIENTS	REIMBURSE PROVIDERS FOR APPLICATION ASSISTANCE	WAIVER EXPIRATION DATE
	Losing Coverage Postpartum	Losing Coverage for Any Reason	Based Solely on Income	Men	Limited to Those 19 and Older				
Alabama			133%		X		X*		9/30/11
Arizona	2 years						X*		9/30/11
Arkansas			200%						1/31/12
California			200%	X		X			10/31/10
Delaware		2 years							9/30/10
Florida		2 years							11/30/10
Illinois		†	200%		X				3/31/12
Iowa	‡		200%			X	X*		1/31/11
Louisiana			200%		X		X*	X	7/1/11
Maryland	5 years								6/30/11
Michigan			185%		X		X*		3/1/11
Minnesota			200%	X		X	X		6/30/11
Mississippi			185%						9/30/11
Missouri			185%		X				9/30/10
New Mexico			185%		X†				10/31/10
New York	‡		200%	X			X		9/30/11
North Carolina			185%	X	X		X		12/31/10
Oklahoma			185%	X	X			X	10/31/10
Oregon			185%	X		X <sup>Ω</sup>	X	X	10/31/12
Pennsylvania			185%		X <sup>ψ</sup>	X <sup>Ω</sup>	X		6/1/12
Rhode Island	2 years								9/30/11
South Carolina			185%				X*		12/31/10
Texas			185%		X <sup>ψ</sup>		X*		12/31/11
Virginia	‡		133%	X			X		3/31/11
Washington			200%	X			X	X	11/30/10
Wisconsin			200%	X		X <sup>Ω</sup>	X		12/31/10
Wyoming	Unlimited				X				8/31/13
<b>TOTAL</b>	<b>4</b>	<b>2</b>	<b>21</b>	<b>9</b>	<b>11</b>	<b>6</b>	<b>15</b>	<b>4</b>	

\* Only for clients born in state.

† State also extends Medicaid eligibility for family planning services to these individuals.

‡ Applies to women ages 18-50.

Ω Use state funds to reimburse for some or all initial visits.

ψ Expansion includes women who are at least 18 years of age.

## Women and Medicaid in Nebraska

(As of February 2010)

Medicaid, the national health insurance program for low-income people, plays a critical role in providing health coverage for women. Nationally, nearly 17 million nonelderly women—including 8 percent of those living in Nebraska—are covered through Medicaid.<sup>1,2</sup> In fact, women comprise the majority (67 percent) of Nebraska's adult Medicaid beneficiaries.<sup>3</sup> Women are more likely than men to qualify for Medicaid because they tend to be poorer and are more likely to meet the program's stringent eligibility criteria. Women are also more likely to hold low-wage or part-time jobs that do not offer employer-sponsored health benefits, so Medicaid may be their only possible source of coverage.<sup>4,5</sup>

Medicaid is jointly funded by the federal and state governments and is administered by the states. Though states must comply with a host of federal Medicaid requirements, they can exercise flexibility with regards to certain program elements. There is considerable state variation, for instance, in who is able to get coverage through Medicaid, the income level needed to qualify, and the services that the program covers.

### **Nearly one in ten women in Nebraska receives health care coverage through Medicaid.**<sup>6</sup>

- Medicaid is the most important source of coverage for low-income women. In 2006-07, 22 percent of all low-income women in Nebraska were enrolled in the program.<sup>7</sup>

### **Medicaid ensures that women in Nebraska have access to a comprehensive set of important health care services.**

- Medicaid programs are required to provide certain health services to some covered populations—including family planning services, inpatient and outpatient hospital care, and pregnancy-related care—and the program has traditionally provided beneficiaries with a comprehensive set of health benefits. The Deficit Reduction Act of 2005, however, allows states to provide more limited benefit packages (without coverage for mental health services or prescription drugs, for example) to certain enrollees.<sup>8</sup>
- Nebraska's Medicaid program also covers treatment for breast and cervical cancer for low-income women, though to be eligible for this treatment women must be screened

### **Medicaid Eligibility Limits for Women in Nebraska, 2010<sup>1</sup>**

- ⊙ **Women with dependent children:** 58% of the Federal Poverty Level (FPL)<sup>2</sup>
- ⊙ **Women without dependent children:** Not eligible (regardless of income)
- ⊙ **Pregnant women:** 185% of the FPL
- ⊙ **Disabled and aged women:** 100% of the FPL
- ⊙ **Women who have breast and cervical cancer:** 250% of the FPL

*Notes:* 1. May include eligibility limits for the Children's Health Insurance Program (CHIP) or state-funded public health insurance programs. 2. The FPL in 2010 is \$10,830 annually for an individual or \$18,310 for a family of three.

*Source:* Kaiser Family Foundation, State Health Facts, [www.statehealthfactsonline.org](http://www.statehealthfactsonline.org) (Accessed February 2010).

and diagnosed as part of the CDC's National Breast and Cancer Early Detection Program. The federal guidelines for the CDC program establish an eligibility baseline to target services to uninsured and underinsured women at or below 250 percent of the FPL.<sup>9</sup> In 2006, 356 women were enrolled in Nebraska's breast and cervical cancer treatment program.<sup>10</sup>

### **Reproductive health services are a vital component of women's Medicaid coverage.**

- In 2006, Medicaid provided basic health services to a total of 7.3 million American women of reproductive age (15-44 years old).<sup>11</sup>
- Medicaid is the largest public funder of family planning services in the United States. In 2006, the program contributed \$1.3 billion toward family planning nationally, accounting for 71 percent of all public spending on these essential services.<sup>12</sup>
- Medicaid is also an essential source of coverage for maternity care, and covers 40 percent of all births in Nebraska.<sup>13</sup> The program covers prenatal visits and vitamins, ultrasound and amniocentesis screenings, childbirth by vaginal or caesarean delivery, and 60 days of postpartum care.<sup>14</sup> Nationally, pregnancy-related services account for the largest share of Medicaid's hospital charges.<sup>15</sup>

### **Nebraska's Medicaid program is important for low-income women of all ages.**

- For elderly women who meet income eligibility requirements, the program covers high-cost services provided in a skilled nursing facility, as well as home and community-based health care for women who are entitled to nursing facility services.<sup>16</sup>
- 35 percent of all female Medicaid beneficiaries in Nebraska were age 50 or older in 2007.<sup>17</sup> These women typically rely on the program for: health care related to a physical or mental disability or chronic condition; treatment for breast or cervical cancer; long-term care services; or, cost-sharing required under Medicare.<sup>18</sup>

### **Women and Medicaid in Nebraska: What Can Women's Advocates Do?**

*Women's advocates can work to strengthen and improve their state's Medicaid program while protecting against cuts in services and/or eligibility.* Policymakers will continue to debate the role that Medicaid and other public coverage programs should play in the U.S. health care system. Budget pressures at the state and federal level will continue to pose threats to this essential health insurance program. Advocates should understand Medicaid's significance for women and support legislation that will strengthen Medicaid, ensure that the program is adequately funded, and improve program enrollees' access to care.

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<sup>1</sup> Kaiser Family Foundation, *Women's Health Insurance Coverage* (Oct. 2009), <http://www.kff.org/womenshealth/upload/6000-08.pdf>

<sup>2</sup> Kaiser Family Foundation, *Health Insurance Coverage of Women Ages 18-64, by State, 2007-2008* (Oct. 2009), <http://www.kff.org/womenshealth/upload/1613-09.pdf>



Center for Medicaid, CHIP and Survey & Certification

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SMDL#10-013  
ACA# 4

July 2, 2010

RE: Family Planning Services Option  
and New Benefit Rules for Benchmark Plans

Dear State Health Official:

This letter is intended to provide guidance on the implementation of two Medicaid benefits-related provisions in the Affordable Care Act (ACA); P.L. 111-148, as amended by the Health Care and Education Recovery Act of 2010; P.L. 111-152. Both provisions were effective as of March 23, 2010.

This letter provides guidance on *section 2303 of ACA: State Eligibility Option for Family Planning Services*, which establishes a new Medicaid eligibility group and the option for States to begin providing medical assistance for family planning services and supplies to individuals eligible under this new group. Under this new option, Federal funding will be available for States to provide coverage under the State plan for family planning and family planning-related services and supplies to individuals (men and women) that States could previously offer only through demonstration projects.

Additionally, this letter provides guidance on *section 2001(c) of ACA: Medicaid Coverage for the Lowest Income Populations*, which makes certain benefit changes that were enacted as part of the Affordable Care Act to benchmark plans.

## STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES

### Background

Since 1972, States have been required to provide family planning services and supplies to Medicaid populations. Prior to ACA, States did not have the option to provide family planning services and supplies under their Medicaid State plans to individuals otherwise ineligible for Medicaid, including parents with incomes above State eligibility levels and non-disabled adults who were not caring for children. Because the provision of such services has been found to be cost effective for the Medicaid program, the Secretary of Health and Human Services has granted targeted section 1115 family planning demonstrations to permit States to cover family planning services and supplies for individuals not otherwise eligible for Medicaid. With the enactment of ACA, States now have the option to offer, under State plan authority, eligibility for family planning coverage for individuals who were previously ineligible for Medicaid.

### The New Family Planning Eligibility Group

Section 2303 of ACA establishes a new optional categorically needy group that became effective on March 23, 2010. Specifically, section 2303(a)(1) of ACA establishes a new eligibility group under section 1902(a)(10)(A)(ii)(XXI) of the Social Security Act (the Act). Individuals eligible under the new family planning group are individuals (men and women):

- Who are not pregnant; and
- Whose income does not exceed the income eligibility level established by the State.

Note that the income level established by the State may not exceed the highest income level for pregnant women under the State's Medicaid or CHIP State plan. For purposes of determining eligibility and complying with section 1902(a)(17)(B) of the Act, States have the option to consider only the income of the applicant or recipient. Additionally, States may determine income eligibility for individuals under this family planning option by using the same methodology that would apply for pregnant women. This includes the methodology that counts the applicant as a household of two (or more depending on the presence of others in the family) when determining income eligibility.

In addition, the State has the option of including in this new, optional group, individuals who would have been eligible for an approved section 1115 family planning demonstration, had they applied for such demonstration on or before January 1, 2007, using the eligibility standards and procedures imposed by the State at that time. States must not restrict eligibility based on age. Under standard Medicaid rules, however, States may limit services based on medical necessity.

Some of the individuals that a State might cover under this new option (depending on their income) may be eligible for a more comprehensive set of benefits as States implement Medicaid and other coverage expansions under the ACA. Taking up the new family planning eligibility group does not preclude or in any way affect receipt of the increased matching rate (based on the requirements in effect when this group becomes mandatory in 2014). CMS will issue separate guidance on the matching rate provisions in the new health insurance reform legislation.

### Benefits Available to Individuals in the New Family Planning Group; Applicable Federal Matching Rates

The services available for this new group are described in section 2303(a)(3) of ACA, amending section 1902(a)(10)(G) of the Act. Services available are limited to family planning services and supplies described in section 1905(a)(4)(C), as well as such "medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting." We are interpreting this language to provide for coverage of both family planning and family planning-related services, maintaining their longstanding separate definitions.

- Family planning services and supplies are described in section 1905(a)(4)(C). These services and supplies are reimbursable at the 90 percent matching rate under the new family planning option. These are the same services that are covered at the 90 percent matching rate for other Medicaid State plan beneficiaries. Individuals in this new family

planning group must receive the same 1905(a)(4)(C) services that other categorically needy individuals receive.

- Family planning-related services are medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting. These services can be covered under the new option but are reimbursable at the State's regular Federal medical assistance percentage (FMAP) rate.

### *Family Planning-Related Services*

Family planning-related services have historically been considered those services provided in a family planning setting as part of or as follow-up to a family planning visit. Such services are provided because they were identified, or diagnosed, during a family planning visit. As noted above, these services are reimbursable at the State's regular FMAP rate.

The following are examples of family planning-related services:

- Drugs for the treatment of sexually-transmitted diseases (STD) or sexually-transmitted infections (STI), except for HIV/AIDS and hepatitis, when the STD/STI is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may be covered. In addition, subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.
- Some States and family planning programs encourage men to have an annual visit at the office/clinic. Such an annual family planning visit may include a comprehensive patient history, physical, laboratory tests, and contraceptive counseling.
- Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may be covered.
- Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to a family planning service in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.
- Treatment of Major Complications

The following are examples of treatment of major complications that States may cover:

- Treatment of a perforated uterus due to an intrauterine device insertion;
- Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or,
- Treatment of surgical or anesthesia-related complications during a sterilization procedure.

It should be noted that for persons who have had a sterilization, States must cover family planning-related services that were provided as part of, or as follow-up to, the family planning visit in which the sterilization procedure took place.

### Presumptive Eligibility

A new section 1920C of the Act, as added by section 2303(b) of ACA, gives States that have adopted the new family planning eligibility group the option of also providing a period of presumptive eligibility based on preliminary information that an individual meets the eligibility criteria for family planning services in new section 1902(ii). The presumptive eligibility period allows health providers to receive reimbursement (and States to receive Federal matching funds) for medical assistance for an individual who has been determined presumptively eligible by a qualified entity during a specific period. In general, a qualified entity is an entity that is eligible to receive payments under the approved State plan and is determined by the State agency to be capable of making presumptive eligibility determinations. Please note that the State may limit the classes of entities that may become qualified entities to ensure program integrity.

The qualified entity must inform the State agency of the presumptive eligibility determination within 5 working days after the determination is made and inform the presumptively eligible individual that he or she must file an application for assistance no later than the last day of the month following the month during which the determination is made. The State agency must provide the qualified entities with necessary forms for the individual to file an application and information on how to assist individuals in completing the forms. Documentation for various factors of eligibility, such as citizenship, are not required for the presumptive determination, but will be requested when the application is filed. The State's reasonable opportunity period for submission of citizenship documentation also begins at this point. Please refer to the letter to State Health Officials (SHO# 09-016) issued December 28, 2009 for further guidance on citizenship documentation. Nothing prevents a State from using a simplified application form as its presumptive eligibility form. This can streamline the process and help ensure that all individuals are considered for ongoing eligibility.

The actual presumptive eligibility period begins with the date on which the qualified entity determines that the individual is eligible based on preliminary information. The presumptive eligibility period ends with and includes the earlier of:

1. The day on which a formal eligibility determination is made for the family planning program under the Medicaid State plan; or
2. For an individual who does not file an application by the last day of the month following the month during which the individual was determined presumptively eligible, the last day of that month is the last day of the presumptive eligibility period. For example, if an individual is determined presumptively eligible on April 1, but the individual does not file an application by May 31, then the last day of the presumptive eligibility period is May 31.

For individuals determined to be presumptively eligible under this category, medical assistance shall be limited to family planning services and supplies described in section 1905(a)(4)(C), and at the State's option, medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting (family planning-related services, as described above).

### Converting Family Planning Section 1115 Demonstrations

Currently, 22 States have approved stand-alone section 1115 family planning demonstrations. If a State with a demonstration wants to adopt the new State plan family planning optional group, it would need to submit a SPA to select this option (see below). In addition, the State should notify its project officer and the CMS Regional Office State representative of its request to terminate the family planning demonstration at such time as the SPA is approved. Since States would be shifting a population from the demonstration to the Medicaid State plan, the State would *not* need to submit a demonstration phase-out plan as defined in the special terms and conditions. However, the State should notify individuals that they are no longer enrolled in a section 1115 research and demonstration project, but instead are now enrolled in the Medicaid State plan option for family planning services. In addition, the State must submit a final report on its demonstration no later than 12 months after terminating the demonstration. With respect to budget neutrality, CMS would apply budget neutrality terms through the effective date of the SPA.

Please note, if a State that was providing family planning services through a section 1115 demonstration on March 23, 2010 chooses the State plan option, it must, at a minimum, maintain current eligibility until the State has established a health benefit exchange under ACA (or October 1, 2019 for individuals under age 19) due to statutory maintenance of effort requirements under the American Recovery and Reinvestment Act (ARRA) of 2009 (Pub.L. 111-5) and ACA.

Five States have comprehensive section 1115 demonstrations that include a targeted family planning component. If a State wishes to cover the family planning population under the Medicaid State plan, it should submit a SPA and a Demonstration amendment removing the population as of the effective date of the SPA.

A State electing to keep this population in its targeted or comprehensive demonstration may do so as well. However, the State may need to submit an amendment to the demonstration in order to renegotiate budget neutrality.

### Other Applicable Rules

All rules applicable under the Medicaid program in general apply to this new optional eligibility group, including rules relating to cost sharing, citizenship, immigration, and third party liability.

In addition, a State that elects to extend eligibility to this group must include consideration of this new eligibility group when it determines whether an individual who has qualified under another eligibility category continues to qualify for Medicaid. For example, under existing regulatory requirements, before terminating coverage for a woman who has been eligible for

Medicaid as a pregnant woman and will lose such eligibility at the end of the 60-day post partum period, the State must perform an ex parte review to determine whether the woman would be eligible under another eligibility group. If the State elects to offer coverage under the new family planning eligibility group, this review must include consideration of whether the woman is eligible under that new group.

### Submission of SPAs

To implement this new optional group, States will need to submit an amendment to their Medicaid State plan. We are ready to work with States interested in adopting this new option and to assist States in amending their plans.

## RECENT CHANGES TO MEDICAID BENCHMARK BENEFITS

### Background

On April 30, 2010, a final rule on State Flexibility for Medicaid Benefit Packages was published in the Federal Register (75 FR 23068), which revised the December 3, 2008, final rule (73 FR 73694). This final rule became effective on July 1, 2010 and implements provisions of section 6044 of the Deficit Reduction Act of 2005 (Pub. L. 109-171), which added a new section 1937 that allows States to amend their Medicaid State plans to provide for the use of benefit packages other than the standard benefit package for certain populations. These alternative benefit packages are referred to as benchmark and benchmark-equivalent benefit packages. The April 30 final rule also incorporates provisions of ARRA and implements provisions of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (Pub. L. 111-3). This final rule delineates what benefit packages qualify as benchmark packages, what would constitute a benchmark-equivalent package, and which specific services must be included in a benchmark benefit plan or provided as an additional service. However, the rule did not address the ACA provisions relating to benchmark plans, including sections 2001(c) and 2303(c) which amended section 1937 of the Act. This letter describes the new ACA provisions in 2001(c) and 2303(c) that were effective upon enactment (March 23, 2010).

Specifically, section 2001(c) of ACA adds mental health services and prescription drug coverage to the list of required services that must be included in benchmark-equivalent coverage. In addition, section 2303(c) of ACA requires States providing medical assistance to individuals described in section 1905(a)(4)(C) of the Act, through enrollment in benchmark or benchmark-equivalent coverage, to cover family planning services and supplies.

### Implementation

The above services are requirements of benchmark and benchmark-equivalent coverage for States that provide coverage through such plans. Accordingly, States that choose to provide medical assistance through benchmark or benchmark-equivalent coverage must now comply with all provisions of the April 30, 2010 final rule, as well as the provisions of section 2001(c) and 2303(c) of ACA described in this letter. CMS will apply these requirements in reviewing new State plan amendments and monitoring currently approved State Medicaid plans. Note that beginning in 2014, benchmark and benchmark-equivalent plans must begin providing at least

essential health benefits, as described in Section 1302(b). These issues will be addressed at a later date.

We hope this information will be helpful. CMS is available to provide technical assistance to States with existing benchmark plans to ensure the plans comply with these benefit rules. Questions regarding this guidance may be directed to Ms. Vikki Wachino, Director, Family and Children's Health Programs Group, at (410) 786-5647. We look forward to our continuing work together as we implement this important legislation.

Sincerely,

/S/

Cindy Mann  
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators  
Division of Medical and Children's Health

Ann C. Kohler  
NASMD Executive Director  
American Public Human Services Association

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Director, Health Committee  
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National Governors Association

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National Academy for State Health Policy

Christine Evans, M.P.H.  
Director, Government Relations  
Association of State and Territorial Health Officials

# FISCAL NOTE

LEGISLATIVE FISCAL ANALYST ESTIMATE

ESTIMATE OF FISCAL IMPACT – STATE AGENCIES *				
	FY 2009-10		FY 2010-11	
	EXPENDITURES	REVENUE	EXPENDITURES	REVENUE
GENERAL FUNDS	16,579			
CASH FUNDS				
FEDERAL FUNDS	16,579			
OTHER FUNDS				
TOTAL FUNDS	33,158		See below	

\*Does not include any impact on political subdivisions. See narrative for political subdivision estimates.

This bill requires the Department of Health and Human Services to apply for a waiver or an amendment to an existing waiver for the purpose of providing medical assistance for family planning services for persons whose family earned income is at or below 185% of the federal poverty level.

A half-time program specialist would be needed to develop the waiver. The costs would be \$33,158 (\$16,579 GF and FF) in FY 10 and \$13,726 (\$6,863 GF and FF) in FY 11.

The Department of Health and Human Services estimates that it could take up to 15 months from the effective date of the bill to receive federal waiver approval and implementation begins. The department also estimates based on the U. S. Census statistics that approximately 24,725 women who currently do not qualify would become eligible for family planning services at 185% of the federal poverty level. The approximate cost per recipient is \$184. The state match for family planning services is 10% with 90% paid by the federal government. Assuming an implementation date of December 2010, for seven months in FY 11, the cost of family planning services is estimated to be \$2,653,817 (\$265,382 GF and \$2,388,435 FF).

Eligibility would be based on income only. The department estimates that one eligibility worker is needed per 1,000 applicants. The cost would be \$817,946 (\$408,973 GF and FF) in FY 11. Under the current eligibility determination process, this number of workers would be needed. The department is transitioning to a new application process called ACCESSNebraska. This will be an on-line and phone application process with all records filed and stored electronically. Currently, online application is available and by FY 12, the process will be fully automated with the option to apply over the phone. The number of eligibility workers is projected to decrease every year starting in FY 10 with the largest decline in FY 12. With the implementation of the waiver estimated to be December 2010 along with the phased-in implementation of ACCESSNebraska, it is likely fewer than 24 additional workers may be required.

An evaluation of other states family planning waivers was conducted by the CNA Corporation under contract with the federal Centers for Medicare and Medicaid (CMS). The report published in 2003 showed family planning waivers saved millions of dollars in all six state programs that were evaluated. The states were Alabama, Arkansas, California, New Mexico, Oregon and South Carolina. In calculating the potential savings in Nebraska, the department assumes 4% of the women receiving services would have otherwise have had a birth that would be covered by Medicaid. Using this assumption, the savings would be \$11,210,315 (\$4,484,126 GF and \$6,726,189 FF) in FY 12. This is based on the cost of prenatal care and delivery at \$9,360 and medical services for an infant up to one year of age at \$1,975. Prenatal care, delivery and medical care for a newborn is matched at 60% from the federal government with 40% paid by the state.

The net minimum annual savings in FY 12 and beyond is estimated to be \$5,842,969 (\$3,620,213 GF and \$2,222,756 FF).

## Women and Medicaid in Nebraska

(As of February 2010)

Medicaid, the national health insurance program for low-income people, plays a critical role in providing health coverage for women. Nationally, nearly 17 million nonelderly women—including 8 percent of those living in Nebraska—are covered through Medicaid.<sup>1,2</sup> In fact, women comprise the majority (67 percent) of Nebraska's adult Medicaid beneficiaries.<sup>3</sup> Women are more likely than men to qualify for Medicaid because they tend to be poorer and are more likely to meet the program's stringent eligibility criteria. Women are also more likely to hold low-wage or part-time jobs that do not offer employer-sponsored health benefits, so Medicaid may be their only possible source of coverage.<sup>4,5</sup>

Medicaid is jointly funded by the federal and state governments and is administered by the states. Though states must comply with a host of federal Medicaid requirements, they can exercise flexibility with regards to certain program elements. There is considerable state variation, for instance, in who is able to get coverage through Medicaid, the income level needed to qualify, and the services that the program covers.

### Nearly one in ten women in Nebraska receives health care coverage through Medicaid.<sup>6</sup>

- Medicaid is the most important source of coverage for low-income women. In 2006-07, 22 percent of all low-income women in Nebraska were enrolled in the program.<sup>7</sup>

### Medicaid ensures that women in Nebraska have access to a comprehensive set of important health care services.

- Medicaid programs are required to provide certain health services to some covered populations—including family planning services, inpatient and outpatient hospital care, and pregnancy-related care—and the program has traditionally provided beneficiaries with a comprehensive set of health benefits. The Deficit Reduction Act of 2005, however, allows states to provide more limited benefit packages (without coverage for mental health services or prescription drugs, for example) to certain enrollees.<sup>8</sup>
- Nebraska's Medicaid program also covers treatment for breast and cervical cancer for low-income women, though to be eligible for this treatment women must be screened

#### **Medicaid Eligibility Limits for Women in Nebraska, 2010<sup>1</sup>**

- ⊙ Women with dependent children: 58% of the Federal Poverty Level (FPL)<sup>2</sup>
- ⊙ Women without dependent children: Not eligible (regardless of income)
- ⊙ Pregnant women: 185% of the FPL
- ⊙ Disabled and aged women: 100% of the FPL
- ⊙ Women who have breast and cervical cancer: 250% of the FPL

*Notes:* 1. May include eligibility limits for the Children's Health Insurance Program (CHIP) or state-funded public health insurance programs. 2. The FPL in 2010 is \$10,830 annually for an individual or \$18,310 for a family of three.

*Source:* Kaiser Family Foundation, State Health Facts, [www.statehealthfactsonline.org](http://www.statehealthfactsonline.org) (Accessed February 2010).

and diagnosed as part of the CDC's National Breast and Cancer Early Detection Program. The federal guidelines for the CDC program establish an eligibility baseline to target services to uninsured and underinsured women at or below 250 percent of the FPL.<sup>9</sup> In 2006, 356 women were enrolled in Nebraska's breast and cervical cancer treatment program.<sup>10</sup>

### **Reproductive health services are a vital component of women's Medicaid coverage.**

- In 2006, Medicaid provided basic health services to a total of 7.3 million American women of reproductive age (15-44 years old).<sup>11</sup>
- Medicaid is the largest public funder of family planning services in the United States. In 2006, the program contributed \$1.3 billion toward family planning nationally, accounting for 71 percent of all public spending on these essential services.<sup>12</sup>
- Medicaid is also an essential source of coverage for maternity care, and covers 40 percent of all births in Nebraska.<sup>13</sup> The program covers prenatal visits and vitamins, ultrasound and amniocentesis screenings, childbirth by vaginal or caesarean delivery, and 60 days of postpartum care.<sup>14</sup> Nationally, pregnancy-related services account for the largest share of Medicaid's hospital charges.<sup>15</sup>

### **Nebraska's Medicaid program is important for low-income women of all ages.**

- For elderly women who meet income eligibility requirements, the program covers high-cost services provided in a skilled nursing facility, as well as home and community-based health care for women who are entitled to nursing facility services.<sup>16</sup>
- 35 percent of all female Medicaid beneficiaries in Nebraska were age 50 or older in 2007.<sup>17</sup> These women typically rely on the program for: health care related to a physical or mental disability or chronic condition; treatment for breast or cervical cancer; long-term care services; or, cost-sharing required under Medicare.<sup>18</sup>

### **Women and Medicaid in Nebraska: What Can Women's Advocates Do?**

*Women's advocates can work to strengthen and improve their state's Medicaid program while protecting against cuts in services and/or eligibility.* Policymakers will continue to debate the role that Medicaid and other public coverage programs should play in the U.S. health care system. Budget pressures at the state and federal level will continue to pose threats to this essential health insurance program. Advocates should understand Medicaid's significance for women and support legislation that will strengthen Medicaid, ensure that the program is adequately funded, and improve program enrollees' access to care.

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<sup>1</sup> Kaiser Family Foundation, *Women's Health Insurance Coverage* (Oct. 2009), <http://www.kff.org/womenshealth/upload/6000-08.pdf>

<sup>2</sup> Kaiser Family Foundation, *Health Insurance Coverage of Women Ages 18-64, by State, 2007-2008* (Oct. 2009), <http://www.kff.org/womenshealth/upload/1613-09.pdf>

# STATE MEDICAID FAMILY PLANNING ELIGIBILITY EXPANSIONS

STATE	BASIS FOR ELIGIBILITY			ELIGIBLE CLIENTS INCLUDES		APPLICATION/ REIMBURSEMENT AT FIRST VISIT	ACCESS NECESSARY DOCUMENTS FOR CLIENTS	REIMBURSE PROVIDERS FOR APPLICATION ASSISTANCE	WAIVER EXPIRATION DATE
	Losing Coverage Postpartum	Losing Coverage for Any Reason	Based Solely on Income	Men	Limited to Those 19 and Older				
Alabama			133%		X		X*		9/30/11
Arizona	2 years								9/30/11
Arkansas			200%				X*		1/31/12
California			200%	X		X			10/31/10
Delaware		2 years							9/30/10
Florida		2 years							11/30/10
Illinois		†	200%		X				3/31/12
Iowa	†		200%			X	X*		1/31/11
Louisiana			200%		X		X*	X	7/1/11
Maryland	5 years								6/30/11
Michigan			185%		X		X*		3/1/11
Minnesota			200%	X		X	X		6/30/11
Mississippi			185%						9/30/11
Missouri			185%		X				9/30/10
New Mexico			185%		X†				10/31/10
New York	†		200%	X			X		9/30/11
North Carolina			185%	X	X		X		12/31/10
Oklahoma			185%	X	X			X	10/31/10
Oregon			185%	X		X <sup>Ω</sup>	X	X	10/31/12
Pennsylvania			185%		X <sup>ψ</sup>	X <sup>Ω</sup>	X		6/1/12
Rhode Island	2 years								9/30/11
South Carolina			185%				X*		12/31/10
Texas			185%		X <sup>ψ</sup>		X*		12/31/11
Virginia	†		133%	X			X		3/31/11
Washington			200%	X			X	X	11/30/10
Wisconsin			200%	X		X <sup>Ω</sup>	X		12/31/10
Wyoming	Unlimited				X				8/31/13
<b>TOTAL</b>	<b>4</b>	<b>2</b>	<b>21</b>	<b>9</b>	<b>11</b>	<b>6</b>	<b>15</b>	<b>4</b>	

- \* Only for clients born in state.
- † State also extends Medicaid eligibility for family planning services to these individuals.
- ‡ Applies to women ages 18-50.
- Ω Use state funds to reimburse for some or all initial visits.
- ψ Expansion includes women who are at least 18 years of age.



Center for Medicaid, CHIP and Survey & Certification

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SMDL#10-013

ACA# 4

July 2, 2010

RE: Family Planning Services Option  
and New Benefit Rules for Benchmark Plans

Dear State Health Official:

This letter is intended to provide guidance on the implementation of two Medicaid benefits-related provisions in the Affordable Care Act (ACA); P.L. 111-148, as amended by the Health Care and Education Recovery Act of 2010; P.L. 111-152. Both provisions were effective as of March 23, 2010.

This letter provides guidance on *section 2303 of ACA: State Eligibility Option for Family Planning Services*, which establishes a new Medicaid eligibility group and the option for States to begin providing medical assistance for family planning services and supplies to individuals eligible under this new group. Under this new option, Federal funding will be available for States to provide coverage under the State plan for family planning and family planning-related services and supplies to individuals (men and women) that States could previously offer only through demonstration projects.

Additionally, this letter provides guidance on *section 2001(c) of ACA: Medicaid Coverage for the Lowest Income Populations*, which makes certain benefit changes that were enacted as part of the Affordable Care Act to benchmark plans.

## STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES

### Background

Since 1972, States have been required to provide family planning services and supplies to Medicaid populations. Prior to ACA, States did not have the option to provide family planning services and supplies under their Medicaid State plans to individuals otherwise ineligible for Medicaid, including parents with incomes above State eligibility levels and non-disabled adults who were not caring for children. Because the provision of such services has been found to be cost effective for the Medicaid program, the Secretary of Health and Human Services has granted targeted section 1115 family planning demonstrations to permit States to cover family planning services and supplies for individuals not otherwise eligible for Medicaid. With the enactment of ACA, States now have the option to offer, under State plan authority, eligibility for family planning coverage for individuals who were previously ineligible for Medicaid.

### The New Family Planning Eligibility Group

Section 2303 of ACA establishes a new optional categorically needy group that became effective on March 23, 2010. Specifically, section 2303(a)(1) of ACA establishes a new eligibility group under section 1902(a)(10)(A)(ii)(XXI) of the Social Security Act (the Act). Individuals eligible under the new family planning group are individuals (men and women):

- Who are not pregnant; and
- Whose income does not exceed the income eligibility level established by the State.

Note that the income level established by the State may not exceed the highest income level for pregnant women under the State's Medicaid or CHIP State plan. For purposes of determining eligibility and complying with section 1902(a)(17)(B) of the Act, States have the option to consider only the income of the applicant or recipient. Additionally, States may determine income eligibility for individuals under this family planning option by using the same methodology that would apply for pregnant women. This includes the methodology that counts the applicant as a household of two (or more depending on the presence of others in the family) when determining income eligibility.

In addition, the State has the option of including in this new, optional group, individuals who would have been eligible for an approved section 1115 family planning demonstration, had they applied for such demonstration on or before January 1, 2007, using the eligibility standards and procedures imposed by the State at that time. States must not restrict eligibility based on age. Under standard Medicaid rules, however, States may limit services based on medical necessity.

Some of the individuals that a State might cover under this new option (depending on their income) may be eligible for a more comprehensive set of benefits as States implement Medicaid and other coverage expansions under the ACA. Taking up the new family planning eligibility group does not preclude or in any way affect receipt of the increased matching rate (based on the requirements in effect when this group becomes mandatory in 2014). CMS will issue separate guidance on the matching rate provisions in the new health insurance reform legislation.

### Benefits Available to Individuals in the New Family Planning Group; Applicable Federal Matching Rates

The services available for this new group are described in section 2303(a)(3) of ACA, amending section 1902(a)(10)(G) of the Act. Services available are limited to family planning services and supplies described in section 1905(a)(4)(C), as well as such "medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting." We are interpreting this language to provide for coverage of both family planning and family planning-related services, maintaining their longstanding separate definitions.

- Family planning services and supplies are described in section 1905(a)(4)(C). These services and supplies are reimbursable at the 90 percent matching rate under the new family planning option. These are the same services that are covered at the 90 percent matching rate for other Medicaid State plan beneficiaries. Individuals in this new family

planning group must receive the same 1905(a)(4)(C) services that other categorically needy individuals receive.

- Family planning-related services are medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting. These services can be covered under the new option but are reimbursable at the State's regular Federal medical assistance percentage (FMAP) rate.

### *Family Planning-Related Services*

Family planning-related services have historically been considered those services provided in a family planning setting as part of or as follow-up to a family planning visit. Such services are provided because they were identified, or diagnosed, during a family planning visit. As noted above, these services are reimbursable at the State's regular FMAP rate.

The following are examples of family planning-related services:

- Drugs for the treatment of sexually-transmitted diseases (STD) or sexually-transmitted infections (STI), except for HIV/AIDS and hepatitis, when the STD/STI is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may be covered. In addition, subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.
- Some States and family planning programs encourage men to have an annual visit at the office/clinic. Such an annual family planning visit may include a comprehensive patient history, physical, laboratory tests, and contraceptive counseling.
- Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may be covered.
- Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to a family planning service in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.
- Treatment of Major Complications

The following are examples of treatment of major complications that States may cover:

- Treatment of a perforated uterus due to an intrauterine device insertion;
- Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or,
- Treatment of surgical or anesthesia-related complications during a sterilization procedure.

It should be noted that for persons who have had a sterilization, States must cover family planning-related services that were provided as part of, or as follow-up to, the family planning visit in which the sterilization procedure took place.

### Presumptive Eligibility

A new section 1920C of the Act, as added by section 2303(b) of ACA, gives States that have adopted the new family planning eligibility group the option of also providing a period of presumptive eligibility based on preliminary information that an individual meets the eligibility criteria for family planning services in new section 1902(ii). The presumptive eligibility period allows health providers to receive reimbursement (and States to receive Federal matching funds) for medical assistance for an individual who has been determined presumptively eligible by a qualified entity during a specific period. In general, a qualified entity is an entity that is eligible to receive payments under the approved State plan and is determined by the State agency to be capable of making presumptive eligibility determinations. Please note that the State may limit the classes of entities that may become qualified entities to ensure program integrity.

The qualified entity must inform the State agency of the presumptive eligibility determination within 5 working days after the determination is made and inform the presumptively eligible individual that he or she must file an application for assistance no later than the last day of the month following the month during which the determination is made. The State agency must provide the qualified entities with necessary forms for the individual to file an application and information on how to assist individuals in completing the forms. Documentation for various factors of eligibility, such as citizenship, are not required for the presumptive determination, but will be requested when the application is filed. The State's reasonable opportunity period for submission of citizenship documentation also begins at this point. Please refer to the letter to State Health Officials (SHO# 09-016) issued December 28, 2009 for further guidance on citizenship documentation. Nothing prevents a State from using a simplified application form as its presumptive eligibility form. This can streamline the process and help ensure that all individuals are considered for ongoing eligibility.

The actual presumptive eligibility period begins with the date on which the qualified entity determines that the individual is eligible based on preliminary information. The presumptive eligibility period ends with and includes the earlier of:

1. The day on which a formal eligibility determination is made for the family planning program under the Medicaid State plan; or
2. For an individual who does not file an application by the last day of the month following the month during which the individual was determined presumptively eligible, the last day of that month is the last day of the presumptive eligibility period. For example, if an individual is determined presumptively eligible on April 1, but the individual does not file an application by May 31, then the last day of the presumptive eligibility period is May 31.

For individuals determined to be presumptively eligible under this category, medical assistance shall be limited to family planning services and supplies described in section 1905(a)(4)(C), and at the State's option, medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting (family planning-related services, as described above).

### Converting Family Planning Section 1115 Demonstrations

Currently, 22 States have approved stand-alone section 1115 family planning demonstrations. If a State with a demonstration wants to adopt the new State plan family planning optional group, it would need to submit a SPA to select this option (see below). In addition, the State should notify its project officer and the CMS Regional Office State representative of its request to terminate the family planning demonstration at such time as the SPA is approved. Since States would be shifting a population from the demonstration to the Medicaid State plan, the State would *not* need to submit a demonstration phase-out plan as defined in the special terms and conditions. However, the State should notify individuals that they are no longer enrolled in a section 1115 research and demonstration project, but instead are now enrolled in the Medicaid State plan option for family planning services. In addition, the State must submit a final report on its demonstration no later than 12 months after terminating the demonstration. With respect to budget neutrality, CMS would apply budget neutrality terms through the effective date of the SPA.

Please note, if a State that was providing family planning services through a section 1115 demonstration on March 23, 2010 chooses the State plan option, it must, at a minimum, maintain current eligibility until the State has established a health benefit exchange under ACA (or October 1, 2019 for individuals under age 19) due to statutory maintenance of effort requirements under the American Recovery and Reinvestment Act (ARRA) of 2009 (Pub.L. 111-5) and ACA.

Five States have comprehensive section 1115 demonstrations that include a targeted family planning component. If a State wishes to cover the family planning population under the Medicaid State plan, it should submit a SPA and a Demonstration amendment removing the population as of the effective date of the SPA.

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All rules applicable under the Medicaid program in general apply to this new optional eligibility group, including rules relating to cost sharing, citizenship, immigration, and third party liability.

In addition, a State that elects to extend eligibility to this group must include consideration of this new eligibility group when it determines whether an individual who has qualified under another eligibility category continues to qualify for Medicaid. For example, under existing regulatory requirements, before terminating coverage for a woman who has been eligible for

Medicaid as a pregnant woman and will lose such eligibility at the end of the 60-day post partum period, the State must perform an ex parte review to determine whether the woman would be eligible under another eligibility group. If the State elects to offer coverage under the new family planning eligibility group, this review must include consideration of whether the woman is eligible under that new group.

### Submission of SPAs

To implement this new optional group, States will need to submit an amendment to their Medicaid State plan. We are ready to work with States interested in adopting this new option and to assist States in amending their plans.

## RECENT CHANGES TO MEDICAID BENCHMARK BENEFITS

### Background

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Specifically, section 2001(c) of ACA adds mental health services and prescription drug coverage to the list of required services that must be included in benchmark-equivalent coverage. In addition, section 2303(c) of ACA requires States providing medical assistance to individuals described in section 1905(a)(4)(C) of the Act, through enrollment in benchmark or benchmark-equivalent coverage, to cover family planning services and supplies.

### Implementation

The above services are requirements of benchmark and benchmark-equivalent coverage for States that provide coverage through such plans. Accordingly, States that choose to provide medical assistance through benchmark or benchmark-equivalent coverage must now comply with all provisions of the April 30, 2010 final rule, as well as the provisions of section 2001(c) and 2303(c) of ACA described in this letter. CMS will apply these requirements in reviewing new State plan amendments and monitoring currently approved State Medicaid plans. Note that beginning in 2014, benchmark and benchmark-equivalent plans must begin providing at least

essential health benefits, as described in Section 1302(b). These issues will be addressed at a later date.

We hope this information will be helpful. CMS is available to provide technical assistance to States with existing benchmark plans to ensure the plans comply with these benefit rules. Questions regarding this guidance may be directed to Ms. Vikki Wachino, Director, Family and Children's Health Programs Group, at (410) 786-5647. We look forward to our continuing work together as we implement this important legislation.

Sincerely,

/S/

Cindy Mann  
Director

cc:

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#13

LR 467 Select Committee  
Interim Hearing – Patient Protection & Affordable Care Act  
October 7, 2010

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Nebraska Medical Association

I'm Dr. David Filipi, a family physician and immediate past president of the Nebraska Medical Association. I have been Chief Medical Officer of Methodist Physicians Clinic, an Omaha based multispecialty practice of 160 physicians and am currently Medical Director for Quality Advancement at BCBS of Nebraska. I speak today for the Nebraska Medical Association.

I will share with you today a white paper created several years ago on our ideas for Health Care reform. They include two large concepts: Transparency and Driving down demand for health care services.

First, transparency. As purchasers of health care, patients and employers currently have little solid evidence to make meaningful decisions. We currently go by such soft characteristics as reputation and past customer service. Our literature says quality is now often judged by the appearance of our waiting room. Instead, systems of health care should compete on agreed-upon measures of clinical outcomes, where we can compare apples to apples. What is the rate of surgical infections? Who has better results from heart procedures? Also, we should also know what health care actually costs. Charges by both hospitals and physicians are terribly misleading, as most payers pay a discounted rate. Ironically, the only patients paying full price are those without insurance. Armed with knowledge of both clinical performance on quality and the actual costs of service delivered, the marketplace will force lower costs and increased value.

Public expenditure on comparative outcomes research is another part of transparency. Currently, drugs, devices, and diagnostic procedures are tested and approved if they are proven effective in what they are expected to do. This is required by the FDA so they can be placed in the market.. However, they are not tested against their competitive drug, device or procedure. The development company does not wish to risk failure in such an expensive research project. So, none is done. Physicians must rely on limited, antidotal experience and effective marketing to make decisions to use a new drug or technology. An independent agency to run head to head comparisons is needed to answer the questions, "Is a new expensive drug really better than an older, cheaper one?" "And if better, how better." If a new drug or technology is only marginally better, at a huge increase in cost, is it worth the change?

So much for transparency. Let's talk about driving down demand for health care services. There's four strategies: A healthier Nebraska population, a decrease in defensive medicine delivered, reduction of waste due to service duplication and finally, futile end of life care.

First, a healthier Nebraska. Just like we've handled seat belts, motorcycle helmet use, second hand smoking, and driving while intoxicated, we must focus public policy and private efforts to combat obesity and increase exercise. Obesity and inactivity correlates well to the resource consuming diseases of diabetes and heart disease. And it's just not about the money...it's about quality of life. Those afflicted by these two diseases feel worse and are less productive. To implement programs encouraging better diets and more exercise, we must adequately fund our community departments of public health. The most effective programs are local initiatives.

Second, defensive medical tests and procedures to avoid malpractice claims are a wasteful expense. The Nebraska Medical Association urges true tort reform, such as through specialized, sophisticated, and separate malpractice courts or malpractice immunity if one practices under a recognized national medical standard for a given clinical condition. Either improvement would remove the emotion of a tragic unwanted outcome and significantly cut the cost of defensive medicine.

Third, the reduction of duplicative services. Let's face it. We have a very fragmented health care system,. As physicians and hospitals become more electronic , we must link these systems together so we know what has already been done in other practices and facilities. Fortunately, we have such a linkage in NEHII, or the Nebraska Health information initiative. If your facility is linked to NeHII you can discover what has taken place in other facilities with a connection. NeHII has already been successfully implemented in Omaha, Hastings and North Platte. Not only does it reduce duplication, it improves diagnostic capabilities while reducing drug incompatibilities. Also helpful would be the promotion of primary care physicians and the successful development of the patient centered medical home. I won't repeat the facts already shared by Dr. Rauner. Let's just say that Dr. Paul Grundy, the medical director of IBM, says that his employees in countries with strong primary care systems cost 30% less than those countries weighted toward specialists.

And lastly, let's facilitate the conversation with our patients about how they wish to face their own deaths. We're not talking death squads. We're talking about how much expensive technology our patients want us to apply to defer the inevitable. Let me give an example. We now have a therapy (Provenge) for widespread prostate cancer. It will likely prolong end stage disease for 6 additional months with continued pain and suffering. There is no increased likelihood of cure. Medicare fully pays the nearly \$100,000 bill and the patient pays nearly nothing. Would you, personally, pay \$550 daily out of pocket to live and suffer with widespread cancer for another 182 days?

There you have it. The NMA white paper on health care reform, and my focus today on improving health care transparency while reducing demand for its services. I am pleased to answer any questions you may have.



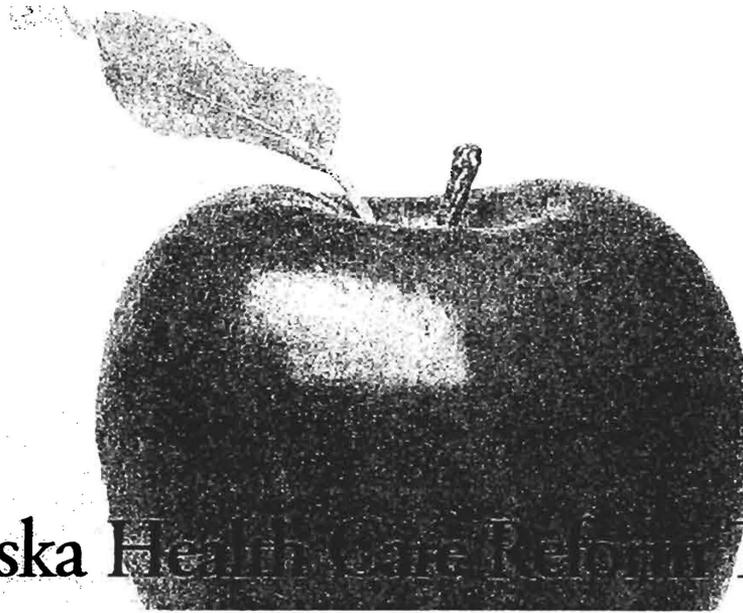
# Nebraska Health Care Reform Task Force

*November 28, 2007*



Nebraska  
Medical  
Association

*Advocating for Physicians and the Health of all Nebraskans*



# Nebraska Health Care Reform Task Force

*November 28, 2007*

This Task Force was constituted by the president of the Nebraska Medical Association in response to a resolution of the House of Delegates passed in September 2006. It has deliberated the contents of the resolution and the charges therein and makes the following proposal to the Association Board of Directors.

## PREAMBLE

The Nebraska Medical Association Health Reform Task Force posits that all Nebraskans should have good access to timely needed health care that emphasizes good health habits, wellness, and prevention, that health care in Nebraska must be of high quality, efficient, affordable and equitably accessible to all. It also posits that good health and access to needed health care are social goods that contribute to the well-being of the state and all its residents.

The Goal, Values, Principles and Recommendations that follow are based on these premises.

## GOAL

“Health care plan outlining high quality, affordable and accessible health care coverage for all Nebraskans,” while exploring the “feasibility of ‘best practices’ and ‘practice guidelines’ to the extent that they can help reduce unnecessary medical expense and engender reasonable expectations on the part of patients.”

## VALUES

- Access for all Nebraskans
- Quality care
- Individual choice and self-determination
- Individual accountability demanded of all participants
- Economic sustainability
- Shared responsibility of all Nebraskans

## PRINCIPLES

- Universal portable insurance coverage
- Cost control
- Health care financing that promotes quality care, preventive care and wellness
- A pluralistic system that promotes competition based on value
- Coverage costs based on broad community rating
- Partnership with patients in medical decision-making
- A health care work force to meet the needs of all Nebraskans
- Public education about healthy living, evidence for optimal care, and wise choices through credible information

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## RECOMMENDATIONS

I) Assure universal health insurance coverage and fair sharing of costs by requiring all Nebraskans not covered by Medicare to have a basic health insurance benefit plan that includes preventive services, mental health care, dental care and long term care. This plan should be developed and reviewed periodically by a panel comprising generalist and specialist physicians, other health professionals and members of the public. The plan may be purchased either by employers or individually. Submission of evidence of insurance could be required when filing state tax returns, paying property taxes, enrolling children in schools, registering an automobile, obtaining a driver's license, or seeking health care.

*Rationale: The U.S. Census Bureau estimated that there were 194,000 uninsured Nebraskans in 2006, -11.1% of the population<sup>1</sup>, and these numbers have been increasing. Families USA has reported that 437,000 Nebraskans (28.2% of the <65 population) lacked health insurance sometime during 2006 and 2007. Of these, 262,000 (60%) were uninsured for more than six months<sup>2</sup>. The uninsured frequently fail to get needed care with the result that their conditions become worse and they incur higher costs and suffer poorer outcomes<sup>3,4</sup>. They frequently resort to Emergency Rooms (ER) for access to care, which also contributes to increased costs. The increased costs of delayed care and ER care are borne by those who are insured. Further, lack of timely access to needed care results in premature deaths and productivity losses estimated to exceed by many times the cost of the medical care needed<sup>5</sup>. There are only three ways to assure access for all Nebraskans to timely needed health care. Either government provides care, government provides tax funded insurance, or private insurance is made available and required. Combinations of these approaches are possible. In our pluralist economy and tax-averse political system, it is unlikely that state government will provide care to or be the insurer of the currently uninsured. To do so would provide incentive for many who are currently insured by employers or individually to drop insurance and opt for government care or government insurance. The state could expand Medicaid and SCHIP coverage but, to assure a sense of solidarity and shared responsibility, the Task Force recommends that all Nebraskans have access to comparable health care coverage. Furthermore, cost shifting from Medicaid results in higher insurance premiums<sup>6</sup>, a state-imposed hidden tax on those who responsibly choose to be insured. The Task Force concluded that the only way to assure that costs are shared fairly is to require all Nebraskans to have private health insurance that*

*provides an equal basic benefit for all. Some will doubt the ability to enforce a requirement but several methods are available<sup>7</sup>. Insurers should be permitted to offer richer coverage than the basic benefit plan, if they choose.*

II) Require all insurers, authorized by the State of Nebraska Department of Insurance to offer plans that satisfy the health insurance requirement, to guarantee issue and renewal of a basic health benefit plan at community rated premiums.

*Rationale: At the present time, persons with pre-existing conditions may be excluded from purchasing health insurance because insurers deny them coverage, will not insure costs arising from pre-existing conditions, or may drop them from coverage if they become ill. Further, even if healthy, premiums escalate with age to reach prohibitive levels for many middle income Nebraskans between 50 and 64. If all Nebraskans are able to purchase and renew health insurance at community rated premiums, it assures equitable sharing of costs and is likely to lower overall costs because timely preventive and chronic disease care are expected to diminish the need for more extensive and expensive care resulting from lack of timely access to needed care.*

III) Subsidize premium costs for low income persons utilizing current Medicaid funds. (Suggested guidelines: 100% premium subsidy for those below 200% of Federal Poverty Level; declining subsidy from 200%-300 or 400% FPL.)†

*Rationale: Many families and individuals cannot afford current high premiums of private health insurance. Family premiums in Nebraska can exceed 20% of Median Family Income and approximate 15% of the income of a family of four at 400% of FPL. To determine the appropriate level of subsidy will require a judgment of what is a reasonable expenditure for health insurance premiums. Some suggest that premium costs should not exceed 8-10% of household income.*

IV) Require insurers to offer plans that reward selection of a "medical home" to facilitate coordinated/integrated care.

*Rationale: This recommendation addresses quality of care and costs. It has demonstrated that continuity of care providing by longitudinal oversight and monitoring by one or a team of professionals results in better health care outcomes at lower cost<sup>8</sup>. In the absence of longitudinal continuing care, there may be*

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poor coordination with different providers caring for different aspects of a person's health with no one provider or team knowing exactly what is being recommended or prescribed for a patient. In the absence of a medical home, many resort to emergency rooms for their point of entry into the system, thereby resulting in poor care coordination and higher costs. Better coordinated care has also been found to diminish health disparities<sup>8</sup>.

V) Emphasize public health and disease prevention. Develop and implement education and counseling strategies in early childhood programs and schools; develop and promote education programs for the public and health professionals addressing:

- healthy lifestyles and disease prevention
- health and health care literacy

Promote and provide incentives for wellness programs in workplaces, schools and the community.

*Rationale: Enhanced public health efforts are essential to improve the health of Nebraskans and to reduce health care costs. Primary, secondary and tertiary prevention practices have been shown to diminish suffering, health care costs and to improve productivity. The U.S. and Nebraska face a pandemic of diseases related to lifestyle, notably diseases related to obesity but others as well. Poor health habits increase the risk of cardiovascular disease, diabetes, cancer, sexually transmitted diseases, especially HIV/AIDS, and others. Life style accounts for ~40% of premature deaths, 80% of them from smoking and obesity<sup>9</sup>. Obesity is estimated to account for 9% of U.S. health care costs<sup>10</sup> and \$454 million in Nebraska in 2003<sup>11</sup>. Improved health habits, disease prevention, and early detection of disease enhance the quality of life and decrease the costs of health care. Workplace health and wellness programs have demonstrated their value by decreasing health risk behaviors, improving health, decreasing costs, and increasing productivity<sup>12-16</sup>. It is estimated that in 2003 Nebraska expended \$1.9 billion in health care costs and economic productivity was diminished by \$6.1 billion because of preventable chronic diseases and their complications<sup>17</sup>. The same study estimates that, implementation of reasonable preventive measures could save \$5.2 billion in health care costs and improve economic productivity by \$17 billion in 2023.*

VI) Promote and educate the public about appropriate use of health care resources and choosing providers based on quality and value.

*Rationale: The public is bombarded with information suggesting that they need particular health care services, leading many to demand and expect care that may be of no benefit, and may carry risks. The public also lacks adequate information to make rational choices of health care providers to assure that they are getting the best care for the lowest reasonable cost. Information and transparency about the quality, cost and value of care should be made available to the public and communicated by well structured public education programs. It is important that these programs take cognizance of the culturally diverse populations of Nebraska.*

VII) Require provider reimbursement based on appropriate medically necessary services utilizing evidence-based, value-adjusted, nationally accepted clinical practice guidelines.

Nationally accepted evidence-based clinical practice guidelines should be subject to review by a panel of Nebraska professionals to assure local applicability.

*Rationale. This recommendation addresses quality of care and costs. One of the drivers of health care costs is the provision of care that does not contribute to health and well-being. The reasons for this include patient demand, uncertainty on the part of practitioners, opportunities for providers to increase income, and defensive medicine (the practice of ordering tests and consultations to avoid or diminish the possibility of malpractice suits). Furthermore, there is evidence that evidence-based interventions are frequently not provided when indicated<sup>18,19</sup>. There is an extensive and growing array of evidence-based clinical practice guidelines that assure quality care and value-based outcomes<sup>20</sup>. Linking reimbursement to evidence-based preventive, diagnostic, or therapeutic interventions should have a positive effect on quality of care, outcomes and costs. There are occasions when it is appropriate to use or not use interventions prescribed by clinical guidelines—every patient is an individual different from other patients. Such deviations from guidelines may be reimbursed if they are individually justified.*

VIII) Limit out-of-pocket expenditures (premiums, deductibles and co-payments). (No OOP expenditures for those under 150% FPL, cap of 5% annual income OOP for those 150-250% FPL, sliding cap of 5-10% for those 250-300% FPL, cap of 10% OOP for those above 300% FPL.# This could apply to each year or be applied to rolling three year average.)

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*Rationale: This recommendation also addresses quality of care and costs. It is well known that cost-sharing reduces health care utilization<sup>21</sup>. It is also well known that excessive cost-sharing reduces utilization of needed health care<sup>22</sup>, especially preventive care<sup>23</sup>. Patients who feel as though they cannot afford prescribed care or monitoring frequently decrease drug dosages, skip medications and necessary monitoring for chronic conditions, and neglect useful screenings for conditions such as breast cancer, high blood pressure and diabetes. This results in greater incidence of preventable diseases and worsening of acute and chronic conditions with higher costs of care and subsequent poorer outcomes, including higher mortality. Health economists characterize the "underinsured" as individuals or families whose premium and out-of-pocket costs exceed 10% of income or 5% of income for those below 200% of poverty<sup>24,25</sup>. Keeping cost sharing within affordable limits improves outcomes and decreases health care costs<sup>26</sup>.*

IX) Support a secure and private statewide health information exchange to promote higher quality, safer and more cost efficient health care.

*Rationale: Individual patients are often provided care by different professionals, hospitals, long term care facilities, and other providers. Difficulty accessing patient health information or failure to communicate patient information between providers may result in lower quality of care, duplication of procedures, poor coordination of care, and higher costs. Ready access to patient health information at the point of care has the potential to improve quality of care and reduce unnecessary medical spending. It is essential that such records be secure and that they are available only to providers who are granted access by the patient. The Nebraska Health Information Initiative (NeHII), a collaboration of many health care stakeholders in the state, was established in 2005. Its goals include:*

- *Sharing timely and accurate patient health care information in a secure environment to improve patient care and*
- *Seamless, electronic medical system by which patients give physicians or other providers access to their health information.*

*It is a means for the state to meet the information needs of Nebraskans and Nebraska health care providers. (S. 1693, a bill that has been reported out of committee to the full United States Senate, will provide matching grants to states and other entities to develop such systems if enacted.)*

X) Establish educational loan forgiveness, scholarships and bonus payment programs, linked to service commitments, for providers who establish and maintain practices in underserved areas.

*Rationale: This recommendation is intended to improve access to timely, high quality care to Nebraskans. Many Nebraskans live in areas of health professional and health care service shortages. The Bureau of Health Professions<sup>27</sup> and the Nebraska Office of Rural Health<sup>28</sup> have designated large parts of the state as health professions shortage areas. These include primary care, dental care, pharmacy services, allied health and mental health, the last perhaps the most acute of the shortages. Nebraska has had low-interest loan and loan repayment programs to attract professionals to rural practice areas for nearly 30 years, yet great shortages persist. The Task Force concluded that greater incentives, linked to accountability, are needed to attract health professionals to locate in and practice in shortage areas. Incentives should be linked to commitments to serve for contracted periods of time in shortage areas.*

XI) Provide incentives for Nebraska educational institutions (public and private) to increase education of health professionals to address workforce shortages.

*Rationale: Nebraska is blessed with a substantial number of institutions that educate health professionals, physicians, nurses, dentists, physician assistants and mental health professionals. But, it also has a large number of health services shortage areas and some areas with shortages of specific professions. In addition to incentives for health professionals to locate in such areas (recommendation X.), incentives to select and educate professionals in ways appropriate to meet the needs of underserved areas should be provided for these institutions.*

XII) Strive to reduce medical costs associated with defensive medicine in collaboration with the legislature and the Nebraska Bar Association.

*Rationale: Defensive medicine is the ordering of tests, procedures, seeking consultation or avoiding interventions with the purpose of decreasing liability to malpractice suits rather than for the benefit of a patient. Such added services increase the cost of health care. It is difficult to quantify exactly how much of Nebraska medical practice is defensive or its costs; it has been estimated that 5-9% of national health care expenditures result*

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from the practice of defensive medicine<sup>29, 30</sup>. A survey of Pennsylvania physicians determined that 93% of physicians reported practicing defensive medicine<sup>31</sup>. Nebraska is relatively favored with respect to malpractice premium, award and settlement costs because of a limit on damages. However, Nebraska physicians relate many anecdotes of the practice of defensive medicine. There are several ways that the malpractice tort system might be modified so that defensive medicine is reduced by diminishing the threat of malpractice suits, thereby improving patient care.

XIII) Collaborate with the Nebraska Hospital Association and others to promote patient safety by encouraging transparency and reporting of adverse events and nosocomial infections.

*Rationale: Medical errors and hospital acquired infections are important causes of injury, death and high costs in American health care. The Institute of Medicine (IOM) estimated that 44,000-98,000 Americans died because of medical errors in 1997 and that the cost of care for those injured by errors was \$17-29 billion<sup>32</sup>. The Centers for Disease Control and Prevention estimated that in 2002 there were 1.7 million hospital acquired infections resulting in 99,000 deaths in the U.S.<sup>33</sup> It has been estimated that hospital acquired infections increased hospital costs more than \$30 billion<sup>34</sup>, a sum that does not include the cost of physicians or lost productivity. In 2003 there were 636 documented "medical misadventures" resulting in injury in Nebraska hospitals<sup>35</sup>.*

XIV) Funding sources:

- premiums from employers and individuals
- existing state and federal Medicaid funds used to subsidize premiums and excess out-of-pocket expenses
- payroll tax of employers who do not provide health insurance
- penalty payments by those who do not voluntarily enroll in the required plan
- if more funding is required, tobacco and alcohol or other taxes may be levied

*Rationale: Adequate and appropriate funding requires participation by both public and private sectors. The Task Force recommends utilization of funds, private and public, that are currently supporting health care for Nebraskans. The Task Force proposal will require a Medicaid waiver to utilize funds to subsidize premiums for low income persons. In 2004, total*

*Nebraska expenditures for personal health care were \$9.782 billion, \$5599 per capita<sup>36</sup>. Of the total, Medicaid expended \$1.387 billion, Medicare \$1.691 billion and private payers \$6.705 billion. Utilizing historic rates of cost growth, it is estimated that in 2007 total expenditures will be -\$12.2 billion, Medicaid expenditures -\$1.84 billion, Medicare expenditures -\$2.14 billion, per capita spending -\$6820.*

*Nebraskans are now paying for health care for the uninsured. The Nebraska Center for Rural Health Research computed that in 2003 \$256.8 million uncompensated hospital costs of care for underinsured and uninsured patients were passed on to private insurers who in turn must pass these costs on to businesses and individuals who pay premiums. The Center further computed that hospitals also shifted \$127.7 million of Medicaid underpayment of costs and \$266.1 million of Medicare underpayments, for a total of \$650.6 million<sup>6</sup>. Again utilizing historic rates of cost growth, it is estimated that in 2007 this hidden tax has reached -\$940 million, approximately 7.7% of total health care costs in Nebraska. But, these represent cost shifting for hospital care only. If one assumes that physicians shift costs proportionate to those of hospitals, this would amount to -\$545 million in 2007 for a total cost shift of -\$1.485 billion, or -12.2% of total personal health care costs of Nebraskans. This tax is borne by businesses, employees and individuals who responsibly buy insurance. Businesses that do not provide health insurance for employees and individuals who can afford but do not purchase health insurance are responsible for -40% of this hidden tax.*

*The Task Force proposes that all businesses and individuals share in the costs of health care for Nebraskans. Businesses may purchase health insurance or pay a tax based on payroll expense. If individuals do not purchase insurance, they should pay a penalty that is sufficient to provide incentive for them to do so. Most believe that insuring all Nebraskans will result in lower costs by enhancing disease prevention and avoiding the higher costs that occur when uninsured and underinsured persons forego care and incur higher costs because their conditions become worse. In the event that costs increase in the short term, the Task Force recommends that a tax be levied on products and practices known to be detrimental to health.*

†FPL 2007 = \$10,210 (1), \$13,690 (2), \$17,170 (3), \$20,650 (4)

#est. NE health care costs 2007 (Economic Policy Institute) = 8-9% of 250% FPL

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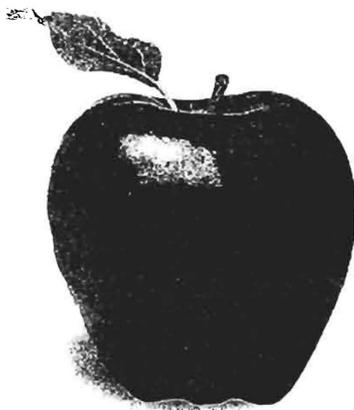
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**RESOURCES AND RESEARCH**

**LR 467 INTERIM STUDY REPORT**

**PATIENT PROTECTION AND  
AFFORDABLE CARE ACT**



**Section-by-Section Analysis  
with Changes Made by Title X and Reconciliation included within Titles I – IX**

Some parts of Title X (the Managers' Amendment) and the *Health Care and Education Reconciliation Act (Reconciliation Act)* made changes to provisions in Titles I – IX of the *Patient Protection and Affordable Care Act*. This section-by-section analysis includes a description of those provisions within the description of the section that was amended. Provisions of Title X and the *Health Care and Education Reconciliation Act* that did not make changes to Titles I - IX are described separately at the end of the document.

**TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS**

**Subtitle A—Immediate Improvements in Health Care Coverage for All Americans**

**Sec. 1001. Amendments to the Public Health Service Act.**

**Sec. 2711. No lifetime or annual limits.** As amended by Section 10101, prohibits plans from establishing lifetime limits, and annual limits beginning in 2014, on the dollar value of benefits. Prior to 2014, plans may only establish restricted annual limits as defined by the Secretary of Health and Human Services (HHS), ensuring access to needed services with minimal impact on premiums.

**Sec. 2712. Prohibition on rescissions.** Prohibits all plans from rescinding coverage except in instances of fraud or misrepresentation.

**Sec. 2713. Coverage of preventive health services.** Requires all new plans to cover preventive services and immunizations recommended by the U.S. Preventive Services Task Force and the CDC, certain child preventive services recommended by the Health Resources and Services Administration (HRSA), and women's preventive care and screening recommended by HRSA, without any cost-sharing.

**Sec. 2714. Extension of dependent coverage.** Requires all plans offering dependent coverage to allow individuals until age 26 to remain on their parents' health insurance. Section 2301 of the *Reconciliation Act* eliminates the requirement that adult children be unmarried.

**Sec. 2715. Development and utilization of uniform explanation of coverage documents and standardized definitions.** Requires the Secretary to develop standards for use by health insurers in compiling and providing an accurate summary of benefits and explanation of coverage for applicants, policyholders or certificate holders, and enrollees. The standards must be in a uniform format, using language that is easily understood by the average enrollee, and must include uniform definitions of standard insurance and medical terms. The

explanation must also describe any cost-sharing, exceptions, reductions, and limitations on coverage, and examples to illustrate common benefits scenarios.

**Sec. 2715A. Provision of additional information.** As added by Section 10101, requires all plans to disclose the information required in section 1311(c), such as claims payment policies and rating practices. Plans that are not offered through the Exchange must submit this information to the Secretary of HHS and the State insurance commissioner and make such information available to the public.

**Sec. 2716. Prohibition of discrimination in favor of highly compensated individuals.** Employers that provide health coverage will be prohibited from limiting eligibility for coverage to highly compensated individuals.

**Sec. 2717. Ensuring quality of care.** Requires the Secretary to develop guidelines for use by health insurers to report information on initiatives and programs that improve health outcomes through the use of care coordination and chronic disease management, prevent hospital readmissions and improve patient safety, and promote wellness and health. As added by Section 10101, protects Second Amendment gun rights by precluding the collection and disclosure of information related to gun ownership or use for purposes of determining premium rates.

**Sec. 2718. Bringing down the cost of health care coverage.** As amended by Section 10101, requires plans offering coverage in the group and individual markets (including grandfathered plans but excluding self-insured plans) to report to the Secretary the amount of premium revenues spent on clinical services, activities to improve quality, and all other non-claims costs as defined by the National Association of Insurance Commissioners and certified by the Secretary of HHS. Beginning in 2011, large group plans that spend less than 85 percent of premium revenue and small group and individual market plans that spend less than 80 percent of premium revenue on clinical services and quality must provide a rebate to enrollees. In addition, each hospital operating within the United States shall publish a list of standard charges for items and services provided by the hospital.

**Sec. 2719. Appeals process.** As amended by Section 10101, requires new plans to implement an effective internal appeals process of coverage determinations and claims and comply with any applicable State external review process. If the State has not established an external review process or the plan is self-insured, the plan shall implement an external review process that meets minimum standards established by the Secretary. The Secretary may deem the external review process of a plan in operation as of enactment to be in compliance with this section.

**Sec. 2719A. Patient protections.** As added by Section 10101, requires that a plan enrollee be allowed to select their primary care provider, or pediatrician in the case of a child, from any available participating primary care provider. Precludes the need for prior authorization or increased cost-sharing for emergency services, whether provided by in-network or out-of-network providers. Plans are precluded from requiring authorization or referral by the plan

for a patient who seeks coverage for obstetrical or gynecological care by a specialist in these areas.

**Sec. 1002. Health insurance consumer information.** The Secretary shall award grants to States to enable them (or the Exchange) to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs. These independent offices will assist consumers with filing complaints and appeals, educate consumers on their rights and responsibilities, and collect, track, and quantify consumer problems and inquiries. Provides \$30 million in funding and is effective upon the date of enactment of the bill.

**Sec. 1003. Ensuring that consumers get value for their dollars.** For plan years beginning in 2010, the Secretary and States will establish a process for the annual review of increases in premiums for health insurance coverage. Requires States to make recommendations to their Exchanges about whether health insurance issuers should be excluded from participation in the Exchanges based on unjustified premium increases. Provides \$250 million in funding to States from 2010 until 2014 to assist States in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage and in providing information and recommendations to the Secretary. As added by Section 10101, allows for the establishment of medical reimbursement data centers to develop fee schedules and other database tools that reflect market rates for medical services.

**Sec. 1004. Effective dates.** Except for sections 1002 and 1003 (effective upon the date of enactment of this Act), this subtitle shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act.

**Subtitle B – Immediate Action to Make Coverage More Affordable and More Available**

**Sec. 1101. Immediate access to insurance for people with a preexisting condition.** Enacts a temporary insurance program with financial assistance for those who have been uninsured for several months and have a pre-existing condition. Ensures premium rate limits for the newly insured population. Provides up to \$5 billion for this program, which terminates when the American Health Benefit Exchanges are operational in 2014. Also establishes a transition to the Exchanges for eligible individuals.

**Sec. 1102. Reinsurance for early retirees.** Establishes a temporary reinsurance program to provide reimbursement to participating employment-based plans, including (as clarified by Section 10102) plans sponsored by State and local governments, for part of the cost of providing health benefits to retirees (age 55-64) and their families. The program reimburses participating employment-based plans for 80 percent of the cost of benefits provided per enrollee in excess of \$15,000 and below \$90,000. The plans are required to use the funds to lower costs borne directly by participants and beneficiaries, and the program incentivizes plans to implement programs and procedures to better manage chronic conditions. The Act appropriates \$5 billion for this fund and funds are available until expended.

**Sec. 1103. Immediate information that allows consumers to identify affordable coverage options.** Establishes an Internet portal for beneficiaries to easily access affordable and comprehensive coverage options. This information will include eligibility, availability, premium rates, cost sharing, and the percentage of total premium revenues spent on health care, rather than administrative expenses, by the issuer. Section 10102 clarifies that the internet portal shall be available to small businesses and shall contain information on coverage options available to small businesses.

**Sec. 1104. Administrative simplification.** Accelerates HHS adoption of uniform standards and operating rules for the electronic transactions that occur between providers and health plans that are governed under the Health Insurance Portability and Accountability Act (such as benefit eligibility verification, prior authorization and electronic funds transfer payments). Establishes a process to regularly update the standards and operating rules for electronic transactions and requires health plans to certify compliance or face financial penalties collected by the Treasury Secretary. The goal of this section is to make the health system more efficient by reducing the clerical burden on providers, patients, and health plans.

**Sec. 1105. Effective dates.** Provides that this subtitle is effective upon enactment.

**Subtitle C – Quality Health Insurance Coverage for All Americans**

**Part 1 – Health Insurance Market Reforms**

**Sec. 1201. Amendment to the Public Health Service Act.**

**Sec. 2701. Fair health insurance premiums.** Establishes that premiums in the individual and small group markets may vary only by family structure, geography, the actuarial value of the benefit, age (limited to a ratio of 3 to 1), and tobacco use (limited to a ratio of 1.5 to 1). Section 10103 clarifies that this provision applies to insured plans in the large group market, not self-insured plans.

**Sec. 2702. Guaranteed availability of coverage.** Each health insurance issuer must accept every employer and individual in the State that applies for coverage, permitting annual and special open enrollment periods for those with qualifying lifetime events.

**Sec. 2703. Guaranteed renewability of coverage.** Requires guaranteed renewability of coverage regardless of health status, utilization of health services or any other related factor.

**Sec. 2704. Prohibition of preexisting condition exclusions or other discrimination based on health status.** No group health plan or insurer offering group or individual coverage may impose any pre-existing condition exclusion or discriminate against those who have been sick in the past.

**Sec. 2705. Prohibiting discrimination against individual participants and beneficiaries based on health status.** No group health plan or insurer offering group or individual

coverage may set eligibility rules based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability – including acts of domestic violence or disability. Permits employers to vary insurance premiums by as much as 30 percent for employee participation in certain health promotion and disease prevention programs. Authorizes a 10-State demonstration to apply such a program in the individual market.

**Sec. 2706. Non-discrimination in health care.** Prohibits discrimination against health care providers acting within the scope of their professional license and applicable State laws.

**Sec. 2707. Comprehensive health insurance coverage.** Requires health insurance issuers in the small group and individual markets to include coverage which incorporates defined essential benefits, provides a specified actuarial value, and requires all health plans to comply with limitations on allowable cost-sharing.

**Sec. 2708. Prohibition on excessive waiting periods.** Prohibits any waiting periods for group coverage that exceeds 90 days. Section 10103 clarifies that waiting periods do not apply to the individual market.

**Sec. 2709. Coverage for individuals participating in approved clinical trials.** As added by Section 10103, prohibits insurers from dropping coverage because an individual chooses to participate in a clinical trial and from denying coverage for routine care that they would otherwise provide just because an individual is enrolled in a clinical trial. Applies to all clinical trials that treat cancer or other life-threatening diseases.

#### **Part II – Other Provisions**

**Sec. 1251. Preservation of right to maintain existing coverage.** Allows any individual enrolled in any form of health insurance to maintain their coverage as it existed on the date of enactment. Section 10103 applies the requirements for medical loss ratios and uniform coverage documents to grandfathered plans. Section 2301 of the *Reconciliation Act* applies the requirements for excessive waiting periods, lifetime limits, rescissions, and extension of young adult coverage to grandfathered plans. Also, applies requirements relating to pre-existing coverage exclusions to group health plans, applies requirements regarding adult child coverage to group health plans only if the adult child is not eligible to enroll in an employer-sponsored plan.

**Sec. 1252. Rating reforms must apply uniformly to all health insurance issuers and group health plans.** Standards and requirements adopted by States must be applied uniformly to all plans in each relevant insurance market in a State.

**Sec. 1253. Annual report on self-insured plans.** As added by Section 10103, requires the Secretary of Labor to prepare an annual report on various aspects of self-insured group health plans.

**Sec. 1254. Study of large group market.** As added by Section 10103, requires the Secretary of HHS to conduct a study of the fully-insured and self-insured group health plan markets to compare characteristics and determine the extent to which new insurance market reforms are likely to cause adverse selection in the large group market.

**Sec. 1255. Effective dates.** Section 10103 redesignates this section, previously 1253, as 1255. All provisions in this subtitle take effect on January 1, 2014. Section 10103 clarifies that the grandfathering takes effect on the date of enactment and applies the prohibition on pre-existing condition exclusions with respect to children effective six months after enactment.

#### **Subtitle D – Available Coverage for All Americans**

##### **Part I—Establishment of Qualified Health Plans**

**Sec. 1301. Qualified health plan defined.** Requires qualified health plans to be certified by Exchanges, provide the essential health benefits package, and be offered by licensed insurers that offer at least one qualified health plan at the silver and gold levels. Section 10104 strikes the community health insurance option from this section, adds multi-state plans, and allows qualified health plans to provide coverage through a qualified direct primary care medical home plan that meets requirements established by the Secretary of HHS.

**Sec. 1302. Essential health benefits requirements.** Defines an essential health benefits package as one that covers essential health benefits, limits cost-sharing, and has a specified actuarial value (pays for a specified percentage of costs), as follows:

1. For the individual and small group markets, requires the Secretary to define essential health benefits, which must be equal in scope to the benefits of a typical employer plan.
2. For all plans in all markets, prohibits out-of-pocket limits that are greater than the limits for Health Savings Accounts. For the small group market, prohibits deductibles that are greater than \$2,000 for individuals and \$4,000 for families. Indexes the limits and deductible amounts by the percentage increase in average per capita premiums.
3. For the individual and small group markets, requires one of the following levels of coverage, under which the plan pays for the specified percentage of costs:

Bronze:	60 percent
Silver:	70 percent
Gold:	80 percent
Platinum:	90 percent

In the individual market, a catastrophic-only plan may be offered to individuals who are under the age of 30 or who are exempt from the individual responsibility requirement because coverage is unaffordable to them or because of a hardship. A catastrophic plan must cover essential health benefits and at least three primary care visits, but must require cost-sharing up to the HSA out-of-pocket limits. Also, if an insurer offers a qualified health plan, it must offer a child-only plan at the same level of coverage. Finally, Section 10104 requires payments by qualified health plans to Federally Qualified Health Centers (FQHCs) to be at least as high as payments to FQHCs under Medicaid.

**Sec. 1303. Special rules.** As amended by Section 10104, this section:

- Affirms that States may prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition.
- Ensures that plans may elect whether or not to cover abortion. Requires a segregation of funds for subsidy-eligible individuals in plans that cover abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted. Subsidy-eligible individuals would pay one premium with two distinct payment transactions, with one going to an allocation account to be used exclusively for payment of such services. Requires State insurance commissioners to ensure compliance with the requirement to segregate federal funds in accordance with generally accepted accounting requirements and guidance from the Office of Management and Budget (OMB) and Government Accountability Office (GAO). Plans would be required to include in their benefit descriptions whether or not they cover abortion, as they will do for all other benefits. The allocation of the premium into its components would not be advertised or used in enrollment material. All applicants would see the same premium when they are choosing a plan.
- Includes conscience language that prohibits qualified health plans from discriminating against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.
- Ensures that federal and State laws regarding abortion are not preempted.

**Sec. 1304. Related definitions.** Defines the small group market as the market in which a plan is offered by a small employer that employs 1-100 employees. Defines the large group market as the market in which a plan is offered by a large employer that employs more than 100 employees. Before 2016, a State may limit the small group market to 50 employees. As amended by Section 10104, defines an "educated health care consumer," and requires Exchanges to consult with enrollees who are educated health care consumers.

#### **Part II—Consumer Choices and Insurance Competition through Health Benefit Exchanges**

**Sec. 1311. Affordable choices of health benefit plans.** Requires the Secretary to award grants, available until 2015, to States for planning and establishment of American Health Benefit Exchanges. By 2014, requires States to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and includes a SHOP Exchange for small businesses. Requires the Secretary to:

- Establish certification criteria for qualified health plans, requiring such plans to meet marketing requirements, ensure a sufficient choice of providers, include essential community providers in their networks, be accredited on quality, implement a quality improvement strategy, use a uniform enrollment form, present plan information in a standard format, and provide data on quality measures.
- Develop a rating system for qualified health plans, including information on enrollee satisfaction, and a model template for an Exchange's Internet portal.
- Determine an initial and annual open enrollment period, as well as special enrollment periods for certain circumstances.

Allows States to require benefits in addition to essential health benefits, but States must defray the cost of such additional benefits. Section 10104 clarifies that States must make payments to cover the cost of additional benefits directly to individuals or plans, and not to Exchanges. Requires Exchanges to certify qualified health plans, operate a toll-free hotline and Internet website, rate qualified health plans, present plan options in a standard format, inform individuals of eligibility for Medicaid and CHIP, provide an electronic calculator to calculate plan costs, and grant certifications of exemption from the individual responsibility requirement. Beginning in 2015, requires Exchanges to be self-sustaining and allows them to charge assessments or user fees. Allows Exchanges to certify qualified health plans if they meet certification criteria and offering them is in the interests of individuals and employers, and, as amended by Section 10104, requires Exchanges to consider the reasonableness of premium rate increases when determining whether to certify and offer plans. Allows regional or interstate Exchanges if the States agree to, and the Secretary approves, such Exchanges. Requires Exchanges to award grants to Navigators, which may include resource partners of the Small Business Administration, to educate the public about qualified health plans, distribute information on enrollment and tax credits, facilitate enrollment, and provide referrals on grievances, complaints, or questions.

As added by Section 10104, requires plans seeking certification by Exchanges to publicly disclose, in plain language, information on claims payment policies, enrollment, denials, rating practices, out-of-network cost-sharing, and enrollee rights. Requires such plans to provide information to enrollees on the amount of cost-sharing for a specific item or service. Requires the Secretary of Labor to update disclosure rules for group health plans to conform to these standards. Requires qualified health plans to implement activities to reduce health disparities, including the use of language services, community outreach, and cultural competency trainings.

**Sec. 1312. Consumer choice.** Allows qualified individuals, defined as individuals who are not incarcerated and who are lawfully residing in a State, to enroll in qualified health plans through that State's Exchange. Allows qualified employers to offer a choice of qualified health plans at one level of coverage; small employers qualify to do so, and States may allow large employers to qualify beginning in 2017. Requires insurers to pool the risk of all enrollees in all plans (except grandfathered plans) in each market, regardless of whether plans are offered through Exchanges. Requires the offering of only qualified health plans through Exchanges to Members of Congress and their staff. As amended by Section 10104, requires the Secretary to establish procedures to allow agents or brokers to enroll individuals and employers in qualified health plans and assist them in applying for tax credits and cost-sharing reductions.

**Sec. 1313. Financial integrity.** Requires Exchanges to keep an accurate accounting of all expenditures and submit annual accounting reports to the Secretary. Requires Exchanges to cooperate with Secretarial investigations and allows for Secretarial audits of Exchanges. If the Secretary finds serious misconduct in a State, allows the Secretary to rescind up to 1 percent of Federal payments to the State. As amended by Section 10104, narrows the application of the False Claims Act's public disclosure bar to ensure that whistleblowers who play a significant role in exposing fraud can be included in otherwise meritorious litigation. Also, requires GAO to study the cost and affordability of qualified health plans offered through Exchanges.

### Part III—State Flexibility Relating to Exchanges

**Sec. 1321. State flexibility in operation and enforcement of Exchanges and related requirements.** Requires the Secretary, in consultation with NAIC, to set standards for Exchanges, qualified health plans, reinsurance, and risk adjustment. Requires States to implement these standards by 2014. If the Secretary determines before 2013 that a State will not have an Exchange operational by 2014, or will not implement the standards, requires the Secretary to establish and operate an Exchange in the State and to implement the standards. Presumes that a State operating an Exchange before 2010 meets the standards, and establishes a process for the State to come into compliance with the standards.

**Sec. 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.** Requires the Secretary to award loans for start-up costs and grants to meet solvency requirements, until July 1, 2013, to member-run nonprofits that will offer qualified health plans. As amended by Section 10104, such loans must be repaid within 15 years. Establishes an Advisory Board with members appointed by the Comptroller General, to terminate by 2016. Prohibits health insurance issuers that existed on July 16, 2009 or governmental organizations from qualifying for the program. Allows participants to form a private purchasing council to enter into collective purchasing arrangements for items and services, but which may not set provider payment rates. Prohibits government representatives from serving on the board of directors of participants or the council. Appropriates \$6 billion for the CO-OP program, and exempts participants from taxation.

**Sec. 1323. Community health insurance option.** This section was struck by Section 10104.

**Sec. 1323. Funding for the territories.** As redesignated and added by Section 1204 of the *Reconciliation Act*, increases federal funding in the Senate bill for Puerto Rico, Virgin Islands, Guam, American Samoa, and the Northern Marianas Islands by \$2 billion. Effective July 1, 2011, raises the caps on federal Medicaid funding for each of the territories. Allows each territory to elect to operate a Health Benefits Exchange, by October 1, 2013.

**Sec. 1324. Level playing field.** Requires qualified health plans offered under the CO-OP program, or as multi-state plans, to be subject to all Federal and State laws that apply to private health insurers.

### Part IV—State Flexibility to Establish Alternative Programs

**Sec. 1331. State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid.** Allows States to contract, through a competitive process that includes negotiation of premiums, cost-sharing, and benefits, with standard health plans for individuals who are not eligible for Medicaid or other affordable coverage and have income below 200 percent of the Federal Poverty Level (FPL). Requires the Secretary to certify that participating individuals do not have to pay more in premiums and cost-sharing than they would have paid under qualified health plans, and that the plans cover essential health benefits.

Requires the Secretary to transfer to participating States 95 percent of the tax credits and cost-sharing reductions that would have been provided to individuals enrolled in standard health plans if they were enrolled in qualified health plans. Section 10104 clarifies that legal immigrants whose income is less than 133 percent of the Federal Poverty Level (FPL), and who are not eligible for Medicaid by virtue of the five year waiting period, are eligible for the basic health program.

**Sec. 1332. Waiver for State innovation.** Beginning in 2017, allows States to apply for a waiver for up to 5 years of requirements relating to qualified health plans, Exchanges, cost-sharing reductions, tax credits, the individual responsibility requirement, and shared responsibility for employers. Requires States to enact a law and to comply with regulations that ensure transparency. Requires the Secretary to provide to a State the aggregate amount of tax credits and cost-sharing reductions that would have been paid to residents of the State in the absence of a waiver. Requires the Secretary to determine that the State plan for a waiver will provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as this title would provide; and that it will not increase the Federal deficit.

**Sec. 1333. Provisions relating to offering of plans in more than one State.** By July 1, 2013, requires the Secretary, in consultation with NAIC, to issue regulations for interstate health care choice compacts, which can be entered into beginning in 2016. Under such compacts, qualified health plans could be offered in all participating States, but insurers would still be subject to the consumer protection laws of the purchaser's State. Insurers would be required to be licensed in all participating States (or comply as if they were licensed), and to clearly notify consumers that a policy may not be subject to all the laws and regulations of the purchaser's State. Requires States to enact a law to enter into compacts and Secretarial approval, but only if the Secretary determines that the compact will provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as this title would provide; and that it will not increase the Federal deficit or weaken enforcement of State consumer protection laws.

**Sec. 1334. Multi-State Plans.** As added by Section 10104, requires the Office of Personnel Management (OPM) to contract with health insurers to offer at least two multi-state qualified health plans (at least one non-profit) through Exchanges in each State. Requires OPM to negotiate contracts in a manner similar to the manner in which it negotiates contracts for Federal Employees Health Benefits Program (FEHBP), and allows OPM to prohibit multi-state plans that do not meet standards for medical loss ratios, profit margins, and premiums. Requires multi-state plans to cover essential health benefits and meet all of the requirements of a qualified health plan; States may require multi-state plans to offer additional benefits, but must pay for the additional cost. Multi-state plans must comply with 3:1 age rating, except States may require more protective age rating. Multi-state plans must comply with the minimum standards and requirements of FEHBP, unless they conflict with the PPACA. Guarantees that FEHBP will maintain a separate risk pool and remain a separate program.

## Part V—Reinsurance and Risk Adjustment

**Sec. 1341. Transitional reinsurance program for individual and small group markets in each State.** For 2014, 2015, and 2016, requires States to establish a nonprofit reinsurance entity that collects payments from insurers market and makes payments to insurers in the individual market that cover high-risk individuals. Requires the Secretary to establish Federal standards for the determination of high-risk individuals, a formula for payment amounts, and the contributions required of insurers, which must total \$25 billion over the three years.

**Sec. 1342. Establishment of risk corridors for plans in individual and small group markets.** Requires the Secretary to establish risk corridors for qualified health plans in 2014, 2015, and 2016. If a plan's costs (other than administrative costs) exceed 103 percent of total premiums, the Secretary makes payments to the plan to defray the excess. If a plan's costs (other than administrative costs) are less than 97 percent of total premiums, the plan makes payments to the Secretary.

**Sec. 1343. Risk adjustment.** Requires States to assess charges on health plans with enrollees of lower-than-average risk, and to provide payments to health plans with enrollees of higher-than-average risk. Risk adjustment applies to plans in the individual and small group markets, but not to grandfathered health plans.

### *Subtitle E—Affordable Coverage Choices for All Americans*

## Part I – Premium Tax Credits and Cost-Sharing Reductions

**Sec. 1401. Refundable tax credit providing premium assistance for coverage under a qualified health plan.** Amends the Internal Revenue Code to provide tax credits to assist with the cost of health insurance premiums.

**Sec. 36B. Refundable credit for coverage under a qualified health plan.** As amended by Section 1001 of the *Reconciliation Act*, the premium assistance credit amount is two percent for those up to 133 percent of poverty, and calculated on sliding scale starting at three percent of income for those at or above 133 percent of poverty and phasing out to 9.5 percent of income for those at 300-400 percent of poverty. The reference premium is the second lowest cost silver plan available in the individual market in the rating area in which the taxpayer resides. The premium assistance credits do not take into account benefits mandated by States. Employees offered coverage by an employer under which the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs or the premium exceeds 9.5 percent of the employee's income are eligible for the premium assistance credit. This section also provides for reconciliation of the premium assistance credit amount at the end of the taxable year and for a study on the affordability of health insurance coverage by the Comptroller General. The *Reconciliation Act* requires each Exchange to report to the Secretary and to the taxpayer information regarding health insurance coverage and any tax credits received.

**Sec. 1402. Reduced cost-sharing for individuals enrolling in qualified health plans.** The standard out-of-pocket maximum limits (\$5,950 for individuals and \$11,900 for families) would be reduced to one-third for those between 100-200 percent of poverty, one-half for those between 200-300 percent of poverty, and to two-thirds for those between 300-400 percent of poverty. As amended by Section 1001 of the *Reconciliation Act*, the plan's share of total allowed costs of benefits would be increased to 94 percent for those between 100-150 percent of poverty (i.e., the individual's liability is limited to 10 percent on average); 87 percent for those between 150-200 percent of poverty; 73 percent for those between 200-250 percent of poverty; and 70 percent for those between 250-400 percent of poverty. The cost-sharing assistance does not take into account benefits mandated by States.

**Sec. 1411. Procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost-sharing, and individual responsibility exemptions.** The Secretary shall establish a program for determining whether an individual applying for coverage in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, is a citizen or national of the United States or an alien lawfully present in the United States and meets the income and coverage requirements; whether an individual's coverage under an employer-sponsored health benefits plan is treated as unaffordable; and whether to grant a certification attesting that, for purposes of the individual responsibility requirement, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

**Sec. 1412. Advance determination and payment of premium tax credits and cost-sharing reductions.** Allows for the advanced payment of premium assistance tax credits and cost-sharing reductions for eligible individuals. Prohibits any Federal payments to individuals who are not lawfully present in the United States.

**Sec. 1413. Streamlining of procedures for enrollment through an Exchange and State Medicaid, CHIP, and health subsidy programs.** Requires the Secretary to establish a system for the residents of each State to apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. The system will ensure that if any individual applying to an Exchange is found to be eligible for Medicaid or a State children's health insurance program (CHIP), the individual is enrolled for assistance under such plan or program.

**Sec. 1414. Disclosures to carry out eligibility requirements for certain programs.** Allows for limited disclosure of tax return information to carry out eligibility requirements for certain programs listed in the Act.

**Sec. 1415. Premium tax credit and cost-sharing reduction payments disregarded for Federal and Federally-assisted programs.** Precludes the premium assistance tax credits and cost-sharing reductions from being counted as income for purposes of determining eligibility for any Federal program or under any State or local program financed in whole or in part with Federal funds.

**Sec. 1416. Study of geographic variation in application of FPL.** As added by Section 10105, directs the Secretary of HHS to study adjusting the definition of "federal poverty level" to reflect cost of living variations among different geographic areas within the United States.

#### **Part II – Small Business Tax Credit**

**Sec. 1421. Credit for employee health insurance expenses of small businesses.** Amends the Internal Revenue Code to provide tax credits to small employers.

**Sec. 45R. Employee health insurance expenses of small employers.** As amended by Section 10105, provides a sliding scale tax credit to small employers with fewer than 25 employees and average annual wages of less than \$50,000 that purchase health insurance for their employees. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000. To be eligible for a tax credit, the employer must contribute at least 50 percent of the total premium cost or 50 percent of a benchmark premium. In 2010 through 2013, eligible employers can receive a small business tax credit for up to 35 percent of their contribution toward the employee's health insurance premium. Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 25 percent of their contribution. In 2014 and beyond, eligible employers who purchase coverage through the State Exchange can receive a tax credit for two years of up to 50 percent of their contribution. Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 35 percent of their contribution.

#### **Subtitle F—Shared Responsibility for Health Care**

#### **Part I – Individual Responsibility**

**Sec. 1501. Requirement to maintain minimum essential coverage.** Contains findings of Congress related to the individual responsibility requirement, which are amended by Section 10106.

**Sec. 5000A. Requirement to maintain minimum essential coverage.** Requires individuals to maintain minimum essential coverage beginning in 2014. As amended by Section 1002 of the *Reconciliation Act*, failure to maintain coverage will result in a penalty of the greater of \$95 or one percent of income in 2014, \$325 or two percent of income in 2015 and \$695 or 2.5 percent of income in 2016, up to a cap of the national average bronze plan premium. Families will pay half the amount for children up to a cap of \$2,250 for the entire family. After 2016, dollar amounts will increase by the annual cost of living adjustment. Exceptions to the individual responsibility requirement to maintain minimum essential coverage are made for religious objectors, individuals not lawfully present, and incarcerated individuals. Exemptions from the penalty will be made for those who cannot afford coverage, taxpayers with income below the filing threshold, members of Indian tribes, those who have received a hardship waiver and those who were not covered for a period of less than three months during the year.

**Sec. 1502. Reporting of health insurance coverage.** Amends the Internal Revenue Code to require the reporting of health insurance coverage.

**Sec. 6055. Reporting of health insurance coverage.** Requires every person that provides coverage to report certain information about the coverage to the IRS.

#### **Part II – Employer Responsibilities**

**Sec. 1511. Automatic enrollment for employees of large employers.** Requires employers with more than 200 employees to automatically enroll new full-time employees in coverage (subject to any waiting period authorized by law) with adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in.

**Sec. 1512. Employer requirement to inform employees of coverage options.** Requires that an employer provide notice to their employees informing them of the existence of an Exchange. Also, if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium assistance tax credit and cost sharing reduction. Finally, if the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

**Sec. 1513. Shared responsibility for employers.** As amended by the *Reconciliation Act*, requires an employer with at least 50 full-time employees that does not offer coverage and has at least one full-time employee receiving a premium assistance tax credit to make a payment of \$2,000 per full-time employee. Includes the number of full-time equivalent employees for purposes of determining whether an employer has at least 50 employees. Exempts the first 30 full-time employees for the purposes of calculating the amount of the payment. Section 10106 clarifies that the calculation of full-time workers is made on a monthly basis. The *Reconciliation Act* eliminates the penalty for waiting periods before an employee may enroll in coverage. An employer with at least 50 employees that does offer coverage but has at least one full-time employee receiving the premium assistance tax credit will pay the lesser of \$3,000 for each of those employees receiving a tax credit or \$2,000 for each of their full-time employees total, not including the first 30 workers. The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments.

**Sec. 1514. Reporting of employer health insurance coverage.** Requires large employers to report to the Secretary whether it offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, the length of any applicable waiting period, the lowest cost option in each of the enrollment categories under the plan, and the employer's share of the total allowed costs of benefits provided under the plan. The employer must also report the number and names of full-time employees receiving coverage.

**Sec. 1515. Offering of exchange-participating qualified health plans through cafeteria plans.** Amends the Internal Revenue Code related to cafeteria plans.

**Sec. 125(f)(3). Certain exchange-participating health plans not qualified.** Plans provided through the exchange will not be an eligible benefit under an employer-sponsored cafeteria plan, except in the case of qualified employers (i.e., small employers, and, after 2017, large employers in electing states) offering a choice of plans to their employees through the exchange.

*Subtitle G—Miscellaneous Provisions*

**Sec. 1551. Definitions.** Applies the definitions contained in section 2791 of the Public Health Service Act to this title.

**Sec. 1552. Transparency in government.** Not later than 30 days after the date of enactment of this Act, the HHS Secretary shall publish on the HHS website a list of all of the authorities provided to the Secretary under this Act.

**Sec. 1553. Prohibition against discrimination on assisted suicide.** Prevents the Federal government, and any State or local government or health care provider that receives Federal financial assistance from subjecting any individual or institutional health care entity to discrimination on the basis that the entity does not provide assisted suicide, euthanasia, or mercy killing.

**Sec. 1554. Access to therapies.** Prevents the HHS Secretary from promulgating certain regulations limiting access to health care services.

**Sec. 1555. Freedom not to participate in Federal health insurance programs.** Provides that no individual, company, business, nonprofit entity, or health insurance issuer shall be required to participate in any Federal health insurance program created under this Act.

**Sec. 1556. Equity for certain eligible survivors.** Provides for improvements to the Black Lung Benefits Act.

**Sec. 1557. Nondiscrimination.** Protects individuals against discrimination under the Civil Rights Act, the Education Amendments Act, the Age Discrimination Act, and the Rehabilitation Act, through exclusion from participation in or denial of benefits under any health program or activity.

**Sec. 1558. Protection for employees.** Amends the Fair Labor Standards Act to ensure that no employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee has received a premium tax credit or for other reasons.

**Sec. 1559. Oversight.** The Inspector General of the Department of HHS shall have oversight authority with respect to the administration and implementation of this title as it relates to such Department.

**Sec. 1560. Rules of construction.** Nothing in this title shall be construed to modify, impair, or supersede the operation of any antitrust laws. Nothing in this title shall modify or limit the application of the exemption for Hawaii's Prepaid Health Care Act under ERISA. Nothing in this title shall be construed to prohibit an institution of higher education from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable Federal, State, or local law.

**Sec. 1561. Health information technology enrollment standards and protocols.** Requires the development of standards and protocols to promote the interoperability of systems for enrollment of individuals in Federal and State health and human services programs. These standards shall allow for electronic data matching, and electronic documentation. The Secretary may require State or other entities to incorporate such standards as a condition of receiving Federal health information technology funds.

**Sec. 1562. GAO study regarding the rate of denial of coverage and enrollment by health insurance issuers and group health plans.** As added by Section 10107, Directs the GAO to study the rate of denial of coverage and enrollment by health insurance issuers and group health plans.

**Sec. 1563. Conforming amendments.** Provides for technical and conforming amendments.

**Sec. 1563. Small business procurement.** Section 10107 moved this section, previously Section 1562, to Section 1563. Disallows any waiver of small business contracts under the Federal Acquisition Regulation of the Small Business Act.

**TITLE II – ROLE OF PUBLIC PROGRAMS**

*Subtitle A – Improved Access to Medicaid*

**Sec. 2001. Medicaid coverage for the lowest income populations.**

**Eligibility.** Creates a new State option to provide Medicaid coverage through a State plan amendment beginning on April 1, 2010, as amended by Section 10201. Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents). Creates a new mandatory Medicaid eligibility category for all such "newly-eligible" individuals with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. Effective April 1, 2010, states have the option to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment.

**Benefits.** Newly-eligible, non-elderly, non-pregnant individuals would receive benchmark or benchmark-equivalent coverage consistent with the requirements of section 1937 of the Social Security Act. Benchmark and benchmark-equivalent coverage would be required to provide at least essential benefits (as defined for the Exchange) and prescription drugs and mental health services would be added to the list of services that must be covered at actuarial equivalence.

**Increased Federal assistance.** As amended by Section 1201 of the *Reconciliation Act*, strikes the provision for a permanent 100 percent federal matching rate for Nebraska for the Medicaid costs of newly eligible individuals. Provides federal Medicaid matching payments for the costs of services to newly eligible individuals at the following rates: 100 percent in 2014, 2015, and 2016; 95 percent in 2017; 94 percent in 2018; 93 percent in 2019; and 90 percent thereafter. In the case of expansion states, additional federal support for covering nonpregnant childless adults is phased-in so that in 2019 and thereafter, expansion states would receive the same FMAP as other states for newly-eligible and previously-eligible nonpregnant childless adults.

**Maintenance of income eligibility.** States would be required to maintain the same income eligibility levels through December 31, 2013 for all adults. This "maintenance of effort" (MOE) requirement would be extended through September 30, 2019 for all children currently covered in Medicaid or CHIP. Between January 1, 2011 and January 1, 2014, a State would be exempt from the MOE requirement for optional, non-pregnant, non-disabled, adult populations whose family income is above 133 percent of FPL if the State certifies to the Secretary that the State is currently experiencing a budget deficit or projects to have a budget deficit in the following State fiscal year.

**Sec. 2002. Income eligibility for nonelderly determined using modified adjusted gross income.** Beginning January 1, 2014, States would be required to use modified adjusted gross income to determine Medicaid eligibility, the same measure used in the State Exchanges. Income disregards and asset tests would generally no longer apply in Medicaid, except for individuals eligible for long-term services and supports and individuals that are eligible for Medicaid through another program. As amended by Section 1004 of the *Reconciliation Act*, applies a five percent income disregard for all Medicaid applicants.

**Sec. 2003. Requirement to offer premium assistance for employer-sponsored insurance.** Requires States to offer premium assistance and wrap-around benefits to all Medicaid beneficiaries who are offered employer-sponsored insurance (ESI) if it is cost-effective to do so, based on current law requirements.

**Sec. 2004. Medicaid coverage for former foster care children.** As amended by Section 10201, Makes the State option to cover former foster children in Medicaid mandatory, moves the effective date up to 2014, and limits it to only those children who have aged out of the foster care system as of the date of enactment. Children who qualify for Medicaid through this eligibility pathway would receive all benefits under Medicaid, including EPSDT.

**Sec. 2005. Payments to territories.** Section 1204 of the *Reconciliation Act*, redesignates funding for the territories as Section 1323, above.

**Sec. 2006. Special adjustment to FMAP determination for certain States recovering from a major disaster.** Reduces projected decreases in Medicaid funding for States that have experienced major, statewide disasters.

**Sec. 2007. Medicaid Improvement Fund rescission.** Rescinds funds available in the Medicaid Improvement Fund (MIF) for fiscal years 2014 through 2018.

***Subtitle B – Enhanced Support for the Children's Health Insurance Program***

**Sec. 2101. Additional Federal financial participation for CHIP.** Upon enactment, States would be required to maintain income eligibility levels for CHIP through September 30, 2019. From fiscal year 2014 to 2019, States would receive a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent. CHIP-eligible children who cannot enroll in CHIP due to Federal allotment caps would be eligible for tax credits in the State Exchange. As amended by Section 10203, extends the current reauthorization period of CHIP for two years, through September 30, 2015. States will receive a 23 percentage point increase in their federal match rates beginning fiscal year 2016 through fiscal year 2019. This provision also increases outreach and enrollment grants by \$40 million, makes some children of public employees eligible for CHIP, and precludes transitioning coverage from CHIP to the Exchange without Secretarial certification. It also requires insurers in the Exchange to report to the Secretary on pediatric quality measures.

**Sec. 2102. Technical corrections.** Makes technical corrections to selected provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the American Recovery and Reinvestment Act of 2009 (ARRA).

***Subtitle C – Medicaid and CHIP Enrollment Simplification***

**Sec. 2201. Enrollment Simplification and coordination with State Health Insurance Exchanges.** Allows individuals to apply for and enroll in Medicaid, CHIP or the Exchange through a State-run website. Requires State Medicaid and CHIP programs and the Exchange to coordinate enrollment procedures to provide seamless enrollment for all programs.

**Sec. 2202. Permitting hospitals to make presumptive eligibility determinations for all Medicaid eligible populations.** Allows any hospital the option, based off preliminary information, to provide Medicaid services during a period of presumptive eligibility to members of all Medicaid eligibility categories.

***Subtitle D – Improvements to Medicaid Services***

**Sec. 2301. Coverage for freestanding birth center services.** Requires coverage of services provided by free-standing birth centers.

**Sec. 2302. Concurrent care for children.** Allows children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness.

**Sec. 2303. State eligibility option for family planning services.** Adds a new optional categorically-needy eligibility group to Medicaid comprised of (1) non-pregnant individuals with income up to the highest level applicable to pregnant women covered under Medicaid or CHIP, and (2) individuals eligible under the standards and processes of existing section 1115 waivers that provide family planning services and supplies. Benefits would be limited to family planning services and supplies, including related medical diagnostic and treatment services.

**Sec. 2304. Clarification of definition of medical assistance.** Clarifies that "medical assistance" encompasses both payment for services provided and the services themselves.

**Subtitle E – New Options for States to Provide Long-Term Services and Supports**

**Sec. 2401. Community First Choice Option.** Establishes an optional Medicaid benefit through which States could offer community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require the level of care offered in a hospital, nursing facility, or intermediate care facility for the mentally retarded. As amended by Section 1205 of the *Reconciliation Act*, October 1, 2011 is the effective date for this policy.

**Sec. 2402. Removal of barriers to providing home and community-based services.** Removes barriers to providing HCBS by giving States the option to provide more types of HCBS through a State plan amendment to individuals with higher levels of need, rather than through a waiver, and to extend full Medicaid benefits to individuals receiving HCBS under a State plan amendment.

**Sec. 2403. Money Follows the Person Rebalancing Demonstration.** Extends the Money Follows the Person Rebalancing Demonstration through September 30, 2016 and changes the eligibility rules for individuals to participate in the demonstration project by requiring that individuals reside in an inpatient facility for not less than 90 consecutive days.

**Sec. 2404. Protection for recipients of home and community-based services against spousal impoverishment.** Requires States to apply spousal impoverishment rules to beneficiaries who receive HCBS. This provision would apply for a five-year period beginning on January 1, 2014.

**Sec. 2405. Funding to expand State Aging and Disability Resource Centers.** Appropriates, to the Secretary of HHS, \$10 million for each of FYs 2010 through 2014 to carry out Aging and Disability Resource Center (ADRC) initiatives.

**Sec. 2406. Sense of the Senate regarding long-term care.** Expresses the Sense of the Senate that during the 111<sup>th</sup> Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need, in the community as well as in institutions.

**Subtitle F – Medicaid Prescription Drug Coverage**

**Sec. 2501. Prescription drug rebates.** The flat rebate for single source and innovator multiple source outpatient prescription drugs would increase from 15.1 percent to 23.1 percent, except the rebate for clotting factors and outpatient drugs approved by the Food and Drug Administration exclusively for pediatric indications would increase to 17.1 percent. The basic rebate percentage for multi-source, non-innovator drugs would increase from 11 percent to 13 percent. Drug manufacturers would also be required to pay rebates for drugs dispensed to Medicaid beneficiaries who receive care from a Medicaid managed care organization (MCO). Total rebate liability would be limited to 100 percent of the average manufacturer price (AMP). Additional revenue generated by these increases will be remitted to the federal government. As amended by Section 1206 of the *Reconciliation Act*, for purposes of applying the additional rebate, narrows the definition of a new formulation of a drug to a line extension of a single source or innovator multiple source drug that is an oral solid dosage form of the drug.

**Sec. 2502. Elimination of exclusion of coverage of certain drugs.** Beginning with drugs dispensed on January 1, 2014, smoking cessation drugs, barbiturates, and benzodiazepines would be removed from Medicaid's excludable drug list.

**Sec. 2503. Providing adequate pharmacy reimbursement.** Requires the Secretary to calculate the Federal upper limit (FUL) as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies.

**Subtitle G – Medicaid Disproportionate Share Hospital (DSH) Payments**

**Sec. 2551. Disproportionate share hospital payments.** As amended by Section 1203 of the *Reconciliation Act*, lowers the reduction in federal Medicaid DSH payments from \$18.1 billion to \$14.1 billion and advances the reductions to begin in fiscal year 2014. Directs the Secretary to develop a methodology for reducing DSH allotments to all states in order to achieve the mandated reductions. Extends through FY 2013 the federal DSH allotment for a state that has a \$0 allotment after FY 2011.

**Subtitle H – Improved Coordination for Dual Eligible Beneficiaries**

**Sec. 2601. 5-year period for demonstration projects.** Clarifies that Medicaid waivers for coordinating care for dual eligible beneficiaries could be authorized for as long as five years.

**Sec. 2602. Providing Federal coverage and payment coordination for dual eligible beneficiaries.** Requires the Secretary to establish a Federal Coordinated Health Care Office (CHCO) within CMS by March 1, 2010. The purpose of the CHCO would be to bring together officials of the Medicare and Medicaid programs to (1) more effectively integrate benefits under those programs, and (2) improve the coordination between the Federal and State governments for

individuals eligible for benefits under both Medicare and Medicaid (dual eligibles) to ensure that dual eligibles have full access to the items and services to which they are entitled.

*Subtitle I – Improving the Quality of Medicaid for Patients and Providers*

**Sec. 2701. Adult health quality measures.** Directs the Secretary of HHS to develop a set of quality measures for Medicaid eligible adults that is similar to the quality measurement program for children enacted in the Children’s Health Insurance Program Reauthorization Act of 2009. The Secretary and the States will report on the development of and improvements to the quality measurement program on a regular basis.

**Sec. 2702. Payment adjustment for health care-acquired conditions.** Prohibits Medicaid payment for services related to a health care-acquired condition. The Secretary will develop a list of health care-acquired conditions for Medicaid based on those defined under Medicare as well as current State practices.

**Sec. 2703. State option to provide health homes for enrollees with chronic conditions.** Provide States the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination.

**Sec. 2704. Demonstration project to evaluate integrated care around a hospitalization.** Establishes a demonstration project, in up to eight States, to study the use of bundled payments for hospital and physicians services under Medicaid.

**Sec. 2705. Medicaid global payment system demonstration project.** Establishes a demonstration project, in coordination with the CMS Innovation Center, in up to five States that would allow participating States to adjust their current payment structure for safety net hospitals from a fee-for-service model to a global capitated payment structure.

**Sec. 2706. Pediatric Accountable Care Organization demonstration project.** Establishes a demonstration project that allows qualified pediatric providers to be recognized and receive payments as Accountable Care Organizations (ACO) under Medicaid. The pediatric ACO would be required to meet certain performance guidelines. Pediatric ACOs that met these guidelines and provided services at a lower cost would share in those savings.

**Sec. 2707. Medicaid emergency psychiatric demonstration project.** Requires the Secretary of HHS to establish a three-year Medicaid demonstration project in up to eight States. Participating States would be required to reimburse certain institutions for mental disease (IMDs) for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition.

*Subtitle J – Improvements to the Medicaid and CHIP Payment and Access Commission*

**Sec. 2801. MACPAC assessment of policies affecting all Medicaid beneficiaries.** Clarifies the topics to be reviewed by the Medicaid and CHIP Payment and Access Commission (MACPAC) including Federal Medicaid and CHIP regulations, additional reports of State-specific data, and an assessment of adult services in Medicaid. The provision would also authorize \$11 million to fund MACPAC for FY2010.

*Subtitle K – Protections for American Indians and Alaska Natives*

**Sec. 2901. Special rules relating to Indians.** Prohibits cost-sharing for Indians enrolled in a qualified health benefit plan in the individual market through a State Exchange. Also, facilities operated by the Indian Health Service (IHS) and Indian, Tribal, and Urban Indian facilities (IT/Us) would be added to the list of agencies that could serve as an “Express Lane” agency able to determine Medicaid and CHIP eligibility.

**Sec. 2902. Elimination of sunset for reimbursement for all Medicare Part B services furnished by certain Indian hospitals and clinics.** Removes the sunset provision, allowing IHS and IT/U services to continue to be reimbursed by Medicare Part B.

*Subtitle L – Maternal and Child Health Services*

**Sec. 2951. Maternal, infant, and early childhood home visiting programs.** Provides funding to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s). Model options would be targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.

**Sec. 2952. Support, education, and research for postpartum depression.** Provides support services to women suffering from postpartum depression and psychosis and also helps educate mothers and their families about these conditions. Provides support for research into the causes, diagnoses, and treatments for postpartum depression and psychosis.

**Sec. 2953. Personal responsibility education.** Provides \$75 million per year through FY2014 for Personal Responsibility Education grants to States for programs to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS. Funding is also available for 1) innovative teen pregnancy prevention strategies and services to high-risk, vulnerable, and culturally under-represented populations, 2) allotments to Indian tribes and tribal organizations, and 3) research and evaluation, training, and technical assistance.

**Sec. 2954. Restoration of funding for abstinence education.** Appropriates \$50 million per year through FY 2014 for abstinence education.

**Sec. 2955. Inclusion of information about the importance of having a health care power of attorney in transition planning for children aging out of foster care and independent living programs.** Enables children aging out of the foster care system to have the opportunity to designate a medical power of attorney prior to emancipation from foster care. States must supply information and an opportunity for the child to designate another individual to make medical decisions on their behalf should they be unable to participate in such decision making process as part of the transition process for children expected to age out of the foster care system.

### **TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE**

#### ***Subtitle A—Transforming the Health Care Delivery System***

##### **Part I – Linking Payment to Quality Outcomes under the Medicare Program**

**Sec. 3001. Hospital value-based purchasing program.** The proposal would establish a value-based purchasing program for hospitals starting in FY2013. Under this program, a percentage of hospital payment would be tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care. Quality measures included in the program (and in all other quality programs in this title) will be developed and chosen with input from external stakeholders. Section 10335 clarifies that the hospital VBP program shall not include measures of hospital readmissions.

**Sec. 3002. Improvements to the physician quality reporting initiative.** Extends through 2014 payments under the PQRI program, which provide incentives to physicians who report quality data to Medicare. Creates appeals and feedback processes for participating professionals in PQRI. Establishes a participation pathway for physicians completing a qualified Maintenance of Certification program with their specialty board of medicine. Beginning in 2014, physicians who do not submit measures to PQRI will have their Medicare payments reduced. Section 10327 provides an additional 0.5 percent Medicare payment bonus to physicians who successfully report quality measures to CMS via the new Maintenance of Certification program and eliminates the MA Regional Plan Stabilization Fund.

**Sec. 3003. Improvements to the physician feedback program.** Expands Medicare's physician resource use feedback program to provide for development of individualized reports by 2012. Reports will compare the per capita utilization of physicians (or groups of physicians) to other physicians who see similar patients. Reports will be risk-adjusted and standardized to take into account local health care costs.

**Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, inpatient psychiatric hospitals and hospice programs.** Establishes a path toward value-based purchasing for long-term care hospitals, inpatient rehabilitation facilities, and hospice providers by requiring the Secretary to implement quality measure reporting programs for these providers in FY2014. Providers under this section who do not successfully participate in the program would be subject to a reduction in their annual market basket update. Section 10322 also

establishes a quality measure reporting program for inpatient psychiatric hospitals beginning FY2014.

**Sec. 3005. Quality reporting for PPS-exempt cancer hospitals.** Establishes a quality measure reporting program for PPS-exempt cancer hospitals beginning in FY2014. Providers under this section who do not successfully participate in the program would be subject to a reduction in their annual market basket update.

**Sec. 3006. Plans for a value-based purchasing program for skilled nursing facilities and home health agencies.** Directs the Secretary to submit a plan to Congress by FY2012 outlining how to effectively move these providers into a value-based purchasing payment system. As amended by Section 10301, requires the Secretary of HHS to develop a plan to reimburse Ambulatory Surgery Centers (ASCs) based on the quality and efficiency of care delivered in ASCs.

**Sec. 3007. Value-based payment modifier under the physician fee schedule.** Directs the Secretary of HHS to develop and implement a budget-neutral payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver. Quality and cost measures will be risk-adjusted and geographically standardized. The Secretary will phase-in the new payment system over a two-year period beginning in 2015.

**Sec. 3008. Payment adjustment for conditions acquired in hospitals.** Starting in FY2015, hospitals in the top 25th percentile of rates of hospital acquired conditions for certain high-cost and common conditions would be subject to a payment penalty under Medicare. This provision also requires the Secretary to submit a report to Congress by January 1, 2012 on the appropriateness of establishing a healthcare acquired condition policy related to other providers participating in Medicare, including nursing homes, inpatient rehabilitation facilities, long-term care hospitals, outpatient hospital departments, ambulatory surgical centers, and health clinics.

##### **Part II – National Strategy to Improve Health Care Quality**

**Sec. 3011. National strategy.** Requires the Secretary to establish and update annually a national strategy to improve the delivery of health care services, patient health outcomes, and population health. Establishes, not later than January 1, 2011, a Federal health care quality internet website. Section 10302 clarifies that the limitations on use of comparative effectiveness data apply to the development of the National Strategy for Quality Improvement.

**Sec. 3012. Interagency Working Group on Health Care Quality.** Requires the President to convene an Interagency Working Group on Health Care Quality comprised of Federal agencies to collaborate on the development and dissemination of quality initiatives consistent with the national strategy.

**Sec. 3013. Quality measure development.** Authorizes \$75 million over 5 years for the development of quality measures at AHRQ and the Centers for Medicare and Medicaid Services

(CMS). Quality measures developed under this section will be consistent with the national strategy. As amended by Section 10303, requires the Secretary of HHS to develop and publicly report on patient outcomes measures.

**Sec. 3014. Quality measurement.** Provides \$20 million to support the endorsement and use of endorsed quality and efficiency measures by the HHS Secretary for use in Medicare, reporting performance information to the public, and in health care programs.

**Sec. 3015. Data Collection; Public Reporting.** Requires the Secretary to collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information. As amended by Section 10305, requires the Secretary of HHS to develop a plan for the collection and public reporting of quality measures.

### Part III – Encouraging Development of New Patient Care Models

**Sec. 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS.** Establishes within the Centers for Medicare and Medicaid Services (CMS) a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Dedicated funding is provided to allow for testing of models that require benefits not currently covered by Medicare. Successful models can be expanded nationally. Section 10306 adds payment reform models to the list of projects for the Center to consider, including rural telehealth expansions and the development of a rapid learning network. Ensures that quality measures used by the Center are consistent with the quality framework within the underlying bill, and requires the Secretary to focus on models that both improve quality and reduce costs.

**Sec. 3022. Medicare shared savings program.** Rewards Accountable Care Organizations (ACOs) that take responsibility for the costs and quality of care received by their patient panel over time. ACOs can include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others). ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program. Section 10307 provides additional flexibility to the Secretary of HHS to implement innovative payment models for participating Accountable Care Organizations, including models currently used in the private sector.

**Sec. 3023. National pilot program on payment bundling.** Directs the Secretary to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models. Requires the Secretary to establish this program by January 1, 2013 for a period of five years. Before January 1, 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will improve patient care and reduce spending. Section 10308 provides the Secretary of HHS authority to expand the payment bundling pilot if it is

found to improve quality and reduce costs. Also, directs the Secretary to test bundled payment arrangements involving continuing care hospitals within the bundling pilot program.

**Sec. 3024. Independence at home demonstration program.** Creates a new demonstration program for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system that utilizes physician and nurse practitioner directed home-based primary care teams aimed at reducing expenditures and improving health outcomes.

**Sec. 3025. Hospital readmissions reduction program.** Beginning in FY2012, this provision would adjust payments for hospitals paid under the inpatient prospective payment system based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for the three conditions with risk adjusted readmission measures that are currently endorsed by the National Quality Forum. Also, provides the Secretary authority to expand the policy to additional conditions in future years and directs the Secretary to calculate and make publicly available information on all patient hospital readmission rates for certain conditions. Section 10309 makes a technical correction to the hospital readmissions payment policy establishing in the underlying section.

**Sec. 3026. Community-based care transitions program.** Provides funding to hospitals and community-based entities that furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission.

**Sec. 3027. Extension of gainsharing demonstration.** The Deficit Reduction Act of 2005 authorized a demonstration to evaluate arrangements between hospitals and physicians designed to improve the quality and efficiency of care provided to beneficiaries. This provision would extend the demonstration through September 30, 2011 and extend the date for the final report to Congress on the demonstration to September 30, 2012. It would also authorize an additional \$1.6 million in FY2010 for carrying out the demonstration.

### Subtitle B – Improving Medicare for Patients and Providers

#### Part I – Ensuring Beneficiary Access to Physician Care and Other Services

**Sec. 3101. Increase in the physician payment update.** This section is repealed by Section 10310.

**Sec. 3102. Extension of the work geographic index floor and revisions to the practice expense geographic adjustment under the Medicare physician fee schedule.** Extends a floor on geographic adjustments to the work portion of the fee schedule through the end of 2010, with the effect of increasing practitioner fees in rural areas. Also provides immediate relief to areas negatively impacted by the geographic adjustment for practice expenses, and requires the Secretary of HHS to improve the methodology for calculating practice expense adjustments beginning in 2012. As amended by Section 1108 of the *Reconciliation Act*, accelerates phase-in of Medicare physician practice expense adjustment for areas with below average practice expense payment rates. In 2010, the national blend would be increased from ¼ to ½.

**Sec. 3103. Extension of exceptions process for Medicare therapy caps.** Extends the process allowing exceptions to limitations on medically necessary therapy until December 31, 2010.

**Sec. 3104. Extension of payment for technical component of certain physician pathology services.** Extends a provision that directly reimburses qualified rural hospitals for certain clinical laboratory services through the end of 2010.

**Sec. 3105. Extension of ambulance add-ons.** Extends bonus payments made by Medicare for ground and air ambulance services in rural and other areas through the end of 2010. Section 10311 requires the Secretary of HHS to implement the extension of the ambulance payment bonuses on January 1, 2010.

**Sec. 3106. Extension of certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities.** Extends Sections 114 (c) and (d) of the Medicare, Medicaid and SCHIP Extension Act of 2007 by two years, as amended by Section 10312.

**Sec. 3107. Extension of physician fee schedule mental health add-on.** Increases the payment rate for psychiatric services by 5 percent for two years, through the end of 2010.

**Sec. 3108. Permitting physician assistants to order post-hospital extended care services.** Authorizes physician assistants to order skilled nursing care services in the Medicare program beginning in 2011.

**Sec. 3109. Exemption of certain pharmacies from accreditation requirements.** Allows pharmacies with less than 5 percent of revenues from Medicare DMEPOS billings to be exempt from accreditation requirements until the Secretary of HHS develops pharmacy-specific standards.

**Sec. 3110. Part B special enrollment period for disabled TRICARE beneficiaries.** Creates a twelve-month special enrollment period for military retirees, their spouses (including widows/widowers) and dependent children, who are otherwise eligible for TRICARE and entitled to Medicare Part A based on disability or ESRD, but who have declined Part B.

**Sec. 3111. Payment for bone density tests.** Restores payment for dual-energy x-ray absorptiometry (DXA) services furnished during 2010 and 2011 to 70 percent of the Medicare rate paid in 2006.

**Sec. 3112. Revision to the Medicare Improvement Fund.** Eliminates the remaining funds in the Medicare Improvement Fund.

**Sec. 3113. Treatment of certain complex diagnostic laboratory tests.** Creates a demonstration program to test the impact of direct payments for certain complex laboratory tests on Medicare quality and costs.

**Sec. 3114. Improved access for certified nurse-midwife services.** Increases the payment rate for certified nurse midwives for covered services from 65 percent of the rate that would be paid were a physician performing a service to the full rate.

#### **PART II – Rural Protections**

**Sec. 3121. Extension of outpatient hold harmless provision.** Extends the existing outpatient hold harmless provision through the end of FY2010 and would allow Sole Community Hospitals with more than 100 beds to also be eligible to receive this adjustment through the end of FY2010.

**Sec. 3122. Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas.** Reinstates the policy included in the Medicare Modernization Act of 2003 (P.L. 108-173) that provides reasonable cost reimbursement for laboratory services provided by certain small rural hospitals from July 1, 2010 to July 1, 2011.

**Sec. 3123. Extension of the Rural Community Hospital Demonstration Program.** Extends the program for five years, as amended by Section 10313, expands eligible sites to additional States and additional rural hospitals, and makes adjustments to payment levels provided within the demonstration program.

**Sec. 3124. Extension of the Medicare-dependent hospital (MDH) program.** Extends the Medicare-dependent hospital program by one year through October 1, 2012. It would also require HHS to study whether certain urban hospitals should qualify for the MDH program.

**Sec. 3125. Temporary improvements to the Medicare inpatient hospital payment adjustment for low-volume hospitals.** Expands the program providing a temporary adjustment to inpatient hospital payments for certain low-volume hospitals through FY2012 and would modify eligibility requirements regarding distance from another facility. Also, in Section 10314, modifies requirements regarding the number of eligible discharges.

**Sec. 3126. Improvements to the demonstration project on community health integration models in certain rural counties.** The Medicare Improvements for Patients and Providers Act (MIPPA, P.L. 110-275) authorized a demonstration project that will allow eligible rural entities to test new models for the delivery of health care services in rural areas. This provision will expand the demonstration to allow additional counties to participate and will also allow physicians to participate in the demonstration project.

**Sec. 3127. MedPAC study on adequacy of Medicare payments for health care providers serving in rural areas.** This provision would require MedPAC to review payment adequacy for rural health care providers serving the Medicare program, including an analysis of the rural payment adjustments included in this legislation and beneficiaries' access to care in rural communities.

**Sec. 3128. Technical correction related to critical access hospital services.** This provision clarifies that CAHs can continue to be eligible to receive 101 percent of reasonable costs for providing outpatient care regardless of eligible billing method the facility uses and for providing qualifying ambulance services.

**Sec. 3129. Extension of and revisions to Medicare rural hospital flexibility program.** This provision extends the Flex Grant program through 2012 and will allow Flex grant funding to be used to support rural hospitals' efforts to implement delivery system reform programs, such as value-based purchasing programs, bundling, and other quality programs.

### **Part III – Improving Payment Accuracy**

**Sec. 3131. Payment adjustments for home health care.** This provision would direct the Secretary to improve payment accuracy through rebasing home health payments starting in 2014, as amended by Section 10315, based on an analysis of the current mix of services and intensity of care provided to home health patients. The provision would also establish a 10 percent cap on the amount of reimbursement a home health provider can receive from outlier payments and would reinstate an add-on payment for rural home health providers from April 1, 2010 through 2015. In addition, it would require the Secretary to submit a report to Congress by March 1, 2011 on recommended payment reforms related to serving patients with varying severity of illness or to improve beneficiary access to care. As amended by Section 10315, directs the Secretary to study improving access to home health care for certain patients, including those with high-severity levels of illness, low-income and living in underserved areas, and provides the Secretary authority to conduct a demonstration program based on the results of the study.

**Sec. 3132. Hospice reform.** This provision would require the Secretary to update Medicare hospice claims forms and cost reports by 2011. Based on this information, the Secretary would be required to implement changes to the hospice payment system to improve payment accuracy in FY2013. The Secretary would also impose certain requirements on hospice providers designed to increase accountability in the Medicare hospice program.

**Sec. 3133. Improvement to Medicare disproportionate share hospital (DSH) payments.** This provision would require the Secretary to update hospital payments to better account for hospitals' uncompensated care costs. Starting in FY2014, hospitals' Medicare Disproportionate Share Hospital (DSH) payments would be reduced to reflect lower uncompensated care costs relative to increases in the number of insured. As amended by Section 1104 of the *Reconciliation Act*, reduces the 10-year reduction in Medicare DSH payments by \$3 billion..

**Sec. 3134. Misvalued codes under the physician fee schedule.** Directs the Secretary to regularly review fee schedule rates for physician services paid for by Medicare, including services that have experienced high growth rates. Strengthens the Secretary's authority to adjust fee schedule rates that are found to be misvalued or inaccurate.

**Sec. 3135. Modification of equipment utilization factor for advanced imaging services.** As

amended by Section 1107 of the Reconciliation Act, effective January 1, 2011, takes into account the CMS imaging rule that went into effect on January 1, 2010, but sets the assumed utilization rate at 75 percent for the practice expense portion of advanced diagnostic imaging services. Excludes low-tech imaging such as ultrasound, x-rays and EKGs from this adjustment. Also adjusts the technical component discount on single session imaging studies on contiguous body parts from 25 percent to 50 percent.

**Sec. 3136. Revision of payment for power-driven wheelchairs.** Eliminates the option for Medicare to purchase power-driven wheelchairs with a lump-sum payment at the time the chair is supplied. Medicare would continue to make the same payments for power-driven chairs over a 13-month period. Purchase option for complex rehabilitative power wheelchairs would be maintained.

**Sec. 3137. Hospital wage index improvement.** Extends reclassifications under section 508 of the Medicare Modernization Act (P.L 108-173) through the end of FY2010. In addition, requires the Secretary to provide recommendations to Congress on ways to comprehensively reform the Medicare wage index system by December 31, 2011. Also directs the Secretary to restore the reclassification thresholds used to determine hospital reclassifications to the percentages used in FY2009, starting in FY2011 until the first fiscal year that is on or after the date the Secretary submits the report to Congress on reforming the wage index system. Section 10317 clarifies the Secretary may only use wage data of certain eligible hospitals in carrying out this provision if doing so does not result in lower wage index adjustments for affected facilities.

**Sec. 3138. Treatment of certain cancer hospitals.** Directs the Secretary to study whether existing cancer hospitals that are exempt from the inpatient prospective payment system have costs under the outpatient prospective payment system (OPPS) that exceed costs of other hospitals, and to make an appropriate payment adjustment under OPPS based on that analysis.

**Sec. 3139. Payment for biosimilar biological products.** Sets the add-on payment rate for biosimilar products reimbursement under Medicare Part B at 6 percent of the average sales price of the brand biological product.

**Sec. 3140. Medicare hospice concurrent care demonstration program.** Directs the Secretary to establish a three-year demonstration program that would allow patients who are eligible for hospice care to also receive all other Medicare covered services during the same period of time. The demonstration would be conducted in up to 15 hospice programs in both rural and urban areas and would evaluate the impacts of the demonstration on patient care, quality of life and spending in the Medicare program.

**Sec. 3141. Application of budget neutrality on a national basis in the calculation of the Medicare hospital wage index floor.** Starting on October 1, 2010, the provision would require application of budget neutrality associated with the effect of the imputed rural and rural floor to be applied on a national, rather than State-specific basis through a uniform, national adjustment to the area wage index.

**Sec. 3142. HHS study on urban Medicare-dependent hospitals.** Requires the Secretary to conduct a study on the need for additional Medicare payments for certain urban Medicare-dependent hospitals paid under the inpatient prospective payment system.

**Sec. 3143. Protecting home health benefits.** Ensures that guaranteed Medicare home health benefits will not be reduced.

**Subtitle C – Provisions Related to Part C**

**Sec. 3201. Medicare Advantage payment.** This section was repealed by Section 1102 of the *Reconciliation Act*, described below.

**Sec. 3202. Benefit protection and simplification.** Prohibits Medicare Advantage plans from charging beneficiaries cost sharing for covered services that is greater than what is charged under the traditional fee-for-service program. Requires plans that provide extra benefits to give priority to cost sharing reductions, wellness and preventive care, and then benefits not covered under Medicare.

**Sec. 3203. Application of coding intensity adjustment during MA payment transition.** This section was repealed by Section 1102 of the *Reconciliation Act*, described below.

**Sec. 3204. Simplification of annual beneficiary election periods.** Provides extra time for CMS, Medicare Advantage plans and prescription drug plans to process enrollment paperwork during annual enrollment periods and eliminates a duplicative open enrollment period for Medicare Advantage plans. Allows beneficiaries to disenroll from a Medicare Advantage plan and return to the traditional fee-for-service program from January 1 to March 15 of each year.

**Sec. 3205. Extension for specialized MA plans for special needs individuals.** Extends the SNP program through 2013 and requires SNPs to be NCQA approved. Allows HHS to apply a frailty payment adjustment to fully-integrated, dual-eligible SNPs that enroll frail populations. Requires HHS to transition beneficiaries enrolled in SNPs that do not meet statutory target definitions and requires dual-eligible SNPs to contract with State Medicaid programs beginning 2013. Also requires an evaluation of Medicare Advantage risk adjustment for chronically ill populations.

**Sec. 3206. Extension of reasonable cost contracts.** Extends the period of time for which cost plans may operate in areas that have other health plan options.

**Sec. 3207. Technical correction to MA private fee-for-service plans.** Allows employer-sponsored private fee-for-service plans authorized under 1857(i)(2) with current enrollment to use, beginning 2011, a CMS service area waiver available to employer and union group health plans that are coordinated care plans.

**Sec. 3208. Making senior housing facility demonstration permanent.** Allows demonstration plans that serve residents in continuing care retirement communities to operate under the

Medicare Advantage program.

**Sec. 3209. Authority to deny plan bids.** Authorizes the HHS Secretary to deny bids submitted by Medicare Advantage and prescription plans, beginning in 2011, that propose to significantly increase beneficiary cost sharing or decrease benefits offered under the plan.

**Sec. 3209. Development of new standards for certain Medigap plans.** Requires HHS to request NAIC revisions to the standards for benefit packages classified as “C” and “F” so that these packages include nominal cost sharing that encourages the use of appropriate Part B physician services.

**Subtitle D – Medicare Part D Improvements for Prescription Drug Plans and MA–PD Plans**

**Sec. 3301. Medicare coverage gap discount program.** Requires drug manufacturers to provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning January 1, 2011.

**Sec. 3302. Improvement in determination of Medicare part D low-income benchmark premium.** Removes Medicare Advantage rebates and quality bonus payments from the calculation of the low-income subsidy benchmark.

**Sec. 3303. Voluntary de minimis policy for subsidy-eligible individuals under prescription drug plans and MA–PD plans.** Allows Part D plans that bid a nominal amount above the regional low-income subsidy (LIS) benchmark to absorb the cost of the difference between their bid and the LIS benchmark in order to remain a \$0 premium LIS plan.

**Sec. 3304. Special rule for widows and widowers regarding eligibility for low-income assistance.** Allows the surviving spouse of an LIS-eligible couple to delay LIS redetermination for one year after the death of a spouse.

**Sec. 3305. Improved information for subsidy-eligible individuals reassigned to prescription drug plans and MA–PD plans.** Requires HHS, beginning in 2011, to transmit formulary and coverage determination information to subsidy-eligible beneficiaries who have been automatically reassigned to a new Part D low-income subsidy plan.

**Sec. 3306. Funding outreach and assistance for low-income programs.** Provides \$45 million for outreach and education activities to State Health Insurance Programs, Administration on Aging, Aging Disability Resource Centers and the National Benefits Outreach and Enrollment.

**Sec. 3307. Improving formulary requirements for prescription drug plans and MA–PD plans with respect to certain categories or classes of drugs.** Codifies the current six classes of clinical concern, removes the criteria specified in section 176 of MIPPA that would have been used by HHS to identify protected classes of drugs and gives the Secretary authority to identify classes of clinical concern through rulemaking.

**Sec. 3308. Reducing part D premium subsidy for high-income beneficiaries.** Reduces the Part D premium subsidy for beneficiaries with incomes above the Part B income thresholds.

**Sec. 3309. Elimination of cost sharing for certain dual-eligible individuals.** Eliminates cost sharing for beneficiaries receiving care under a home and community-based waiver program who would otherwise require institutional care.

**Sec. 3310. Reducing wasteful dispensing of outpatient prescription drugs in long-term care facilities under prescription drug plans and MA-PD plans.** Requires Part D plans to develop drug dispensing techniques to reduce prescription drug waste in long-term care facilities.

**Sec. 3311. Improved Medicare prescription drug plan and MA-PD plan complaint system.** Requires the Secretary to develop and maintain a plan complaint system to handle complaints regarding Medicare Advantage and Part D plans or their sponsors.

**Sec. 3312. Uniform exceptions and appeals process for prescription drug plans and MA-PD plans.** Requires Part D plans to use a single, uniform exceptions and appeals process.

**Sec. 3313. Office of the Inspector General studies and reports.** Requires the OIG to conduct a study comparing prescription drug prices paid under the Medicare Part D program to those paid under State Medicaid programs.

**Sec. 3314. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out-of-pocket threshold under part D.** Allows drugs provided to beneficiaries by AIDS Drug Assistance Programs or the Indian Health Service to count toward the annual out-of-pocket threshold.

**Sec. 3315. Immediate reduction in coverage gap for 2010.** This section was repealed by Section 1101 of the *Reconciliation Act*, described below.

*Subtitle E – Ensuring Medicare Sustainability*

**Sec. 3401. Revision of certain market basket updates and incorporation of productivity improvements into market basket updates that do not already incorporate such improvements.** Incorporates a productivity adjustment into the market basket update for inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals and inpatient rehabilitation facilities beginning in various years and implements additional market basket reductions for certain providers. It would also incorporate a productivity adjustment into payment updates for Part B providers who do not already have such an adjustment. Section 10319 modifies market adjustments for inpatient hospitals, inpatient rehabilitation facilities, inpatient psychiatric hospitals and outpatient hospitals in 2012 and 2013 and for long-term care hospitals in 2011, 2012 and 2013. Also, modifies market basket adjustments for home health providers in 2013 and hospice providers in 2013 through 2019. Section 1105 of the *Reconciliation Act* revises the hospital market basket reduction that is in addition to the productivity adjustment as follows: -0.3 in FY14 and -0.75 in

FY17, FY18 and FY19. Removes Senate provision that eliminates the additional market basket for hospitals based on coverage levels. Providers affected are inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals and outpatient hospitals.

**Sec. 3402. Temporary adjustment to the calculation of part B premiums.** For higher-income beneficiaries who pay a higher Part B premium rate, freezes the income thresholds at 2010 levels through 2019.

**Sec. 3403. Independent Payment Advisory Board.** Creates an independent, 15-member Payment Advisory Board tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years when Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress would be allowed to consider an alternative provision on a fast-track basis. The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. As amended by Section 10320, requires the Board to make annual recommendations to the President, Congress, and private entities on actions they can take to improve quality and constrain the rate of cost growth in the private sector. Requires the Board to make non-binding Medicare recommendations to Congress in years in which Medicare growth is below the targeted growth rate. Clarifies that the Board is prohibited from making recommendations that would reduce premium supports for low-income Medicare beneficiaries. Beginning in 2020, limits the Board's binding recommendations to Congress to only every-other-year if the growth in overall health spending exceeds growth in Medicare spending; such recommendations would focus on slowing overall health spending while maintaining or enhancing beneficiary access to quality care under Medicare. Changes the name of the Board to the "Independent Payment Advisory Board."

*Subtitle F—Health Care Quality Improvements*

**Sec. 3501. Health care delivery system research; Quality improvement technical assistance.** Builds on the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (AHRQ) to support research, technical assistance and process implementation grants. Grants funded under this section will identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services.

**Sec. 3502. Grants or contracts to establish community health teams to support the patient-centered medical home.** Creates a program to establish and fund the development of community health teams to support the development of medical homes by increasing access to comprehensive, community based, coordinated care. Section 10321 clarifies that nurse practitioners and other primary care providers can participate in community care teams.

**Sec. 3503. Grants to implement medication management services in treatment of chronic disease.** Creates a program to support medication management services by local health providers. Medication management services will help manage chronic disease, reduce medical

errors, and improve patient adherence to therapies while reducing acute care costs and reducing hospital readmissions.

**Sec. 3504. Design and implementation of regionalized systems for emergency care.** Provides funding to the Assistant Secretary for Preparedness and Response to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems. Requires the HHS Secretary to support emergency medicine research, including pediatric emergency medical research.

**Sec. 3505. Trauma care centers and service availability.** Reauthorizes and improves the trauma care program, providing grants administered by the HHS Secretary to States and trauma centers to strengthen the nation's trauma system. Grants are targeted to assist trauma care centers in underserved areas susceptible to funding and workforce shortages.

**Sec. 3506. Program to facilitate shared decisionmaking.** Establishes a program at HHS for the development, testing, and disseminating of educational tools to help patients, caregivers, and authorized representatives understand their treatment options.

**Sec. 3507. Presentation of prescription drug benefit and risk information.** Requires the Food and Drug Administration (FDA) to evaluate and determine if the use of drug fact boxes which would clearly communicate drug risks and benefits and support clinician and patient decision making in advertising and other forms of communication for prescription medications is warranted.

**Sec. 3508. Demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals.** Establishes a program at AHRQ to give grants to academic institutions to develop and implement academic curricula that integrate quality improvement and patient safety into health professionals' clinical education.

**Sec. 3509. Office of women's health.** Provides for women's health offices at various Federal agencies to improve prevention, treatment, and research for women in health programs.

**Sec. 3510. Patient navigator program.** Reauthorizes demonstration programs to provide patient navigator services within communities to assist patients overcome barriers to health services. Program facilitates care by assisting individuals coordinate health services and provider referrals, assist community organizations in helping individuals receive better access to care, information on clinical trials, and conduct outreach to health disparity populations.

**Sec. 3511. Authorization of appropriations.**

**Sec. 3512. GAO study and report on causes of action.** As added by Section 10201, directs the Comptroller General to conduct a study, within two years of enactment, as to whether implementation of provisions in the legislation would result in the establishment of a new cause of action or claim.

**Subtitle G – Protecting and Improving Guaranteed Medicare Benefits**

**Sec. 3601. Protecting and improving guaranteed Medicare benefits.** Reaffirms that Medicare guaranteed benefits will not be reduced and that any savings generated for the Medicare program will extend the solvency of the Medicare trust funds, reduce Medicare premiums and cost-sharing, and improve or expand guaranteed Medicare benefits or protect access to providers.

**Sec. 3602. No cuts in guaranteed benefits.** Reaffirms that benefits guaranteed to Medicare Advantage plan participants will not be reduced or eliminated.

**TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH**

**Subtitle A – Modernizing Disease Prevention and Public Health Systems**

**Sec. 4001. National Prevention, Health Promotion and Public Health Council.** Creates an interagency council dedicated to promoting healthy policies at the Federal level. The Council shall consist of representatives of Federal agencies that interact with Federal health and safety policy, including the departments of HHS, Agriculture, Education, Labor, Transportation, and others. The Council will establish a national prevention and health promotion strategy and develop interagency working relationships to implement the strategy. The Council will report annually to Congress on the health promotion activities of the Council and progress in meeting goals of the national strategy.

**Sec. 4002. Prevention and Public Health Fund.** Establishes a Prevention and Public Health Investment Fund. The goal of the Investment Fund is to provide an expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs. This will involve a dedicated, stable funding stream for prevention, wellness and public health activities authorized by the Public Health Service Act.

**Sec. 4003. Clinical and community preventive services.** Expands the efforts of, and improves the coordination between, two task forces which provide recommendations for preventive interventions. The U.S. Preventive Services Task Force is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness of clinical preventive services such as colorectal cancer screening or aspirin to prevent heart disease, and develops recommendations for their use. The Community Preventive Services Task Force uses a public health perspective to review the evidence of effectiveness of population-based preventive services such as tobacco cessation, increasing physical activity and preventing skin cancer, and develops recommendations for their use.

**Sec. 4004. Education and outreach campaign regarding preventive benefits.** Directs the Secretary to convene a national public/private partnership for the purposes of conducting a national prevention and health promotion outreach and education campaign. The goal of the

campaign is to raise awareness of activities to promote health and prevent disease across the lifespan. The Secretary will conduct a national media campaign on health promotion and disease prevention focusing on nutrition, physical activity, and smoking cessation using science-based social research. The Secretary shall also maintain a web-based portal that provides informational guidelines on health promotion and disease prevention to health care providers and the public as well as a personalized prevention plan tool for individuals to determine their disease risks and obtain tailored guidance on health promotion and disease prevention. In addition, the Secretary will provide guidance and relevant information to States and health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children and adults. Each State would be required to design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services.

**Subtitle B – Increasing Access to Clinical Preventive Services**

**Sec. 4101. School-based health centers.** Authorizes a grant program for the operation and development of School-Based Health Clinics, which will provide comprehensive and accessible preventive and primary health care services to medically underserved children and families. Appropriates \$50 million each year for fiscal years 2010 through 2013 for expenditures for facilities and equipment. Section 10402 adds vision services to the list of health services for which a School Based Health Center should provide referrals.

**Sec. 4102. Oral healthcare prevention activities.** Establishes an oral healthcare prevention education campaign at CDC focusing on preventive measures and targeted towards key populations including children and pregnant women. Creates demonstration programs on oral health delivery and strengthens surveillance capacity.

**Sec. 4103. Medicare coverage of annual wellness visit providing a personalized prevention plan.** Provides coverage under Medicare, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services. Such services would include a comprehensive health risk assessment. The personalized prevention plan would take into account the findings of the health risk assessment and include elements such as: a five- to ten-year screening schedule; a list of identified risk factors and conditions and a strategy to address them; health advice and referral to education and preventive counseling or community-based interventions to address modifiable risk factors such as physical activity, smoking, and nutrition. Section 10402 clarifies that Medicare beneficiaries are eligible for the initial preventive physical exam in their first year of Medicare coverage and for personalized prevention services annually thereafter.

**Sec. 4104. Removal of barriers to preventive services in Medicare.** This section would waive beneficiary coinsurance requirements for most preventive services, requiring Medicare to cover 100 percent of the costs. Services for which no coinsurance or deductible would be required are the personalized prevention plan services and any covered preventive service if it is recommended with a grade of A or B by the U.S. Preventive Services Task Force. Section

10406 clarifies that Medicare beneficiaries do not have to pay coinsurance (including co-pays and deductibles) for preventive services delivered in all settings.

**Sec. 4105. Evidence-based coverage of preventive services in Medicare.** This section would authorize the Secretary to modify the coverage of any currently covered preventive service in the Medicare program to the extent that the modification is consistent with U.S. Preventive Services Task Force recommendations and the services are not used for diagnosis or treatment. The Secretary will also conduct a provider and beneficiary outreach program regarding covered preventive services. This section also authorizes a Government Accountability Office (GAO) study of the utilization of and payment for Medicare covered preventive services, the use of health information technology in coordinating such services, and whether there are barriers to the utilization of such services.

**Sec. 4106. Improving access to preventive services for eligible adults in Medicaid.** The current Medicaid State option to provide other diagnostic, screening, preventive, and rehabilitation services would be expanded to include: (1) any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force and (2) with respect to adults, immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration. States that elect to cover these additional services and vaccines, and also prohibit cost-sharing for such services and vaccines, would receive an increased Federal medical assistance percentage (FMAP) of one percentage point for these services.

**Sec. 4107. Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid.** States would be required to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use. Such services would include diagnostic, therapy and counseling services, and prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration for cessation of tobacco use by pregnant women. This section would also prohibit cost-sharing for these services.

**Sec. 4108. Incentives for prevention of chronic diseases in Medicaid.** The Secretary would award grants to States to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions.

**Subtitle C – Creating Healthier Communities**

**Sec. 4201. Community transformation grants.** This section authorizes the Secretary to award competitive grants to eligible entities for programs that promote individual and community health and prevent the incidence of chronic disease. Communities can carry out programs to prevent and reduce the incidence of chronic diseases associated with overweight and obesity, tobacco use, or mental illness; or other activities that are consistent with the goals of promoting

healthy communities. Section 10403 ensures that 20 percent of the Community Transformation Grants are awarded to rural and frontier areas.

**Sec. 4202. Healthy aging, living well; evaluation of community-based prevention and wellness programs for Medicare beneficiaries.** The goal of this program is to improve the health status of the pre-Medicare-eligible population to help control chronic disease and reduce Medicare costs. The CDC would provide grants to States or large local health departments to conduct pilot programs in the 55-to-64 year old population. Pilot programs would evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease or at-risk for chronic disease receive clinical treatment to reduce risk. Pilot programs would be evaluated for success in controlling Medicare costs in the community. Additionally, the Centers for Medicare & Medicaid Services (CMS) would conduct a comprehensive assessment of community-based disease self-management programs that help control chronic diseases. The Secretary would then develop a plan for improving access to such services for Medicare beneficiaries.

**Sec. 4203. Removing barriers and improving access to wellness for individuals with disabilities.** Requires the Access Board to establish standards for accessibility of medical diagnostic equipment to individuals with disabilities.

**Sec. 4204. Immunizations.** Authorizes States to purchase adult vaccines under CDC contracts. Currently, 23 States purchase vaccines under CDC contracts. These contracts for adult vaccines provide savings that range from 23-69 percent compared to the private sector cost. Authorizes a demonstration program to improve immunization coverage. Under this program, CDC will provide grants to States to improve immunization coverage of children, adolescents, and adults through the use of evidence-based interventions. States may use funds to implement interventions that are recommended by the Community Preventive Services Task Force, such as reminders or recalls for patients or providers, or home visits. Reauthorizes the Immunization Program in Section 317 of the Public Health Service Act. This section would also require a GAO study and report to Congress on coverage of vaccines under Medicare Part D and the impact on access to those vaccines.

**Sec. 4205. Nutrition labeling of standard menu items at chain restaurants.** This initiative represents a compromise between the Menu Education and Labeling (MEAL) Act, sponsored by Senator Harkin, and the Labeling Education and Nutrition (LEAN) Act, sponsored by Senators Carper and Murkowski. Under the terms of the compromise, a restaurant that is part of a chain with 20 or more locations doing business under the same name (other restaurants are exempt) would be required to disclose calories on the menu board and in a written form, available to customers upon request, additional nutrition information pertaining to total calories and calories from fat, as well as amounts of fat, saturated fat, cholesterol, sodium, total carbohydrates, complex carbohydrates, sugars, dietary fiber, and protein.

**Sec. 4206. Demonstration project concerning individualized wellness plan.** This pilot program provides at-risk populations who utilize community health centers with a

comprehensive risk-factor assessment and an individualized wellness plan designed to reduce risk factors for preventable conditions.

**Sec. 4207. Reasonable break time for nursing mothers.** This initiative would amend the Fair Labor Standard Act to require employers to provide break time and a place for breastfeeding mothers to express milk. This would not apply to an employer with fewer than 50 employees, and there are no monetary damages.

***Subtitle D – Support for Prevention and Public Health Innovation***

**Sec. 4301. Research on optimizing the delivery of public health services.** The Secretary, acting through the Director of CDC, shall provide funding for research in the area of public health services and systems. This research shall include examining best practices relating to prevention, analyzing the translation of interventions from academic institutions to clinics and communities, and identifying effective strategies for delivering public health services in real world settings. CDC shall annually report research findings to Congress.

**Sec. 4302. Understanding health disparities; data collection and analysis.** Ensures that any ongoing or new Federal health program achieve the collection and reporting of data by race, ethnicity, primary language and any other indicator of disparity. The Secretary shall analyze data collected to detect and monitor trends in health disparities and disseminate this information to the relevant Federal agencies.

**Sec. 4303. CDC and employer-based wellness programs.** Requires the CDC to study and evaluate best employer-based wellness practices and provide an educational campaign and technical assistance to promote the benefits of worksite health promotion to employers.

**Sec. 4304. Epidemiology-Laboratory Capacity Grants.** Establishes a program at the CDC that awards grants to assist State, local, and tribal public health agencies in improving surveillance for and responses to infectious diseases and other conditions of public health importance. Amounts received under the grants shall be used to strengthen epidemiologic capacity, enhance laboratory practices, improve information systems, and develop outbreak control strategies. Requires the Director of the CDC to issue national standards on information Exchange systems to public health entities for the reporting of infectious diseases and other conditions of public health importance in consultation with the National Coordinator for Health Information Technology.

**Sec. 4305. Advancing research and treatment for pain care management.** Authorizes an Institute of Medicine Conference on Pain Care to evaluate the adequacy of pain assessment, treatment, and management; identify and address barriers to appropriate pain care; increase awareness; and report to Congress on findings and recommendations. Also authorizes the Pain Consortium at the National Institutes of Health to enhance and coordinate clinical research on pain causes and treatments. Establishes a grant program to improve health professionals' understanding and ability to assess and appropriately treat pain.

**Sec. 4306. Funding for childhood obesity demonstration project.** The Children's Health Insurance Program Reauthorization Act of 2009 included several provisions designed to improve the quality of care under Medicaid and CHIP. This law directed the Secretary to initiate a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity. This section appropriates \$25 million for the childhood obesity demonstration project and adjusts the demonstration time period to fiscal years 2010 through 2014.

**Subtitle E -- Miscellaneous Provisions**

**Sec. 4401. Sense of the Senate concerning CBO scoring.** This section is struck by Section 10405.

**Sec. 4402. Effectiveness of Federal health and wellness initiatives.** The Secretary of Health and Human Services will evaluate the effectiveness of existing Federal health and wellness initiatives. The Secretary will consider whether such programs are effective in achieving their stated goals and evaluate their effect on the health and productivity of the Federal workforce.

**TITLE V—HEALTH CARE WORKFORCE**

**Subtitle A--Purpose and Definitions**

**Sec. 5001. Purpose.**

**Sec. 5002. Definitions.**

**Subtitle B--Innovations in the Health Care Workforce**

**Sec. 5101. National health care workforce commission.** Establishes a national commission tasked with reviewing health care workforce and projected workforce needs. The overall goal of the Commission is to provide comprehensive, unbiased information to Congress and the Administration about how to align Federal health care workforce resources with national needs. Congress will use this information when providing appropriations to discretionary programs or in restructuring other Federal funding sources. As amended by Section 10501, adds representation from small businesses to the Commission membership; adds an examination of the barriers of entering and remaining in primary care careers as a high-priority area for the Commission; and includes optometrists and ophthalmologists as members of the health care workforce.

**Sec. 5102. State health care workforce development grants.** Competitive grants are created for the purpose of enabling State partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels. Grants will support innovative approaches to increase the number of skilled health care workers such as health care career pathways for young people and adults.

**Sec. 5103. Health care workforce assessment.** Codifies the existing national center and establishes several regional centers for health workforce analysis to collect, analyze, and report data related to Title VII (of the Public Health Service Act) primary care workforce programs. The centers will coordinate with State and local agencies collecting labor and workforce statistical information and coordinate and provide analyses and reports on Title VII to the Commission.

**Sec. 5104. Interagency task force to assess and improve access to health care in the State of Alaska.** As added by Section 10501, establishes a temporary Task Force to assess health care access and develop a strategy to improve health care delivery in Alaska.

**Subtitle C--Increasing the Supply of the Health Care Workforce**

**Sec. 5201. Federally supported student loan funds.** Eases current criteria for schools and students to qualify for loans, shorten payback periods, and decreases the non-compliance provision to make the primary care student loan program more attractive to medical students.

**Sec. 5202. Nursing student loan program.** Increases loan amounts and updates the years for nursing schools to establish and maintain student loan funds.

**Sec. 5203. Health care workforce loan repayment programs.** Establishes a loan repayment program for pediatric subspecialists and providers of mental and behavioral health services to children and adolescents who are or will be working in a Health Professional Shortage Area, Medically Underserved Area, or with a Medically Underserved Population.

**Sec. 5204. Public health workforce recruitment and retention program.** Offers loan repayment to public health students and workers in exchange for working at least 3 years at a federal, state, local, or tribal public health agency.

**Sec. 5205. Allied health workforce recruitment and retention program.** Offers loan repayment to allied health professionals employed at public health agencies or in settings providing health care to patients, including acute care facilities, ambulatory care facilities, residences, and other settings located in Health Professional Shortage Areas, Medically Underserved Areas, or serving Medically Underserved Populations.

**Sec. 5206. Grants for States and local programs.** Awards scholarships to mid-career public and allied health professionals employed in public and allied health positions at the Federal, State, tribal, or local level to receive additional training in public or allied health fields.

**Sec. 5207. Funding for National Health Service Corps.** Increases and extends the authorization of appropriations for the National Health Service Corps scholarship and loan repayment program for FY10-15.

**Sec. 5208. Nurse-managed health clinics.** Strengthens the health care safety-net by creating a \$50 million grant program administered by HRSA to support nurse-managed health clinics.

**Sec. 5209. Elimination of cap on the Commissioned Corps.** Eliminates the artificial cap on the number of Commissioned Corps members, allowing the Corps to expand to meet national public health needs.

**Sec. 5210. Establishing a Ready Reserve Corps.** Establishes a Ready Reserve Corps within the Commissioned Corps for service in times of national emergency. Ready Reserve Corps members may be called to active duty to respond to national emergencies and public health crises and to fill critical public health positions left vacant by members of the Regular Corps who have been called to duty elsewhere.

***Subtitle D—Enhancing Health Care Workforce Education and Training***

**Sec. 5301. Training in family medicine, general internal medicine, general pediatrics, and physician assistantship.** Provides grants to develop and operate training programs, provide financial assistance to trainees and faculty, enhance faculty development in primary care and physician assistant programs, and to establish, maintain, and improve academic units in primary care. Priority is given to programs that educate students in team-based approaches to care, including the patient-centered medical home.

**Sec. 5302. Training opportunities for direct care workers.** Authorizes funding over three years to establish new training opportunities for direct care workers providing long-term care services and supports.

**Sec. 5303. Training in general, pediatric, and public health dentistry.** Reinstates a separate line of dental funding in Title VII of the Public Health Service Act. Allows dental schools and education programs to use grants for pre-doctoral training, faculty development, dental faculty loan repayment, and academic administrative units.

**Sec. 5304. Alternative dental health care provider demonstration project.** Authorizes the Secretary to award grants to establish training programs for alternative dental health care providers to increase access to dental health care services in rural, tribal, and underserved communities.

**Sec. 5305. Geriatric education and training; career awards; comprehensive geriatric education.** Authorizes funding to geriatric education centers to support training in geriatrics, chronic care management, and long-term care for faculty in health professions schools and family caregivers; develop curricula and best practices in geriatrics; expand the geriatric career awards to advanced practice nurses, clinical social workers, pharmacists, and psychologists; and establish traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing.

**Sec. 5306. Mental and behavioral health education and training grants.** Awards grants to schools for the development, expansion, or enhancement of training programs in social work,

graduate psychology, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health.

**Sec. 5307. Cultural competency, prevention, and public health and individuals with disabilities training.** Reauthorizes and expands programs to support the development, evaluation, and dissemination of model curricula for cultural competency, prevention, and public health proficiency and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs.

**Sec. 5308. Advanced nursing education grants.** Strengthens language for accredited Nurse Midwifery programs to receive advanced nurse education grants in Title VIII of the Public Health Service Act.

**Sec. 5309. Nurse education, practice, and retention grants.** Awards grants to nursing schools to strengthen nurse education and training programs and to improve nurse retention.

**Sec. 5310. Loan repayment and scholarship program.** Adds faculty at nursing schools as eligible individuals for loan repayment and scholarship programs.

**Sec. 5311. Nurse faculty loan program.** Establishes a Federally-funded student loan repayment program for nurses with outstanding debt who pursue careers in nurse education. Nurses agree to teach at an accredited school of nursing for at least 4 years within a 6-year period.

**Sec. 5312. Authorization of appropriations for parts B through D of title VIII.** Authorizes \$338 million to fund Title VIII of the Public Health Service Act nursing programs.

**Sec. 5313. Grants to promote the community health workforce.** Authorizes the Secretary to award grants to States, public health departments, clinics, hospitals, Federally qualified health centers, and other nonprofits to promote positive health behaviors and outcomes in medically underserved areas through the use of community health workers. Community health workers offer interpretation and translation services, provide culturally appropriate health education and information, offer informal counseling and guidance on health behaviors, advocate for individual and community health needs, and can provide some direct primary care services and screenings. Section 10501 clarifies the definition and activities of community health workers.

**Sec. 5314. Fellowship training in public health.** Authorizes the Secretary to address workforce shortages in State and local health departments in applied public health epidemiology and public health laboratory science and informatics.

**Sec. 5315. United States Public Health Sciences Track.** Directs the Surgeon General to establish a U.S. Public Health Sciences Track to train physicians, dentists, nurses, physician assistants, mental and behavior health specialists, and public health professionals emphasizing team-based service, public health, epidemiology, and emergency preparedness and response in affiliated institutions. Students receive tuition remission and a stipend and are accepted as

Commission Corps officers in the U.S. Public Health Service with a 2-year service commitment for each year of school covered.

**Sec. 5316. Rural physician training grants.** As added by Section 10501, establishes a grant program for medical schools to recruit and train medical students to practice medicine in underserved rural communities.

**Sec. 5317. Demonstration grants for family nurse practitioner training programs.** As added by Section 10501, establishes a training demonstration program that supports recent Family Nurse Practitioner graduates in primary care for a twelve month period in Federally Qualified Health Centers (FQHCs) and nurse-managed health clinics. The demonstration is authorized from 2011 through 2014.

**Subtitle E—Supporting the Existing Health Care Workforce**

**Sec. 5401. Centers of excellence.** The Centers of Excellence program, which develops a minority applicant pool to enhance recruitment, training, academic performance and other supports for minorities interested in careers in health, is reauthorized at 150 percent of 2005 appropriations, \$50 million.

**Sec. 5402. Health professions training for diversity.** Provides scholarships for disadvantaged students who commit to work in medically underserved areas as primary care providers, and expands loan repayments for individuals who will serve as faculty in eligible institutions. Funding is increased from \$37 to \$51 million for 2009 through 2013.

**Sec. 5403. Interdisciplinary, community-based linkages.** Authorizes funding to establish community-based training and education grants for Area Health Education Centers (AHECs) and Programs. Two programs are supported - Infrastructure Development Awards and Points of Service Enhancement and Maintenance Awards - targeting individuals seeking careers in the health professions from urban and rural medically underserved communities.

**Sec. 5404. Workforce diversity grants.** Expands the allowable uses of nursing diversity grants to include completion of associate degrees, bridge or degree completion program, or advanced degrees in nursing, as well as pre-entry preparation, advanced education preparation, and retention activities.

**Sec. 5405. Primary care extension program.** Creates a Primary Care Extension Program to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. The Agency for Healthcare Research and Quality (AHRQ) will award planning and program grants to State hubs including, at a minimum, the State health department, State-level entities administering Medicare and Medicaid, and at least one health professions school. These State hubs may also include Quality Improvement Organizations, AHECs, and other quality and training organizations.

**Subtitle F—Strengthening Primary Care and Other Workforce Improvements**

**Sec. 5501. Expanding access to primary care services and general surgery services.** Beginning in 2011, provides primary care practitioners, as well as general surgeons practicing in health professional shortage areas, with a 10 percent Medicare payment bonus for five years. Section 10501 removes the budget-neutrality adjustment that would have offset half of the cost of the primary care and general surgery bonuses.

**Sec. 5502. Medicare Federally qualified health center improvements.** Directs the Secretary of Health and Human Services to develop and implement a prospective payment system (PPS) for Medicare-covered services furnished by Federally Qualified Health Centers (FQHCs). Additionally, adds remaining Medicare-covered preventive services to the list of services eligible for reimbursement when furnished by an FQHC. Section 10501 clarifies that the Secretary of HHS shall vary payments to FQHCs based on the type, duration, and intensity of services they deliver and establishes an annual FQHC market basket update.

**Sec. 5503. Distribution of additional residency positions.** Beginning July 1, 2011, directs the Secretary to redistribute residency positions that have been unfilled for the prior three cost reports and directs those slots for training of primary care physicians. In distributing the residency slots under this section, special preference will be given to programs located in States with a low physician resident to general population ratio and to programs located in States with the highest ratio of population living in a health professional shortage area (HPSA) relative to the general population.

**Sec. 5504. Counting resident time in outpatient settings and allowing flexibility for jointly operated residency training programs.** Modifies rules governing when hospitals can receive indirect medical education (IME) and direct graduate medical education (DGME) funding for residents who train in a non-provider setting so that any time spent by the resident in a non-provider setting shall be counted toward DGME and IME if the hospital incurs the costs of the stipends and fringe benefits.

**Sec. 5505. Rules for counting resident time for didactic and scholarly activities and other activities.** Modifies current law to allow hospitals to count resident time spent in didactic conferences toward IME costs in the provider (i.e., hospital) setting and toward DGME in the non-provider (i.e., non-hospital) setting. Section 10501 clarifies that the Secretary is not required to reopen certain settled cost reports in applying changes to Medicare graduate medical education payment rules related to didactic training.

**Sec. 5506. Preservation of resident cap positions from closed hospitals.** Directs the Secretary to redistribute medical residency slots from a hospital that closes on or after the date that is two years before enactment of the this legislation based on certain criteria.

**Sec. 5507. Demonstration project to address health professions workforce needs; extension of family-to-family health information centers.** Establishes a demonstration grant program through competitive grants to provide aid and supportive services to low-income individuals with

the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to experience labor shortages or be in high demand. The demonstration grant is to serve low-income persons including recipients of assistance under State Temporary Assistance for Needy Families (TANF) programs.

Also establishes a demonstration program to competitively award grants for up to six States for three years to develop core training competencies and certification programs for personal and home care aides. Extends funding for family-to-family health information centers at \$5 million for FY2010 through FY2012.

**Sec. 5508. Increasing teaching capacity.** Directs the Secretary to establish a grant program to support new or expanded primary care residency programs at teaching health centers and authorizes \$25 million for FY2010, \$50 million for FY2011 and FY2012 and such sums as may be necessary for each fiscal year thereafter to carry out such program. Also provides \$230 million in funding under the Public Health Service Act to cover the indirect and direct expenses of qualifying teaching health centers related to training primary care residents in certain expanded or new programs.

**Sec. 5509. Graduate nurse education demonstration program.** This provision directs the Secretary to establish a demonstration program to increase graduate nurse education training under Medicare and authorizes \$50 million to be appropriated from the Medicare Hospital Insurance Trust Fund for each of the fiscal years 2012 through 2015 for such purpose.

**Subtitle G—Improving Access to Health Care Services**

**Sec. 5601. Spending for Federally Qualified Health Centers (FQHCs).** Authorizes the following appropriations: FY2010 - \$2.98B; FY2011 - \$3.86B; FY2012 - \$4.99B; FY 2013 - \$6.44B; FY2014 - \$7.33B; FY2015 - \$8.33B.

**Sec. 5602. Negotiated rulemaking for development of methodology and criteria for designating medically underserved populations and health professions shortage areas.** Directs the Secretary, in consultation with stakeholders, to establish a comprehensive methodology and criteria for designating medically underserved populations and Health Professional Shortage Areas.

**Sec. 5603. Reauthorization of Wakefield Emergency Medical Services for Children Program.** Reauthorizes program to award grants to States and medical schools to support the improvement and expansion of emergency medical services for children needing trauma or critical care treatment.

**Sec. 5604. Co-locating primary and specialty care in community-based mental health settings.** Authorizes \$50 million in grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings.

**Sec. 5605. Key national indicators.** Establishes a Commission on Key National Indicators to conduct a comprehensive oversight of a newly established key national indicators system, with a required annual report to Congress.

**Sec. 5606. State grants to health care providers who provide services to a high percentage of medically underserved populations or other special populations.** As added by Section 10501, creates a grant program to support health care providers who treat a high percentage of medically underserved populations.

**TITLE VI—TRANSPARENCY AND PROGRAM INTEGRITY**

**Subtitle A – Physician Ownership and Other Transparency**

**Sec. 6001. Limitation on Medicare exception to the prohibition on certain physician referrals for hospitals.** Prohibits physician-owned hospitals that do not have a provider agreement prior to December 31, 2010, (as amended by Section 1106 of the *Reconciliation Act*) to participate in Medicare. Such hospitals that have a provider agreement prior to December 31, 2010, could continue to participate in Medicare under certain requirements addressing conflict of interest, bona fide investments, and patient safety issues, and expansion limitations. As amended by Section 1106 of the *Reconciliation Act*, provides a limited exception to the growth restrictions for grandfathered physician owned hospitals that treat the highest percentage of Medicaid patients in their county (and are not the sole hospital in a county).

**Sec. 6002. Transparency reports and reporting of physician ownership or investment interests.** Requires drug, device, biological and medical supply manufacturers to report transfers of value made to a physician, physician medical practice, a physician group practice, and/or a teaching hospital. Duplicative State or local laws would be preempted by Federal law, however, Federal preemption would not occur for State or local laws that are beyond the scope of this section.

**Sec. 6003. Disclosure requirements for in-office ancillary services exception to the prohibition on physician self-referral for certain imaging services.** Adds an additional requirement to the Medicare in-office ancillary exception that requires the referring physician to inform the patient in writing that the individual may obtain the specified service from a person other than the referring physician, a physician who is a member of the same group practice as the referring physician, or an individual who is directly supervised by the physician or by another physician in the group practice.

**Sec. 6004. Prescription drug sample transparency.** Requires prescription drug manufacturers and distributors to report to the Secretary information pertaining to drug samples currently being collected internally, as required under the Federal Food, Drug and Cosmetic Act.

**Sec. 6005. Pharmacy benefit managers transparency requirements.** Requires a pharmacy benefit manager (PBM) or a health benefits plan that provides pharmacy benefits management services that contract with health plans under Medicare or the Exchange to report to the

Secretary information regarding the generic dispensing rate: the rebates, discounts, or price concessions negotiated by the PBM and the payment difference between health plans and PBMs and the PBMs and pharmacies. All disclosed information would be confidential, except for certain specific purposes.

*Subtitle B – Nursing Home Transparency and Improvement*

**Part I – Improving Transparency of Information**

**Sec. 6101. Required disclosure of ownership and additional disclosable parties information.** Requires that skilled nursing facilities (SNFs) under Medicare and nursing facilities (NFs) under Medicaid make available on request by the Secretary, the Inspector General of the Department of Health and Human Services, the States, and the State long-term care ombudsman, information on ownership, including a description of the governing body and organizational structure of the facility and information regarding additional disclosable parties.

**Sec. 6102. Accountability requirements for skilled nursing facilities and nursing facilities.** Requires SNFs and NFs to implement a compliance and ethics program to be followed by the facility's employees and its agents within 36 months of enactment, and requires the Secretary to evaluate this program and report the results to Congress.

**Sec. 6103. Nursing home compare Medicare website.** Requires the Secretary to publish the following information on the Nursing Home Compare Medicare website: standardized staffing data, links to State internet websites regarding State survey and certification programs, the model standardized complaint form, a summary of substantiated complaints, and the number of adjudicated instances of criminal violations by a facility or its employee.

**Sec. 6104. Reporting of expenditures.** Requires the Secretary to modify cost reports for SNFs to require reporting of expenditures on wages and benefits for direct care staff, breaking out registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff.

**Sec. 6105. Standardized complaint form.** Requires the Secretary to develop a standardized complaint form for use by residents (or a person acting on a resident's behalf) in filing complaints with a State survey and certification agency and a State long-term care ombudsman program. States would also be required to establish complaint resolution processes.

**Sec. 6106. Ensuring staffing accountability.** Requires the Secretary to develop a program for facilities to report staffing information in a uniform format based on payroll data, and to also take into account services provided by any agency or contract staff.

**Sec. 6107. GAO study and report on Five-Star Quality Rating System.** Requires the Government Accountability Office to conduct a study on the Five-Star Quality Rating System which would include an analysis of the systems implementation and any potential improvements to the system.

**Part II – Targeting Enforcement**

**Sec. 6111. Civil money penalties.** Provides the Secretary with authority to reduce civil monetary penalties (CMPs) from the level that they would otherwise be by 50 percent for certain facilities that self-report and promptly correct deficiencies within ten calendar days of imposition. For CMPs that are cited at the level of actual harm and immediate jeopardy, the Secretary would be provided with the authority to place CMPs in an escrow account following completion of the informal dispute resolution process, or the date that is 90 days after the date of the imposition of the CMP, whichever is earlier. If the facility's appeal is successful, the CMP, with interest, would be returned to the facility. If the appeal is unsuccessful, some portion of the proceeds may be used to fund activities that benefit facility residents.

**Sec. 6112. National independent monitor demonstration project.** Directs the Secretary to establish a demonstration project within one year of enactment for developing, testing and implementing a national independent monitor program to conduct oversight of interstate and large intrastate chains. The HHS OIG would evaluate the demonstration project after two years.

**Sec. 6113. Notification of facility closure.** Requires the administrator of a facility that is preparing to close to provide written notification to residents, legal representatives of residents or other responsible parties, the State, the Secretary and the long-term ombudsman program in advance of the closure by at least 60 days. Facilities would be required to prepare a plan for closing the facility by a specified date that is provided to the State, which must approve it and ensure the safe transfer of residents to another facility or alternative setting that the State finds appropriate in terms of quality, services and location, taking into consideration the needs and best interests of each resident.

**Sec. 6114. National demonstration projects on culture change and use of information technology in nursing homes.** Requires the Secretary to conduct two facility-based demonstration projects that would develop best practice models in two areas. The first would be designed to identify best practices in facilities that are involved in the "culture change" movement, including the development of resources where facilities may be able to access information in order to implement culture change. The second demonstration would focus on development of best practices in information technology that facilities are using to improve resident care.

**Part III – Improving staff training**

**Sec. 6121. Dementia and abuse prevention training.** Requires facilities to include dementia management and abuse prevention training as part of pre-employment initial training for permanent and contract or agency staff, and if the Secretary determines appropriate, as part of ongoing in-service training.

**Subtitle C – Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long Term Care Facilities and Providers**

**Sec. 6201. Nationwide program for National and State background checks on direct patient access employees of long-term care facilities and providers.** Requires the Secretary to establish a nationwide program for national and State background checks on direct patient access employees of certain long-term supports and services facilities or providers. This program is based on the background check pilot program in the Medicare Modernization Act.

**Subtitle D – Patient-Centered Outcomes Research**

**Sec. 6301. Patient-Centered Outcomes Research.** Establishes a private, nonprofit entity (the Patient-Centered Outcomes Research Institute) governed by a public-private sector board appointed by the Comptroller General to identify priorities for and provide for the conduct of comparative outcomes research. Requires the Institute to ensure that subpopulations are appropriately accounted for in research designs. Prohibits any findings to be construed as mandates on practice guidelines or coverage decisions and contains patient safeguards to protect against discriminatory coverage decisions by HHS based on age, disability, terminal illness, or an individual's quality of life preference. Provides funding for the Institute and authorizes and provides funding for the Agency for Health Research and Quality to disseminate research findings of the Institute, as well as other government-funded research, to train researchers in comparative research methods and to build data capacity for comparative effectiveness research. Section 10602 clarifies publication rights of researchers with respect to peer-reviewed journals and clarifies that findings published by the Institute do not include practice guidelines, coverage, payment, or policy recommendations. The provision also increases the number of physicians on the Board of Governors from three to four.

**Sec. 6302. Federal coordinating council for comparative effectiveness research.** Upon date of enactment, this provision would sunset the Federal Coordinating Council created in the American Recovery and Reinvestment Act of 2010 (P.L. 111-5).

**Subtitle E – Medicare, Medicaid, and CHIP Program Integrity Provisions**

**Sec. 6401. Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP.**

**Provider Screening.** Requires that the Secretary, in consultation with the HHS Office of Inspector General (HHS OIG), establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP. The Secretary would be required to determine the level of screening according to the risk of fraud, waste, and abuse with respect to each category of provider or supplier. At a minimum, all providers and suppliers would be subject to licensure checks. The Secretary would have the authority to impose additional screening measures based on risk, including fingerprinting, criminal background checks, multi-State data base inquiries, and random or unannounced site visits. An application fee of \$200 for individual practitioners and \$500 for institutional providers and suppliers would be imposed to cover the

costs of screening each time they re-verify their enrollment (every five years). Section 10603 removes the enrollment fee for physicians.

**Disclosure Requirements.** Providers and suppliers enrolling or re-enrolling in Medicare, Medicaid, or CHIP would be subject to new disclosure requirements. Applicants would be required to disclose current or previous affiliations with any provider or supplier that has uncollected debt, has had their payments suspended, has been excluded from participating in a Federal health care program, or has had their billing privileges revoked. The Secretary would be authorized to deny enrollment in these programs if these affiliations pose an undue risk to a program.

**Compliance Programs.** By a date determined by the Secretary, certain providers and suppliers would be required to establish a compliance program. The requirements for the compliance program would be developed by the Secretary and the HHS OIG.

**Sec. 6402. Enhanced Medicare and Medicaid program integrity provisions.**

**Integrated Data Repository.** Requires CMS to include in the integrated data repository (IDR) claims and payment data from the following programs: Medicare (Parts A, B, C, and D), Medicaid, CHIP, health-related programs administered by the Departments of Veterans Affairs (VA) and Defense (DOD), the Social Security Administration, and the Indian Health Service (IHS).

**Access to Data.** The Secretary would be required to enter into data-sharing agreements with the Commissioner of Social Security, the Secretaries of the VA and DOD, and the Director of the IHS to help identify fraud, waste, and abuse. The Committee Bill would grant the HHS OIG and the Department of Justice (DOJ) access to the IDR for the purposes of conducting law enforcement and oversight activities consistent with applicable privacy, security, and disclosure laws.

**Overpayments.** Requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report was due, whichever is later.

**National Provider Identifier.** Requires the Secretary to issue a regulation mandating that all Medicare, Medicaid, and CHIP providers include their NPI on enrollment applications.

**Medicaid Management Information System.** Authorizes the Secretary to withhold the Federal matching payment to States for medical assistance expenditures when the State does not report enrollee encounter data in a timely manner to the State's Medicaid Management Information System (MMIS).

**Permissive Exclusions.** Subjects providers and suppliers to exclusion for providing false information on any application to enroll or participate in a Federal health care program.

Civil Monetary Penalties. Expands the use of Civil Monetary Penalties (CMPs) to excluded individuals who order or prescribe an item or service, make false statements on applications or contracts to participate in a Federal health care program, or who know of an overpayment and do not return the overpayment. Each violation would be subject to CMPs of up to \$50,000.

Testimonial Subpoena Authority. The Secretary would be able to issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence that relates to matters under investigation or in question by the Secretary.

Surety Bonds. Requires that the Secretary take into account the volume of billing for a DME supplier or home health agency when determining the size of the surety bond. The Secretary would have the authority to impose this requirement on other providers and suppliers considered to be at risk by the Secretary.

Payment Suspensions. Authorizes the Secretary to suspend payments to a provider or supplier pending a fraud investigation. As amended by Section 1304 of the *Reconciliation Act*, allows a 90-day period of enhanced oversight and withholding of payment in cases where the HHS Secretary identifies a significant risk of fraud among DME suppliers.

Health Care Fraud and Abuse Control Account. As amended by Section 1301 of the *Reconciliation Act*, increases Health Care Fraud and Abuse Control (HCFAC) funding by \$350 million over the next decade. The provision would also permanently apply the CPI-U adjustment to HCFAC and Medicare Integrity Program (MIP) funding.

Medicare and Medicaid Integrity Programs. Requires Medicare and Medicaid Integrity Program contractors to provide the Secretary and the HHS OIG with performance statistics, including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment for such activities.

**Sec. 6403. Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank.** Requires the Secretary to maintain a national health care fraud and abuse data collection program for reporting certain adverse actions taken against health care providers, suppliers, and practitioners, and submit information on the actions to the National Practitioner Data Bank (NPDB). The Secretary would also be required to establish a process to terminate the Healthcare Integrity and Protection Databank (HIPDB) and ensure that the information formerly collected in the HIPDB is transferred to the NPDB.

**Sec. 6404. Maximum period for submission of Medicare claims reduced to not more than 12 months.** Beginning January 2010, the maximum period for submission of Medicare claims would be reduced to not more than 12 months.

**Sec. 6405. Physicians who order items or services required to be Medicare enrolled physicians or eligible professionals.** Requires durable medical equipment (DME) or home health services to be ordered by a Medicare eligible professional or physician enrolled in the Medicare program. The Secretary would have the authority to extend these requirements to other

Medicare items and services to reduce fraud, waste, and abuse. Section 10604 clarifies that only physicians enrolled in the Medicare program may order home health services under Medicare Part A and Part B.

**Sec. 6406. Requirement for physicians to provide documentation on referrals to programs at high risk of waste and abuse.** Beginning January 1, 2010, the Secretary would have the authority to disenroll, for no more than one year, a Medicare enrolled physician or supplier that fails to maintain and provide access to written orders or requests for payment for DME, certification for home health services, or referrals for other items and services. The provision would also extend the HHS OIG's permissive exclusion authority to include individuals or entities that order, refer, or certify the need for health care services that fail to provide adequate documentation to verify payment.

**Sec. 6407. Face-to-face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare.** Requires physicians to have a face-to-face encounter with the individual prior to issuing a certification for home health services or DME. The Secretary would be authorized to apply the face-to-face encounter requirement to other items and services based upon a finding that doing so would reduce the risk of fraud, waste, and abuse. Section 10605 clarifies that the face-to-face encounter required prior to certification for home health services may be performed by a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant.

**Sec. 6408. Enhanced penalties.** Subjects persons who fail to grant HHS OIG timely access to documents, for the purpose of audits, investigations, evaluations, or other statutory functions, to CMPs of \$15,000 for each day of failure. Also, persons who knowingly make, use, or cause to be made or used any false statement to a Federal health care program would be subject to a CMP of \$50,000 for each violation. The violations that could be subject to the imposition of sanctions and CMPs by the Secretary would include Medicare Advantage (MA) or Part D plans that: (1) enroll individuals in a MA or Part D plan without their consent, (2) transfer an individual from one plan to another for the purpose of earning a commission, (3) fail to comply with marketing requirements and CMS guidance, or (4) employ or contract with an individual or entity that commits a violation. Penalties for MA and Part D plans that misrepresent or falsify information would be increased to up to three times the amount claimed by a plan or plan sponsor based on the misrepresentation or falsified information.

**Sec. 6409. Medicare self-referral disclosure protocol.** Within six months of enactment, the Secretary, in cooperation with the HHS OIG, would be required to establish a self-referral disclosure protocol to enable health care providers and suppliers to disclose actual or potential violations of the physician self-referral law.

**Sec. 6410. Adjustments to the Medicare durable medical equipment, prosthetics, orthotics, and supplies competitive acquisition program.** Requires the Secretary to expand the number of areas to be included in round two of the competitive bidding program from 79 of the largest

metropolitan statistical areas (MSAs) to 100 of the largest MSAs, and to use competitively bid prices in all areas by 2016.

**Sec. 6411. Expansion of the Recovery Audit Contractor (RAC) program.** Requires States to establish contracts with one or more Recovery Audit Contractors (RACs). These State RAC contracts would be established to identify underpayments and overpayments and to recoup overpayments made for services provided under State Medicaid plans as well as State plan waivers. The Secretary would also be required to expand the RAC program to Medicare Parts C and D.

*Subtitle F – Additional Medicaid Program Integrity Provisions*

**Sec. 6501. Termination of provider participation under Medicaid if terminated under Medicare or other State plan.** Requires States to terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another State's Medicaid program.

**Sec. 6502. Medicaid exclusion from participation relating to certain ownership, control, and management affiliations.** Requires Medicaid agencies to exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that: (1) has failed to repay overpayments during the period as determined by the Secretary; (2) is suspended, excluded, or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.

**Sec. 6503. Billing agents, clearinghouses, or other alternate payees required to register under Medicaid.** Requires any agents, clearinghouses, or other alternate payees that submit claims on behalf of health care providers to register with the State and the Secretary in a form and manner specified by the Secretary.

**Sec. 6504. Requirement to report expanded set of data elements under MMIS to detect fraud and abuse.** Requires States and Medicaid managed care entities to submit data elements from MMIS as determined necessary by the Secretary for program integrity, program oversight, and administration.

**Sec. 6505. Prohibition on payments to institutions or entities located outside of the United States.** Prohibits States from making any payments for items or services provided under a Medicaid State plan or waiver to any financial institution or entity located outside of the United States.

**Sec. 6506. Overpayments.** Extends the period for States to repay overpayments to one year when a final determination of the amount of the overpayment has not been determined due to an ongoing judicial or administrative process. When overpayments due to fraud are pending, State repayments of the Federal portion would not be due until 30 days after the date of the final judgment.

**Sec. 6507. Mandatory State use of national correct coding initiative.** Requires States to make their MMIS methodologies compatible with Medicare's national correct coding initiative (NCCI) that promotes correct coding and controls improper coding.

**Sec. 6508. General effective date.** Requires States to implement fraud, waste, and abuse programs before January 1, 2011.

*Subtitle G—Additional Program Integrity Provisions*

**Sec. 6601. Prohibition on false statements and representations.** Employees and agents of multiple employer welfare arrangements (MEWAs) will be subject to criminal penalties if they provide false statements in marketing materials regarding a plan's financial solvency, benefits, or regulatory status.

**Sec. 6602. Clarifying definition.**

**Sec. 6603. Development of model uniform report form.** To facilitate consistent reporting by private health plans of suspected cases of fraud and abuse, a model uniform reporting form will be developed by the National Association of Insurance Commissioners, under the direction of the HHS Secretary.

**Sec. 6604. Applicability of State law to combat fraud and abuse.** The Department of Labor will adopt regulatory standards and/or issue orders to prevent fraudulent MEWAs from escaping liability for their actions under State law by claiming that State law enforcement is preempted by Federal law.

**Sec. 6605. Enabling the Department of Labor to issue administrative summary cease and desist orders and summary seizures orders against plans in financially hazardous condition.** The Department of Labor is authorized to issue "cease and desist" orders to temporarily shut down operations of plans conducting fraudulent activities or posing a serious threat to the public, until hearings can be completed. If it appears that a plan is in a financially hazardous condition, the agency may seize the plan's assets.

**Sec. 6606. MEWA plan registration with the Department of Labor.** MEWAs will be required to file their Federal registration forms, and thereby be subject to government verification of their legitimacy, before enrolling anyone.

**Sec. 6607. Permitting evidentiary privilege and confidential communications.** Permits the Department of Labor to allow confidential communication among public officials relating to investigation of fraud and abuse.

*Subtitle H – Elder Justice Act*

**Sec. 6701. Short title of subtitle.** The "Elder Justice Act of 2009."

**Sec. 6702. Definitions.** Defines the terms used in this subtitle using the same definitions in section 2011 of the Social Security Act.

**Sec. 6703. Elder Justice.** Requires the Secretary of HHS, in consultation with the Departments of Justice and Labor, to award grants and carry out activities that provide greater protection to those individuals seeking care in facilities that provide long-term services and supports and provide greater incentives for individuals to train and seek employment at such facilities. Owners, operators, and certain employees of these facilities would be required to report suspected crimes committed at a facility. Owners or operators of such facilities would also be required to submit to the Secretary and to the State written notification of an impending closure of a facility within 60 days prior to the closure. In the notice, the owner or operator would be required to include a plan for transfer and adequate relocation of all residents.

**Subtitle F—Sense of the Senate Regarding Medical Malpractice**

**Sec. 6801. Sense of the Senate regarding medical malpractice.** Expresses the sense of the Senate that health reform presents an opportunity to address issues related to medical malpractice and medical liability insurance, states should be encouraged to develop and test alternative models to the existing civil litigation system, and Congress should consider state demonstration projects to evaluate such alternatives.

**Title VII – IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES**

**Subtitle A—Biologics Price Competition and Innovation**

**Sec. 7001. Short Title.** The “Biologics Price Competition and Innovation Act of 2009.”

**Sec. 7002. Approval pathway for biosimilar biological products.** Establishes a process under which the Secretary is required to license a biological product that is shown to be biosimilar to or interchangeable with a licensed biological product, commonly referred to as a reference product. Prohibits the approval of an application as either biosimilar or interchangeable until 12 years from the date on which the reference product is first approved. If FDA approves a biological product on the grounds that it is interchangeable to a reference product, HHS is prohibited from making a determination that a second or subsequent biological product is interchangeable to that same reference product until 1 year after the first commercial marketing of the first interchangeable product.

Authorizes HHS to issue guidance with respect to the licensure of biological products under this new pathway, and it includes provisions governing patent infringement concerns such as the exchange of information, good faith negotiations, and initiation infringement actions. Applies certain provisions of the Food, Drug, and Cosmetic Act to this subtitle with respect to pediatric studies of biological products. Requires HHS to develop recommendations for Congress with respect to the goals for the process for the review of biosimilar biological product applications for the first five fiscal years after FY 2012.

**Sec. 7003. Savings.** The Secretary of the Treasury, in consultation with the HHS Secretary, shall for each fiscal year determine the amount of savings to the Federal Government as a result of the enactment of this subtitle. Notwithstanding any other provision of this subtitle, the savings to the Federal Government generated as a result of the enactment of this subtitle shall be used for deficit reduction.

**Subtitle B—More Affordable Medicines for Children and Underserved Communities**

**Sec. 7101. Expanded participation in 340B program.** As amended by Section 2302 of the *Reconciliation Act*, extends participation in the 340B program to certain children’s hospitals, cancer hospitals, critical access and sole community hospitals, and rural referral centers, and exempts orphan drugs from required discounts for new 340B entities.

**Sec. 7102. Improvements to 340B program integrity.** Establishes new auditing, reporting, and other compliance requirements for the Secretary, and for pharmaceutical manufacturers and 340B covered entities.

**Sec. 7103. GAO study to make recommendations on improving the 340B program.** Requires the GAO to make recommendations to Congress within 18 months on improvements to the 340B program.

**Title VIII – COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS**

**Sec. 8002. Establishment of national voluntary insurance program for purchasing community living assistance services and support (CLASS program).** Establishes a new, voluntary, self-funded public long-term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations. Requires the Secretary to develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides cash benefit that is not less than an average of \$50 per day. No taxpayer funds will be used to pay benefits under this provision. Section 10801 made technical corrections to Title VIII

**TITLE IX – REVENUE PROVISIONS**

**Subtitle A – Revenue Offset Provisions**

**Sec. 9001. Excise tax on high cost employer-sponsored health coverage.** As amended by Section 1401 of the *Reconciliation Act*, levies an excise tax of 40 percent on insurance companies and plan administrators for any health coverage plan that is above the threshold of \$10,200 for single coverage and \$27,500 for family coverage. The tax applies to self-insured plans and plans sold in the group market, but not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). The tax does not apply to

stand-alone dental and vision coverage. The tax applies to the amount of the premium in excess of the threshold. The threshold is indexed at CPI-U plus one percentage point in year 2019 and CPI-U in years thereafter. An increase in the threshold amount of \$1,650 for singles and \$3,450 for families is available for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions. This provision also includes an adjustment for firms whose health costs are higher due to the age or gender of their workers and adjusts the initial threshold if there is unexpected high growth in premiums before 2018.

**Sec. 9002. Inclusion of cost of employer-sponsored health coverage on W-2.** Requires employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2.

**Sec. 9003. Distributions for medicine qualified only if for prescribed drug or insulin.** Conforms the definition of qualified medical expenses for HSAs, FSAs, and HRAs to the definition used for the medical expense itemized deduction. Over-the-counter medicine obtained with a prescription continues to qualify as a qualified medical expense.

**Sec. 9004. Increase in additional tax on distributions from HSAs and Archer MSAs not used for qualified medical expenses.** Increases the additional tax for HSA withdrawals prior to age 65 that are used for purposes other than qualified medical expenses from 10 percent to 20 percent. The additional tax for Archer MSA withdrawals not used for qualified medical expenses would increase from 15 percent to 20 percent.

**Sec. 9005. Limitation on health flexible spending arrangements under cafeteria plans.** Limits the amount of contributions to health FSAs to \$2,500 per year beginning in 2013. The cap is indexed at CPI-U in subsequent years.

**Sec. 9006. Expansion of information reporting requirements.** Requires businesses that pay any amount greater than \$600 during the year to corporate and non-corporate providers of property and services to file an information report with each provider and with the IRS. Information reporting is already required on payments for services to non-corporate providers.

**Sec. 9007. Additional requirements for charitable hospitals.** Establishes new requirements applicable to nonprofit hospitals. The requirements would include a periodic community needs assessment.

**Sec. 9008. Imposition of annual fee on branded prescription pharmaceutical manufacturers and importers.** As amended by Section 1404 of the *Reconciliation Act*, imposes an annual fee on the pharmaceutical manufacturing sector. The amount of the fee is \$2.5 billion in 2011, \$2.8 billion in years 2012-2013, \$3.0 billion in 2014-2016, \$4.0 billion in 2017, \$4.1 billion in 2018 and \$2.8 billion in 2019 and years thereafter. This non-deductible fee is allocated across the industry according to market share with a reduction in share for companies with annual sales of branded pharmaceuticals of less than \$400 million.

**Sec. 9009. Excise Tax on Medical Devices.** As amended by Section 1405 of the *Reconciliation Act*, imposes an excise tax on the sale of medical devices by the manufacturer or importer equal to 2.3 percent of the sales price. The tax is deductible for federal income tax purposes. The excise tax does not apply to any sale of eyeglasses, contact lenses, hearing aids, or any medical device of a type generally purchased by the public at retail. In addition, sales for export and sales of devices for use in further manufacturing are exempt from the excise tax.

**Sec. 9010. Imposition of annual fee on health insurance providers.** Imposes an annual fee on the health insurance sector. As amended by Section 1406 of the *Reconciliation Act*, the amount of the fee is \$8.0 billion in 2014, \$11.3 billion in years 2015-2016, \$13.9 billion in 2017, and \$14.3 billion in 2018. For years after 2018, the amount of the annual fee is the amount for the preceding year increased by the rate of premium growth for the preceding calendar year. This non-deductible fee is allocated across the industry according to market share and does not apply to companies whose net premiums written are \$50 million or less. The fee also does not apply to any employer or governmental entity. Cooperatives and the national plan would be subject to the insurance provider fee. This provision exempts from the fee non-profits which receive more than 80 percent of their gross revenues from government programs that target low-income, elderly, or disabled populations. In addition, only 50 percent of net premiums written by entities who are tax exempt under Internal Revenue Code sections 501(c)(3), (4), (26), and (29) are included for purposes of determining an entity's market share.

**Sec. 9011. Study and report of effect on veterans health care.** The Secretary of the U.S. Department of Veterans Affairs will review and report to Congress on the effect that the fees assessed on pharmaceutical and medical device manufacturers and health insurance providers have on the cost of medical care provided to veterans and veterans' access to medical devices and branded drugs.

**Sec. 9012. Eliminate deduction for expenses allocable to Medicare Part D.** Eliminates the deduction for the subsidy paid by the federal government to employers who maintain prescription drug plans for their Medicare Part D eligible retirees, effective for taxable years beginning after December 31, 2012 (as amended by Section 1407 of the *Reconciliation Act*).

**Sec. 9013. Modification of itemized deduction for medical expenses.** Increases the adjusted gross income threshold for claiming the itemized deduction for medical expenses from 7.5 percent to 10 percent. Individuals age 65 and older would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.

**Sec. 9014. Limitation on excessive remuneration paid by certain health insurance providers.** Limits the deductibility of executive compensation under Section 162(m) for insurance providers if at least 25 percent of the insurance provider's gross premium income from health business is derived from health insurance plans that meet the minimum essential coverage requirements in the bill ("covered health insurance provider"). The deduction is limited to \$500,000 per taxable year and applies to all officers, employees, directors, and other workers or service providers performing services for or on behalf of a covered health insurance provider.

**Sec. 9015. Additional hospital insurance tax on high-income taxpayers.** Increases the hospital insurance tax rate by 0.9 percentage points on an individual taxpayer earning more than \$200,000 (\$250,000 for married couples filing jointly). The revenues from this tax will be credited to the HI trust fund. As amended by Section 1402 of the *Reconciliation Act*, expands the hospital insurance tax to include a 3.8 percent tax on income from interest, dividends, annuities, royalties and rents which are not derived in the ordinary course of trade or business, excluding active S corporation or partnership income, on taxpayers with income above \$200,000 for singles (\$250,000 for married filing jointly).

**Sec. 9016. Special deduction for Blue Cross Blue Shield (BCBS).** Requires that non-profit BCBS organizations have a medical loss ratio of 85 percent or higher in order to take advantage of the special tax benefits provided to them under IRC Section 833, including the deduction for 25 percent of claims and expenses and the 100 percent deduction for unearned premium reserves.

**Sec. 9017. Excise tax on indoor tanning services.** As added by Section 10907, imposes a ten percent tax on amounts paid for indoor tanning services. Indoor tanning services are services that use an electronic product with one of more ultraviolet lamps to induce skin tanning. The tax would be effective for services on or after July 1, 2010.

**Subtitle B – Other Provisions**

**Sec. 9021. Exclusion of health benefits provided by Indian tribal governments.** Provides an exclusion from gross income for the value of specified Indian tribal health benefits.

**Sec. 9022. Establishment of simple cafeteria plans for small businesses.** Establishes Simple Cafeteria Plans that ease participation restrictions so that small businesses can provide tax-free benefits to their employees. Under this provision, self-employed individuals are included as qualified employees. The provision also exempts employers who make contributions for employees under a simple cafeteria plan from pension plan nondiscrimination requirements applicable to highly compensated and key employees.

**Sec. 9023. Qualifying therapeutic discovery project credit.** Creates a two year temporary tax credit subject to an overall cap of \$1 billion to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases. The credit would be available for two years.

**Sec. 9024. Health professionals State loan repayment tax relief.** As added by Section 10908, excludes from gross income payments made under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. This provision is effective for amounts received by an individual in taxable years beginning after December 31, 2008.

**Sec. 9025. Expansion of adoption tax credit and adoption assistance programs.** As added by Section 10909, increases the adoption tax credit and adoption assistance exclusion (\$12,170 for 2009) by \$1,000, and makes the credit refundable. The credit is extended through 2011.

**TITLE X— STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE  
FOR ALL AMERICANS**

Many provisions of Title X made changes to the preceding nine Titles, and descriptions of those changes are included above. Only those provisions of Title X that do not make changes to Titles I – IX are described below.

**Subtitle A – Provisions Relating to Title I**

**Sec. 10108. Free choice vouchers.** Requires employers that offer coverage and make a contribution to provide free choice vouchers to qualified employees for the purchase of qualified health plans through Exchanges. The free choice voucher must be equal to the contribution that the employer would have made to its own plan. Employees qualify if their required contribution under the employer's plan would be between 8 and 9.8 percent of their income. Excludes free choice vouchers from taxation and voucher recipients are not eligible for tax credits.

**Sec. 10109. Development of standards for financial and administrative transactions.** Requires the Secretary to consult stakeholders and the National Committee on Vital and Health Statistics and the Health Information Technology Standards and Policy Committees to identify opportunities to create uniform standards for financial and administrative health care transactions, not already named under HIPAA, that would improve the operation of the health system and reduce costs.

**Subtitle B—Provisions Relating to Title II**

**Part I – Medicaid and CHIP**

**Sec. 10202. Incentives for States to offer home and community based services as a long-term care alternative to nursing homes.** Adds a new policy that creates financial incentives for States to shift Medicaid beneficiaries out of nursing homes and into home and community based services (HCBS). The provision provides Federal Medical Assistance Percentage (FMAP) increases to States to rebalance their spending between nursing homes and HCBS.

**Part II – Support for Pregnant and Parenting Teens and Women**

**Sec. 10211. Definitions.** Defines “eligible institution of higher learning” as having the same meaning as in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001). The terms “accompaniment”, “community service center”, “high school”, “intervention service”, “Secretary”, “State”, “supportive social service”, and “violence” are also defined.

**Sec. 10212. Fund.** Establishes a Pregnancy Assistance Fund for the purpose of awarding competitive grants to States to assist pregnant and parenting teens and women. The fund will be established by the Secretary of Health and Human Services in coordination and collaboration with the Secretary of Education.

**Sec. 10213. Permissible use of funds.** Requires States to use the funds provided by these grants to provide support to pregnant and parenting teens and young women. States may use the funds provided to make funding available to eligible institutions of higher learning.

**Matching requirement.** An eligible institution of higher learning that receives funding under this provision shall contribute non-federal funds equal to 25 percent. Permissible uses of funds include for programs such as those that help pregnant or parenting teens stay in or complete high school, assistance to states in providing intervention services, and outreach so that pregnant and parenting teens and women are aware of services available to them.

**Sec. 10214. Appropriations.** Appropriates \$25 million for each of the fiscal years 2010 through 2019.

### **Part III – Indian Health Care Improvement**

**Sec. 10221. Indian health care improvement.** Authorizes appropriations for the Indian Health Care Improvement Act, including programs to increase the Indian health care workforce, new programs for innovative care delivery models, behavioral health care services, new services for health promotion and disease prevention, efforts to improve access to health care services, construction of Indian health facilities, and an Indian youth suicide prevention grant program.

#### **Subtitle C – Provisions Related to Title III**

**Sec. 10323. Medicare coverage for individuals exposed to environmental health hazards.** Provides Medicare coverage and medical screening services to individuals exposed to environmental health hazards as a result of a public health determination under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

**Sec. 10324. Protections for frontier states.** Starting in fiscal year 2011, establishes hospital wage index and geographic practice expense floors for hospitals and physicians located in states in which at least 50 percent of the counties in the state are frontier.

**Sec. 10325. Revision to skilled nursing facility prospective payment system.** Delays implementation of certain skilled nursing facility “RUGs-IV” payment system changes by one year to October 1, 2011.

**Sec. 10326. Pilot testing pay-for-performance programs for certain Medicare providers.** Provides the Secretary of HHS the authority to test value-based purchasing programs for inpatient rehabilitation facilities, inpatient psychiatric hospitals, long-term care hospitals, certain cancer hospitals and hospice providers by no later than January 1, 2016.

**Sec. 10328. Improvement in Part D medication therapy management (MTM) programs.** Requires Part D prescription drug plans to include a comprehensive review of medications (either in person or through telehealth technology) and a written summary of the review as part of their medication therapy management programs. Plans must also enroll beneficiaries who qualify on a quarterly basis and allow for opt out.

**Sec. 10329. Developing methodology to assess health plan value.** Requires the Secretary of HHS to develop a methodology to measure health plan value.

**Sec. 10330. Modernizing computer and data systems of the Centers for Medicare & Medicaid Services to support improvements in care delivery.** Requires the Secretary of HHS to develop a plan (and a detailed budget for the resources needed to implement such plan) to modernize the computer and data systems of the Centers for Medicare & Medicaid Services to support improvements in care delivery.

**Sec. 10331. Public reporting of performance information.** Requires the Secretary of HHS to develop a “Physician Compare” website where Medicare beneficiaries can compare scientifically-sound measures of physician quality and patient experience measures, provided that such information provides an accurate portrayal of physician performance.

**Sec. 10332. Availability of Medicare data for performance measurement.** Authorizes the release and use of standardized extracts of Medicare claims data to measure the performance of providers and suppliers in ways that protect patient privacy and in accordance with other requirements.

**Sec. 10333. Community-based collaborative care networks.** Provides grants to develop networks of providers to deliver coordinated care to low-income populations.

**Sec. 10334. Minority health.** Codifies the Office of Minority Health at the Department of Health and Human Services (HHS) and a network of minority health offices located within HHS. Elevates the National Center on Minority Health and Health Disparities at the National Institutes of Health from a Center to an Institute. The Offices of Minority Health will monitor health, health care trends, and quality of care among minority patients and evaluate the success of minority health programs and initiatives.

**Sec. 10335. Technical correction to hospital value-based purchasing (VBP) program.** Clarifies that the hospital VBP program shall not include measures of hospital readmissions.

**Sec. 10336. GAO study and report on Medicare beneficiary access to high-quality dialysis services.** Directs the Comptroller General to submit to Congress, within one year of enactment, a study on the impact on Medicare beneficiary access to high-quality dialysis services of the end stage renal disease prospective payment system.

Subtitle D—Provisions Relating to Title IV

**Sec. 10407. Better diabetes care.** Directs the Secretary of HHS to develop a national report card on diabetes to be updated every two years. Directs the Secretary to work with health professionals and States to improve data collection related to diabetes and other chronic diseases. Provides for an Institute of Medicine study on the impact of diabetes on medical care.

**Sec. 10408. Grants for small businesses to provide comprehensive workplace wellness programs.** Authorizes an appropriation of \$200 million to give employees of small businesses access to comprehensive workplace wellness programs.

**Sec. 10409. Cures Acceleration Network.** Authorizes the Cures Acceleration Network, within the National Institutes of Health (NIH), to award grants and contracts to develop cures and treatments of diseases. Grants will be awarded to accelerate the development of medical products and behavioral therapies. The network shall work with the Food and Drug Administration (FDA) to streamline protocols assuring compliance with regulations and standards that meet regulatory requirements at all stages of manufacturing, review, approval, and safety surveillance.

**Sec. 10410. Centers of excellence for depression.** Directs the Administrator of the Substance Abuse and Mental Health Services Administration to award grants to centers of excellence in the treatment of depressive disorders.

**Sec. 10411. Programs relating to congenital heart disease.** Allows the Secretary of HHS to enhance and expand existing infrastructure to track the epidemiology of congenital heart disease and to organize such information into a National Congenital Heart Disease Surveillance System. Expands, intensifies, and coordinates research at the NIH on congenital heart disease.

**Sec. 10412. Automated Defibrillation in Adam's Memory Act.** Amends and reauthorizes through 2014 public access defibrillation programs in Sec. 312 of the Public Health Service Act.

**Sec. 10413. Young women's breast health awareness and support of young women diagnosed with breast cancer.** Directs the Secretary of HHS to develop a national education campaign for young women and health care professionals about breast health and risk factors for breast cancer. Supports prevention research activities at the Centers for Disease Control and Prevention (CDC) on breast cancer in younger women.

Subtitle E – Provisions Relating to Title V

**Sec. 10501. Amendments to Title V.**

- (d) **Loan repayment for faculty at schools that train physician assistants.** Includes faculty at schools for physician assistants as eligible or faculty loan repayment within the workforce diversity program.

(g) **National diabetes prevention program.** Establishes a national diabetes prevention program at the CDC. State, local, and tribal public health departments and non-profit entities can use funds for community-based prevention activities, training and outreach, and evaluation.

(l) **Rural physician training grants.** Authorizes grants for medical schools to establish programs that recruit students from underserved rural areas who have a desire to practice in their hometowns. Programs would provide students with specialized training in rural health issues, and assist them in finding residencies that specialize in training doctors for practice in underserved rural communities.

(m)(1) **Preventive medicine and public health training grant program.** Amends and reauthorizes section 768 of the Public Health Service Act, the preventive medicine and public health residency program.

(n)(1) **National Health Service Corps improvements.** Improves the National Health Service Corps program by increasing the loan repayment amount, allowing for half-time service, and allowing for teaching to count for up to 20% of the Corps service commitment.

**Sec. 10502. Infrastructure to expand access to care.** Provides funding to HHS for construction or debt service on hospital construction costs for a new health facility meeting certain criteria.

**Sec. 10503. Community Health Centers and National Health Service Corps Fund.** Establishes a Community Health Centers and National Health Service Corps Fund. The fund will create an expanded and sustained national investment in community health centers under section 330 of the Public Health Service Act and the National Health Service Corps. As amended by Section 2303 of the *Reconciliation Act*, increases mandatory funding for community health centers to \$11 billion over five years (FY 2011 – FY 2015).

**Sec. 10504. Demonstration project to provide access to affordable care.** Directs the Secretary of HHS to establish a 3-year demonstration project in States to provide comprehensive health care services to the uninsured at reduced fees.

Subtitle F—Provisions Relating to Title VI

**Sec. 10606. Health care fraud enforcement.** Enhances the fraud sentencing guidelines, changes the intent requirement for fraud under the anti-kickback statute, and increases subpoena authority relating to health care fraud.

**Sec. 10607. State demonstration programs to evaluate alternatives to current medical tort litigation.** Authorizes grants to States to test alternatives to civil tort litigation. These models would be required to emphasize patient safety, the disclosure of health care errors, and the early resolution of disputes. Patients would be able to opt-out of these alternatives at any time. The

Secretary of HHS would be required to conduct an evaluation to determine the effectiveness of the alternatives.

**Sec. 10608. Extension of medical malpractice coverage to free clinics.** Extends the protections from liability contained in the Federal Tort Claims Act to free clinics.

**Sec. 10609. Labeling changes.** Modifies requirements applicable to the labeling of generic drugs.

### **The Health Care and Education Reconciliation Act**

Many provisions of the *Health Care and Education Reconciliation Act* made changes to the *Patient Protection and Affordable Care Act*, and descriptions of those changes are included above. Only those provisions of the *Reconciliation Act* that do not make changes to the *Patient Protection and Affordable Care Act* are described below.

#### **TITLE I – COVERAGE, MEDICARE, MEDICAID AND REVENUES**

##### **Subtitle A – Coverage**

**Sec. 1004. Income definitions.** Modifies the definition of income that is used for purposes of tax credit and subsidy eligibility and the individual responsibility requirement. The modifications conform the income definition to information that is currently reported on the Form 1040 and to the present law income tax return filing thresholds. The provision also extends the exclusion from gross income for employer provided health coverage for adult children up to the end of the calendar year in which the child turns age 26.

**Sec. 1005. Implementation funding.** Provides \$1 billion to the Secretary of Health and Human Services to finance the administrative costs of implementing health insurance reform.

##### **Subtitle B - Medicare**

**Sec. 1101. Closing the Medicare prescription drug “donut hole”.** Provides a \$250 rebate for all Medicare Part D enrollees who enter the donut hole in 2010. Builds on pharmaceutical manufacturers’ 50 percent discount on brand-name drugs beginning in 2011 to provide 75 percent coverage for brand-name and generic drugs by 2020 to fill the donut hole.

**Sec. 1102. Medicare Advantage payments.** Freezes Medicare Advantage payments in 2011. Beginning in 2012, the provision reduces Medicare Advantage benchmarks relative to current levels. Benchmarks will vary from 95 percent of Medicare spending in high-cost areas to 115 percent of Medicare spending in low-cost areas, with benchmarks increased by five percentage points in all areas for high-quality plans. Changes will be phased-in over three, five or seven years, depending on the level of payment reductions. Extends CMS authority to adjust risk scores in Medicare Advantage for observed differences in coding patterns relative to fee-for-service and phases up the adjustment beginning in 2014.

**Sec. 1103. Savings from limits on MA plan administrative costs.** Ensures Medicare Advantage plans spend at least 85% of revenue on medical costs or activities that improve quality of care, rather than profit and overhead.

**Sec. 1109. Payment for qualifying hospitals.** Provides an additional payment under the Medicare inpatient prospective payment system to hospitals located in counties in the bottom quartile of counties as ranked by risk adjusted spending per Medicare enrollee.

##### **Subtitle C – Medicaid**

**Sec. 1202. Payments to primary care physicians.** Requires that Medicaid payment rates to primary care physicians for furnishing primary care services be no less than 100% of Medicare payment rates in 2013 and 2014. Provides 100% federal funding for the additional costs to States of meeting this requirement.

##### **Subtitle D – Reducing Fraud, Waste, and Abuse**

**Sec. 1301. Community mental health centers.** Establishes new requirements for community mental health centers that provide Medicare partial hospitalization services in order to prevent fraud and abuse.

**Sec. 1302. Medicare prepayment medical review limitations.** Streamlines procedures to conduct Medicare prepayment reviews to facilitate additional reviews designed to reduce fraud and abuse.

##### **Subtitle E – Revenues**

**Sec. 1408. Elimination of unintended application of cellulosic biofuel producer credit.** Adds an additional revenue provision. Modifies the \$1.01 per gallon cellulosic biofuel producer credit to exclude fuels with significant water, sediment, or ash content, such as black liquor. The provision would exclude from the definition of cellulosic biofuel any fuels that (1) are more than four percent (according to weight) water and sediment in any combination, or (2) have an ash content of more than one percent (according to weight). The provision would be effective for fuel sold or used after January 1, 2010.

**Sec. 1409. Codification of economic substance doctrine and penalties.** Adds an additional revenue provision. Clarifies the application of the economic substance doctrine which has been used by courts to deny tax benefits for transactions lacking economic substance. The provision would also impose a 40 percent strict liability penalty on underpayments attributable to a transaction lacking economic substance (unless the transaction was disclosed, in which case the penalty is 20 percent). This provision is effective for transactions entered into after the date of enactment.

**Sec. 1410. Time for payment of corporate estimated taxes.** Provides for a one-time adjustment to corporate estimated taxes for payments made during calendar year 2014.

*Subtitle F – Other Provisions*

Sec. 1501. TAA for communities. Appropriates \$500 Million a year for fiscal years 2010 through 2014 in the Community College and Career Training Grant program for community colleges to develop and improve educational or career training programs. Ensures that each state receives at least 0.5 percent of the total funds appropriated.

TITLE II – HEALTH, EDUCATION, LABOR, AND PENSIONS

*Subtitle A – Education*

Please see separate section-by-section for the *Health Care and Education Reconciliation Act*, available [here](#).

# Provisions of the Patient Protection and Affordable Care Act (H.R. 3590)<sup>1</sup>

## INDEX BY IMPLEMENTATION DATE<sup>1</sup>

### 2010 – MANDATORY

#### Insurance Reforms

- Adult dependents (Sept.)
- Appeals process (Sept.)
- Consumer rights (Sept.)
- Coverage options information (July)
- Highly compensated individuals (Sept.)
- Information technology standards (Sept.)
- Operating rules
- Premiums, review of increases
- Rescissions (Sept.)

#### Children's Health Insurance Program

- Maintenance of eligibility

#### Medicaid

- Benchmark benefits, family planning services
- Benchmark benefits, minimum requirements
- Enhanced funding, States impacted by disaster
- Freestanding birth centers, mandatory coverage
- HCBS eligibility/ enrollment, prohibit waiver disenrollment (Oct.)
- HCBS plans/ waivers, changes to provisions (Oct)
- HCBS plans/ waivers, eliminate limits to services (Oct.)
- Hospice services for children
- Maintenance of eligibility, Medicaid
- Maintenance of eligibility, Title XXI
- Prescription drugs, minimum rebates
- Prescription drugs, upper payment limit (October)
- Prohibition on cost shift to political subdivisions
- Tobacco cessation for pregnant women (October)

### 2010 – OPTIONAL

#### Insurance Reforms

- Consumer information, grants
- Early retirees reinsurance
- High-risk pools (July)

#### Children's Health Insurance Program

- Eligibility, public agency employees

#### Medicaid

- Demonstration, dual eligibles
- Demonstration, emergency psychiatric (October)
- Demonstration, global capitated model -hospitals
- HCBS eligibility/ enrollment, income expansion (Oct.)
- HCBS plans/ waivers, option to target populations (Oct.)
- HCBS eligibility/ enrollment, optional full benefits (Oct.)
- Funding, Aging and Disability Resource Centers
- Funding, Money Follows the Person extension
- Optional coverage expansion, 133% FPL
- Optional family planning category

### 2010 – NO ACTION

#### Insurance Reforms

- Small business tax credits

#### Medicaid

- Cuts, elimination of Medicaid Improvement Fund
- HCBS administrative rules
- Indian hospitals and ambulatory care clinics
- Indian-related provisions
- Oversight, coordination of dual eligibles
- Oversight, MACPAC
- Oversight, Section 1115 waivers (September)

<sup>1</sup>All provisions are effective January 1 (or immediately in the case of 2010) unless otherwise noted.

# Provisions of the Patient Protection and Affordable Care Act (H.R. 3590)<sup>1</sup>

## INDEX BY IMPLEMENTATION DATE<sup>1</sup>

### 2010 – MANDATORY (cont.)

### 2010 – OPTIONAL (cont.)

### 2010 – NO ACTION (cont.)

#### Medicare and Federal Initiatives

- Community health teams
- Regionalized systems for emergency care

#### Medicare and Federal Initiatives

- Adequacy of Medicare payment in rural areas
- Ambulance add-ons
- Bone density test payment
- Center for Medicare and Medicaid Innovation
- Clinical diagnostic laboratory tests in rural areas (July)
- Clinical education demonstration projects
- Community-based collaborative care network
- Community health integration models
- Federal working group on health care quality
- Frontier State hold harmless
- Health care delivery system research
- High-income beneficiaries prescription drug subsidy reduction
- Hospice concurrent care demonstration
- Hospitals, long-term care
- Hospital wage index
- Hospital wage index floor on a national basis
- Independent laboratory services
- Independent Medicare Advisory Board
- Inpatient hospital payment for low-volume hospitals (Oct.)
- Low-income prescription drug programs, outreach and assistance
- Market basket update changes
- Medicare Advantage reasonable cost contracts
- Medicare Advantage senior housing facility demonstration
- Medicare-dependent hospital program
- Medication management services
- Montana, special funding
- Offices of Minority Health
- Offices of Women's Health
- Part B, special TRICARE enrollment period
- Patient Navigator program
- Performance information, public reporting

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# Provisions of the Patient Protection and Affordable Care Act (H.R. 3590)<sup>1</sup>

## INDEX BY IMPLEMENTATION DATE<sup>1</sup>

### 2010 – MANDATORY (cont.)

#### Public Health

- Federal preventive benefits education and outreach
- State mandate, power of attorney for foster children (October)
- State mandate, early childhood needs assessment (September)

### 2010 – OPTIONAL (cont.)

#### Public Health

- Children emergency medical services reauthorization
- Grants, abstinence education
- Grants, Centers of Excellence/ Depression (Oct.)
- Grants, community health centers
- Grants, Community Transformation
- Grants, Cures Acceleration Network
- Grants, Diabetes Prevention
- Grants, early childhood home visitation
- Grants, epidemiology laboratories
- Grants, healthy aging
- Grants, oral health care
- Grants, pain care management
- Grants, personal responsibility education
- Grants, Prevention and Public Health Fund
- Grants, school-based health centers
- Grants, services for postpartum conditions

### 2010 – NO ACTION (cont.)

#### Medicare and Federal Initiatives (cont.)

- Pharmacy accreditation
- Physicians, geographic factors for Medicare fees
- Physicians, mental health add-on
- Physicians, misvalued codes in the fee schedule
- Physician quality reporting system
- Prescription drug coverage gap rebate
- Provider performance data
- Quality measure development
- Quality measurement
- Rural community hospital demonstration program
- Rural hospital flexibility program (Oct.)
- Rural hospital outpatient hold harmless provision
- Shared decision-making
- Therapy caps exceptions extension
- Trauma care centers

#### Public Health

- Federal councils
- Federal research/ standards, breast health
- Federal research/ standards, diabetes care
- Federal research/ standards, postpartum depression

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# Provisions of the Patient Protection and Affordable Care Act (H.R. 3590)<sup>1</sup>

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### 2010 – MANDATORY (cont.)

#### Health Care Workforce

- GME, Non-provider resident time (July)
- GME, Redistribution of unused residencies
- GME, Redistribution of closed hospital residencies

#### Program Integrity

- Encounter reporting requirements
- Performance statistics on fraud and abuse
- Physician orders for DME and home health in the Medicare program
- Screening providers for fraud, waste, and abuse (September)
- Suspension of payments
- Timing of submission of Medicare claims
- Use of National Correct Coding Initiative (October)

### 2010 – OPTIONAL (cont.)

#### Health Care Workforce

- Access to affordable care
- Community health workforce
- Cultural competency
- Family-to-family health information center extension
- Health care workforce assessment
- Health professions workforce needs
- Mid-career professionals
- Permission for State grants
- Primary care training and enhancement
- State workforce development grants
- Teaching health centers
- Underserved communities, health professionals

### 2010 – NO ACTION (cont.)

#### Health Care Workforce

- Allied health professionals loan forgiveness
- Area health education center
- Centers of Excellence in health professions education
- Connecticut grant
- Dental training
- Disadvantaged individuals programs
- Federally qualified health centers
- Key national indicators
- Mental and behavioral health education
- Mental health settings, co-locating services
- National Health Care Workforce Commission
- National Health Service Corps expansion
- National Health Service Corps programs
- National Health Service Corps teaching credit
- Nurse faculty loan and loan repayment programs
- Nurse loan repayment and scholarship expansion
- Nurse-managed health clinics
- Nurse retention
- Nursing, advanced education grants
- Nursing, appropriations
- Nursing student loan caps
- Nursing, workforce diversity grants
- Pediatric health care workforce
- Primary care loan repayments
- Public health, fellowship training
- Public health workforce
- Ready Reserve Corps creation
- Regular Corps officer cap
- Rulemaking
- Rural physician training
- United States Public Health Sciences Track

#### Program Integrity

- New compliance program
- Provider enrollment moratorium

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# Provisions of the Patient Protection and Affordable Care Act (H.R. 3590)<sup>1</sup>

## INDEX BY IMPLEMENTATION DATE<sup>1</sup>

### 2011 – MANDATORY

#### Insurance Reforms

Non-clinical spending caps  
Consumer information (March)

#### Health Insurance Exchanges

Federal assistance to States (by March)

#### Medicaid

Cuts, funding for health care acquired conditions  
(July)

### 2011 – OPTIONAL

#### Medicaid

HCBS plans/ waivers, Community First Choice  
Option (Oct.)  
Health home option  
Long term care rebalancing (Oct.)  
Grants for Prevention of Chronic Diseases

### 2011 – NO ACTION

#### Insurance Reforms

Federal reports (March)

#### Medicaid

Oversight, quality measures for adults

#### Medicare and Federal Initiatives

Advanced imaging, equipment utilization factor  
Authority to deny Medicare Advantage plan bids  
Cancer hospitals  
CMS data systems  
Community-based care transitions program  
Complex diagnostic laboratory test demonstration  
(July)  
Dialysis services report (March)  
Gainsharing demonstration extension (Sep.)  
Formulary requirements  
Health plan value (Sept.)  
Hospice  
Hospitals, urban Medicare-dependent  
Inspector General prescription drug reports  
Low-income prescription drug assistance for  
widows and widowers  
Low-income prescription drug benchmark  
premium  
Medicare Advantage beneficiary costs  
Medicare Advantage beneficiary election period  
Private fee-for-service Medicare Advantage plans  
Nurse midwife services

<sup>1</sup>All provisions are effective January 1 (or immediately in the case of 2010) unless otherwise noted.

# Provisions of the Patient Protection and Affordable Care Act (H.R. 3590)<sup>1</sup>

## INDEX BY IMPLEMENTATION DATE<sup>1</sup>

### 2011 – MANDATORY (cont.)

#### Program Integrity

- Mandatory enrollment of ordering providers
- NPI on all claims
- Prohibiting payments to providers outside the U.S.
- Provider disclosures (by March)
- Provider exclusion from the Medicaid program
- Provider termination from the Medicaid program
- Recovery audit contractor
- Registration of billing agents
- Return of overpayments
- State reporting requirements

### 2011 – OPTIONAL (cont.)

#### Health Care Workforce

- Alternative dental health care demonstration project
- Primary care extension program

### 2011 – NO ACTION (cont.)

#### Medicare and Federal Initiatives (cont.)

- Part B, income threshold for premiums
- Physician assistants ordering extended care
- Physician Compare website
- Prescription drug plan complaint system
- Prescription drug coverage gap discount program
- Prescription drug coverage gap, including certain costs
- Prescription drug de minimis premiums, voluntary waiving
- Prescription drug information (March)
- Prescription drug information for subsidy-eligible individuals
- Quality improvement, national strategy
- Skilled nursing facility payment methodology (Oct.)
- Value-based purchasing program, other providers
- Wheelchairs, power-driven

#### Public Health

- Prospective Payment System, FQHCs (Data Collection)

#### Health Care Workforce

- Geriatric care
- Long-term care workers
- Nurse practitioner training program
- Preventive medicine and public health training

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# Provisions of the Patient Protection and Affordable Care Act (H.R. 3590)<sup>1</sup>

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### 2012 – MANDATORY

#### Insurance Reform

Quality of care reporting (March)

#### Public Health

State mandate, data collection

### 2012 – OPTIONAL

#### Medicaid

Demonstration, bundled payments for integrated care

Demonstration, pediatric accountable care organization

#### Health Care Workforce

GME, Nurse education demonstration

### 2012 – NO ACTION

#### Medicaid

DSH, special rules for Hawaii

DSH, special rules for Tennessee

#### Medicare and Federal Initiatives

Dual eligibles prescription drug cost sharing

Episode groupers

Hospital readmissions reduction program (Oct.)

Independence at home demonstration program

Long-term care facility prescription dispensing

Medicare Advantage modified benchmarks

Medicare shared saving program

Prescription drug plans, exceptions and appeals process

Value-based purchasing program, hospitals (Oct.)

#### Public Health

Federal research/ standards, diagnostic equipment

<sup>1</sup>All provisions are effective January 1 (or immediately in the case of 2010) unless otherwise noted.

# Provisions of the Patient Protection and Affordable Care Act (H.R. 3590)<sup>1</sup>

## INDEX BY IMPLEMENTATION DATE<sup>1</sup>

### 2013 – MANDATORY

#### Insurance Reforms

Employee notifications (March)

#### Health Insurance Exchanges

Federal approval of a State's Exchange  
Grants/loans to establish CO-OPs

#### Children's Health Insurance Program

Funding, elimination of enrollment bonuses (Oct.)  
Funding, extension through 2015 (Oct.)

#### Medicaid

Primary care services reimbursement  
Disproportionate Share Hospitals, cuts

### 2013 – OPTIONAL

#### Medicaid

Medicaid Preventive Services

### 2013 – NO ACTION

#### Insurance Reforms

Geographic variation in poverty level study

#### Medicare and Federal Initiatives

Cancer hospital quality reporting (Oct.)  
Hospitals, disproportionate share payments (Oct.)  
Medication therapy management (March)  
Payment bundling, national pilot program

<sup>1</sup>All provisions are effective January 1 (or immediately in the case of 2010) unless otherwise noted.

# Provisions of the Patient Protection and Affordable Care Act (H.R. 3590)<sup>1</sup>

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### 2014 – MANDATORY

#### Insurance Reforms

- Cafeteria plans
- Coverage, availability and renewability
- Coverage, clinical trials
- Coverage requirements
- Coverage, use of health status
- Discrimination against providers
- Electronic funds transfers for Medicare
- Employer penalties
- Free Choice Vouchers
- Health insurance coverage reporting
- Health promotion and disease prevention programs
- Financial assistance, advance determinations
- Financial assistance, eligibility for other programs
- Premiums, limits on variance
- Preexisting conditions
- Waiting periods

#### Health Insurance Exchanges

- Construct of Exchanges (includes entire section except health care choice compacts and waivers for innovation, which occur later)
- Administration of Exchanges (includes entire section except federal assistance, federal approval, and self-funding, which are noted in the appropriate years)

#### Children's Health Insurance Program

- Eligibility, modified adjusted gross income

### 2014 – OPTIONAL

### 2014 – NO ACTION

#### Insurance Reforms

- Individual responsibility and penalties
- Financial assistance, premium assistance tax credits
- Financial assistance, reduced cost-sharing

<sup>1</sup>All provisions are effective January 1 (or immediately in the case of 2010) unless otherwise noted.

# Provisions of the Patient Protection and Affordable Care Act (H.R. 3590)<sup>1</sup>

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### 2014 – MANDATORY (cont.)

#### Medicaid

Coverage expansion, 138% FPL  
Coverage expansion, former foster children  
Disproportionate Share Hospital, cuts  
Eligibility, modified adjusted gross income  
Eligibility, online enrollment  
Enhanced funding, FMAP for new eligibles  
Employer sponsored insurance, premium assistance  
HCBS eligibility/ enrollment, spousal impoverishment rules  
Smoking cessation, barbiturates, benzodiazepines

### 2014 – OPTIONAL (cont.)

#### Medicaid

Eligibility, presumptive eligibility

### 2014 – NO ACTION (cont.)

#### Medicaid

Enhanced funding, expansion States

#### Medicare and Federal Initiatives

Facility quality reporting  
Home health care payments  
Hospital acquired conditions (Oct.)  
Medicare Advantage plans for special needs individuals  
Medicare Improvement Fund elimination

#### Public Health

Prospective Payment System, FQHCs (Implementation) (Oct.)

<sup>1</sup>All provisions are effective January 1 (or immediately in the case of 2010) unless otherwise noted.

**Provisions of the Patient Protection and Affordable Care Act (H.R. 3590)<sup>1</sup>**

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**2015 – MANDATORY**

**Health Insurance Exchanges**

Qualified health plan contractors  
Self-funding options

**2015 – OPTIONAL**

**Children's Health Insurance Program**

Funding, enhanced FMAP (Oct.)

**2015 – NO ACTION**

**Medicare and Federal Initiatives**

Medigap benefit package standards  
Value-based payment modifier for physicians

<sup>1</sup>All provisions are effective January 1 (or immediately in the case of 2010) unless otherwise noted.

**Patient Protection and Affordable Care Act (P.L. 111-148):  
Potential Funding Opportunities for States**

The following chart provides a brief summary of many of the funding opportunities contained in the Patient Protection and Affordable Care Act (PPACA), which was signed into law on March 23, 2010 (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). In some instances the law would make funding available for the current federal fiscal year 2010. However, the precise timing, funding amounts, and distribution method that will be used by the Secretary of Health and Human Services (HHS) remains unclear at this time. The chart does not discuss the enhanced FMAP for the Medicaid expansion that takes effect in 2014 or the two-year mandatory increase in reimbursement for certain services delivered by Medicaid primary care physicians. While the chart includes descriptions and limitations associated with the programs, it does not reflect the entirety of the requirements, including reporting requirements, for each initiative discussed.

Several provisions of the PPACA authorize new programs or discretionary funding. Such provisions may authorize a specified level of funding to be appropriated for each federal fiscal year or it may be vague (providing “such sums as may be necessary”). The authorization of appropriations does not provide or guarantee funding will be provided, but rather is intended to provide guidance regarding the amount of funds appropriate to carry out the authorized program/initiative. Through a separate process, Congress will determine if and how much funding to appropriate for these discretionary agencies and programs. These decisions will be made during consideration of the fiscal year 2011 appropriations measures and in each subsequent annual appropriations process.<sup>1</sup>

In addition, PPACA directly provides funding for some agencies and programs, bypassing the two-step authorization-appropriation process. Such spending is referred to as direct spending.<sup>2</sup>

Additional information about the program requirements and limitations may be found at:  
<http://finance.senate.gov/legislation/details/?id=61f4fb98-a3d0-d85c-d33f-f2c598e1d138><sup>3</sup>

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<sup>1</sup> The normal appropriations process typically begins with the President’s budget proposal in early February. The House and Senate then move to adopt a budget resolution. Both chambers then consider appropriations legislation to finalize the specific funding available for the federal fiscal year beginning September 1. See: “Overview of the Authorization-Appropriation Process”, Congressional Research Services: <http://www.rules.house.gov/archives/rs20371.pdf>

<sup>2</sup> Some direct spending is entitlement program spending funded by permanent appropriations in the authorizing law. Other direct spending – referred to as appropriated entitlements – such as Medicaid, is funded in appropriations acts, but the amount appropriated is controlled by the authorizing legislation. See: “Overview of the Authorization-Appropriation Process”, Congressional Research Services: <http://www.rules.house.gov/archives/rs20371.pdf>

<sup>3</sup> The pages referenced in the table correspond to the PDF document posted on the Senate Finance Committee website. The text of the reconciliation measure (P.L.111-152) can be found at: [http://www.rules.house.gov/bills\\_details.aspx?NewsID=4606](http://www.rules.house.gov/bills_details.aspx?NewsID=4606)

Program/ Initiative	Description	Funding	Availability	Limitation
<i>Consumer related initiatives (Page 37, Section 1002)</i>	<ul style="list-style-type: none"> <li>HHS will award grants to states to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs.</li> <li>State must have independent office of health insurance consumer assistance, or an ombudsman, that coordinates with state health insurance regulators and consumer assistance organizations concerning federal health insurance coverage requirements and state law.</li> </ul>	<ul style="list-style-type: none"> <li>Direct appropriation to HHS for \$30 million in grants to states for the first fiscal year.<sup>4</sup></li> <li>In subsequent years, there is authorization for such sums as necessary.</li> </ul>	<ul style="list-style-type: none"> <li>Funds remain available until expended.</li> </ul>	
<i>Annual rate review process for health insurance premiums (Page 40, Section 1003)</i>	<ul style="list-style-type: none"> <li>HHS will award grants to states to establish a process for annual review, beginning with the 2010 plan year, of unreasonable increases in premiums for health coverage. States grant recipients would have to provide HHS with data on premium increase trends and make recommendations on insurer participation in the</li> </ul>	<ul style="list-style-type: none"> <li>Direct appropriation to HHS of \$250 million for grants to states to support the review process.</li> <li>HHS determines funding allocation formula, considering the number of health plans in a state and population.</li> <li>Eligible states would receive between \$1 and \$5 million per grant year.</li> </ul>	<ul style="list-style-type: none"> <li>Grant program is for a five year period, fiscal year 2010 through fiscal year 2014.</li> <li>At the end of FY 2014, any remaining funds will be available as grants to eligible states for planning and implementation of certain insurance reforms and consumer protection related provisions.</li> </ul>	<ul style="list-style-type: none"> <li>State must provide information to HHS and make recommendations to the Exchange based on its rate reviews.</li> </ul>

<sup>4</sup> The effective date is the date of enactment, March 23, 2010.

Program/ Initiative	Description	Funding	Availability	Limitation
	<ul style="list-style-type: none"> <li>state-based exchange.</li> <li>Insurers would also submit information to HHS.</li> <li>States</li> </ul>			
<p><i>High Risk Pools (HRP)</i> (Page 45, Section 1101)</p>	<ul style="list-style-type: none"> <li>HHS will establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals until January 1, 2014.</li> <li>HHS may operate a program directly or contract with states and other eligible entities.</li> </ul>	<ul style="list-style-type: none"> <li>Direct appropriation of \$5 billion to HHS to pay claims for HRP enrollees, as of January 1, 2010.</li> </ul>	<ul style="list-style-type: none"> <li>HHS would establish program within 90 days after the date of enactment.</li> </ul>	<ul style="list-style-type: none"> <li>MOE on the annual funding amount expended for the operation of one or more state HRPs during the year prior to when a state enters into a contract to operate a temporary HRP.</li> </ul>
<p><i>Health Insurance Exchange State Option</i> (Page 130, Section 1311)</p>	<ul style="list-style-type: none"> <li>HHS will award grants to states for planning and activities related to the establishment of a state-based Exchange and a Small Business Health Options Program (SHOP).</li> <li>Prior to January 1, 2013, states must choose whether they will establish and operate an Exchange.</li> <li>In the case of a state that chooses not to establish an Exchange, there is a federal fallback to operate the Exchange.</li> </ul>	<ul style="list-style-type: none"> <li>Direct appropriation to HHS. The amount will be based on the Secretary's determination of the total amount of funding that would be necessary for purposes of the grant program.</li> <li>HHS determines the allocation formula for making grants to states.</li> <li>HHS would reimburse each state for reasonable start-up costs for any exchange or SHOP exchange.</li> </ul>	<ul style="list-style-type: none"> <li>Grants would be available within one year of enactment.</li> <li>Grants may be renewed prior to 2015 if a state demonstrates it is making progress in meeting Exchange requirements.</li> <li>No grants will be awarded after January 1, 2015.</li> </ul>	<ul style="list-style-type: none"> <li>No payments would be available for operational costs after initial start-up completed.</li> <li>State must ensure exchange is self-sustaining beginning January 1, 2015. Exchange may assess each exchange participating plan its proportional share of such costs.</li> </ul>
<p><i>Transitional Reinsurance</i></p>	<ul style="list-style-type: none"> <li>By January 1, 2014, states are required to establish</li> </ul>	<ul style="list-style-type: none"> <li>Federal assessments to insurers will total \$25</li> </ul>	<ul style="list-style-type: none"> <li>Effective for plays years beginning in 2014 through</li> </ul>	<ul style="list-style-type: none"> <li>By January 1, 2014, states must adopt state law or</li> </ul>

Program/ Initiative	Description	Funding	Availability	Limitation
<i>Program for Individual and Small Group Markets (page 226, Section 1341)</i>	<p>(or enter into contract with) one or more applicable entities to operate a temporary reinsurance program which would provide reimbursement for partial costs of premiums.</p> <ul style="list-style-type: none"> <li>All insurers and Third Party Administrators (TPAs) are required to make payments to the reinsurance entity. Non-grandfathered individual market plans covering high-risk individuals will receive payments from the reinsurance entity.</li> </ul>	<p>billion over the period 2014 through 2016.</p> <ul style="list-style-type: none"> <li>States may collect additional amounts from insurers, including for administrative expenses to operate the program.</li> </ul>	<p>2016.</p> <ul style="list-style-type: none"> <li>Insurer contributions are specified for plan years 2014, 2015, and 2016.</li> <li>Remaining insurer payments may be used for the state reinsurance program in plan years 2017 and 2018.</li> </ul>	<p>regulation concerning guidelines for this program.</p> <ul style="list-style-type: none"> <li>HHS can stop taking applications for participation in the program based on the availability of funding.</li> </ul>
<i>Enrollment health information technology (HIT) for health and human services programs (Page 370, Section 1561)</i>	<ul style="list-style-type: none"> <li>HHS grants to eligible entities, including states, to develop new and adapt existing technology systems to implement HIT enrollment standards and protocols.</li> <li>HIT systems will be used to enroll individuals in federal and state health and human services programs.</li> </ul>	<ul style="list-style-type: none"> <li>Not specified</li> </ul>	<ul style="list-style-type: none"> <li>Enrollment HIT systems adopted using these grants would be available to other qualified state, political subdivisions, or other qualified entities at no cost.</li> </ul>	
<i>Medicaid Community First Choice Option (page 461, Section 2401)</i>	<ul style="list-style-type: none"> <li>Establishes the Community First Choice program.</li> <li>States that take up the</li> </ul>	<ul style="list-style-type: none"> <li>States that take up the option will receive a 6 percentage point increase in FMAP for HCBS</li> </ul>	<ul style="list-style-type: none"> <li>States may take up the option as of October 1, 2011.<sup>5</sup></li> </ul>	<ul style="list-style-type: none"> <li>States that take up the option would be required to make certain HCBS attendant services and</li> </ul>

<sup>5</sup> The reconciliation measure (P.L. 111-152) changed the effective date to October 1, 2011 from October 1, 2010.

<b>Program/ Initiative</b>	<b>Description</b>	<b>Funding</b>	<b>Availability</b>	<b>Limitation</b>
	option would receive an FMAP increase for providing HCBS for people with disabilities who require an institutional level of care.	attendant services.		supports available to eligible individuals.
<i>Medicaid Money Follows the Person demonstration program (page 482, Section 2403)</i>	<ul style="list-style-type: none"> <li>Extends existing demonstration authority to award grants to states for the Medicaid Money Follows the Person program, established by the Deficit Reduction Act (P.L. 109-171).<sup>6</sup></li> </ul>	<ul style="list-style-type: none"> <li>Direct appropriation to HHS for \$2.25 billion to extend the program.</li> </ul>	<ul style="list-style-type: none"> <li>Funding available for fiscal years 2011 through 2016.</li> </ul>	<ul style="list-style-type: none"> <li>Existing program requirements, with a modification to reduce the length of stay requirement to 90 days from 6 months.</li> </ul>
<i>Medicaid home and community based services (HCBS) (Page 2141, Section 10202)</i>	<ul style="list-style-type: none"> <li>Creates the State Balancing Incentives Program to provide a temporary FMAP increase for HCBS for states that undertake structural reforms to increase diversion from institutions and expand the number of people receiving HCBS.</li> </ul>	<ul style="list-style-type: none"> <li>States spending less than 25% of total long-term care services and supports (LTSS) expenditures on HCBS will be eligible to receive a 5% increase; states with 25-50% will receive a 2% increase.</li> </ul>		
<i>Aging and Disability Resource Centers (ADRCs) (page 484, Section 2405)</i>	<ul style="list-style-type: none"> <li>The ADRC program provides states with funding to streamline access to long-term care supports and services.</li> </ul>	<ul style="list-style-type: none"> <li>Direct appropriation to HHS-AoA of \$10 million annually.</li> </ul>	<ul style="list-style-type: none"> <li>Funding available for each fiscal year 2010 through 2014.</li> </ul>	<ul style="list-style-type: none"> <li>Existing program requirements.</li> </ul>
<i>Maternal, Infant, and Early Childhood Home Visitation Grant</i>	<ul style="list-style-type: none"> <li>The home visitation program would provide grants to states and other eligible entities to implement evidenced-</li> </ul>	<ul style="list-style-type: none"> <li>Direct appropriation to HHS totaling \$1.5 billion over 5 years.</li> </ul>	<ul style="list-style-type: none"> <li>Specific allocation provided for fiscal years 2010 through 2014.</li> <li>HHS determines the time</li> </ul>	<ul style="list-style-type: none"> <li>State grant recipients must conduct a statewide needs assessment.</li> <li>Grant funds must</li> </ul>

<sup>6</sup> See: [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109\\_cong\\_public\\_laws&docid=f:publ171.109.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_public_laws&docid=f:publ171.109.pdf)

Program/ Initiative	Description	Funding	Availability	Limitation
<i>Program (pg 561, Section 2951)</i>	based models to improve services for families in at-risk communities.		period for the grant. <ul style="list-style-type: none"> <li>• Grants made in a fiscal year will be available through the end of the second succeeding fiscal year after the award.</li> </ul>	supplement, not supplant, state funds.
<i>Personal Responsibility Education Grant Program (page 596, Section 2953)</i>	<ul style="list-style-type: none"> <li>• Personal responsibility education grant program focused on educating adolescents about abstinence and contraception.</li> </ul>	<ul style="list-style-type: none"> <li>• \$75 million per year</li> <li>• State allotments with minimum grant amount to states would \$250,000.</li> <li>• State allotments will be determined by the formula specified in the law.</li> </ul>	<ul style="list-style-type: none"> <li>• Fiscal years 2010 through 2014.</li> <li>• Allotments for a fiscal year remain available through the end of the second succeeding fiscal year.</li> </ul>	<ul style="list-style-type: none"> <li>• Grant funding must be used to supplement, not supplant, state funding for similar programs/ initiatives in fiscal year 2009.</li> <li>• If a state does not submit an application for fiscal year 2010 or 2011, the state will not be eligible to submit an application to receive funds from the allotted amount for the state for in fiscal years 2012 through 2014. Instead, HHS could use these funds to award three-year grants to eligible local entities – in states that do not submit applications – for fiscal years 2012 through 2014. HHS also will use unexpended amounts from state allotments that would otherwise expire to award a three-year grant to eligible entities for fiscal years 2012 through 2014.</li> </ul>

<b>Program/ Initiative</b>	<b>Description</b>	<b>Funding</b>	<b>Availability</b>	<b>Limitation</b>
<i>Medicaid Health Home for Enrollees with Chronic Conditions: planning grant (page 522, Section 2703)</i>	<ul style="list-style-type: none"> <li>Beginning January 1, 2011, there is a Medicaid state option to provide coordinated care to enrollees with chronic conditions.</li> <li>HHS to establish minimum standards for health homes.</li> <li>HHS will award planning grants to states to develop a state plan amendment.</li> </ul>	<ul style="list-style-type: none"> <li>\$25 million maximum planning grant award per state. A total amount for planning grants is not specified.</li> <li>States will receive a 90 percent FMAP for such health home services during the first eight fiscal year quarters that the state plan amendment is in effect.</li> </ul>	<ul style="list-style-type: none"> <li>HHS may make planning grants awards to states beginning January 1, 2011.</li> <li>Planning grant funding available until expended.</li> </ul>	<ul style="list-style-type: none"> <li>State contribution required in order to receive a planning grant.</li> </ul>
<i>Medicaid Integrated Care Hospitalization Demonstration Program (page 532, Section 2704)</i>	<ul style="list-style-type: none"> <li>Establishes a demonstration program to allow states to use bundled payments to promote integration of care around hospitalization.</li> </ul>	<ul style="list-style-type: none"> <li>HHS may select up to eight states to participate.</li> <li>No specific funding authorization included in this section.<sup>7</sup></li> </ul>	<ul style="list-style-type: none"> <li>January 1, 2012 through December 31, 2016.</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
<i>Medicaid Global Payment System Demonstration Project (page 536, Section 2705)</i>	<ul style="list-style-type: none"> <li>Establishes the Medicaid Global Payment System demonstration program to allow states to test paying a safety net hospital system or network using a global capitated payment model.</li> <li>Will operate in coordination with the Center for Medicare and Medicaid Innovation.</li> <li>Budget neutrality requirements under</li> </ul>	<ul style="list-style-type: none"> <li>HHS may select up to five states to participate.</li> <li>Authorization for an appropriation of such sums as necessary.</li> </ul>	<ul style="list-style-type: none"> <li>Fiscal years 2010 through 2012.</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>

<sup>7</sup> While no specific funding was authorized, HHS-CMS may have the flexibility to operate demonstration programs using other authority, for example existing authority and through the new Center for Medicare and Medicaid Innovation.

Program/ Initiative	Description	Funding	Availability	Limitation
	Section 1115A will not apply during the testing and evaluation period for the demonstration project.			
<i>Pediatric Accountable Care Organization Demonstration Program (page 538, Section 2706)</i>	<ul style="list-style-type: none"> <li>Establishes the Pediatric Accountable Care Organization Demonstration Project which authorizes a participating state to allow pediatric medical providers that meet certain requirements to be recognized as an accountable care organization for purposes of receiving incentive payments .</li> </ul>	<ul style="list-style-type: none"> <li>Authorization for such sums as necessary.</li> </ul>	<ul style="list-style-type: none"> <li>Authorizes program from January 1, 2012 through December 31, 2016.</li> </ul>	<ul style="list-style-type: none"> <li>Budget savings requirement.</li> </ul>
<i>Medicaid Emergency Psychiatric Demonstration Project (page 540, Section 2707)</i>	<ul style="list-style-type: none"> <li>Establishes program for emergency psychiatric demonstration project to provide incentive payments to certain institutions for mental disease.</li> </ul>	<ul style="list-style-type: none"> <li>Appropriates \$75 million for fiscal year 2011.</li> <li>HHS establishes method to allocate funds.</li> </ul>	<ul style="list-style-type: none"> <li>Funds allocated beginning fiscal year 2011.</li> <li>Three year period for demonstration project.</li> <li>Funds available for obligation through December 31, 2015.</li> </ul>	
<i>Trauma Care Centers (page 1081, Section 3505)</i>	<ul style="list-style-type: none"> <li>Grant program to promote universal access to trauma care services provided by trauma centers and trauma-related physician specialties.</li> <li>States would apply for grant and in turn award grants to eligible entities.</li> </ul>	<ul style="list-style-type: none"> <li>Authorization for \$100 million for each fiscal year 2010 through 2015.</li> <li>Specific distribution method based on approved appropriation for any fiscal year.</li> </ul>	<ul style="list-style-type: none"> <li>Authorizes funding for fiscal years 2010 through 2015.</li> </ul>	<ul style="list-style-type: none"> <li>States must award at least 40% of their grant funding to safety net trauma centers.</li> <li>A state may not use more than 20% of its grant for administrative expenses.</li> <li>The state must supplement, not supplant, state funding otherwise</li> </ul>

Program/ Initiative	Description	Funding	Availability	Limitation
<i>Medicaid Preventive Services (page 1169, Section 4106)</i>	<ul style="list-style-type: none"> <li>Provides FMAP incentive payment to states that eliminate cost-sharing requirements for Medicaid clinical preventive services that have been recommended by the U.S. Preventive Services Task Force (USPSTF) and for vaccines for adults.</li> </ul>	<ul style="list-style-type: none"> <li>1 percentage point increase in FMAP for states that eliminate cost sharing for preventive services and vaccines for adults.</li> </ul>	<ul style="list-style-type: none"> <li>Enhanced match available beginning January 1, 2013.</li> </ul>	available for similar purposes.
<i>Medicaid Chronic Disease Incentive Payment Program (page 1174, Section 4108)</i>	<ul style="list-style-type: none"> <li>HHS to award grants to states to test approaches that may encourage behavior modification for healthy lifestyles among Medicaid enrollees and to determine scalable solutions.</li> <li>HHS to conduct education/outreach campaign to make states aware of grant program.</li> </ul>	<ul style="list-style-type: none"> <li>Appropriates \$100 million for the 5- year period beginning by January 1, 2011.</li> </ul>	<ul style="list-style-type: none"> <li>Grants to states awarded after HHS develops program criteria, but no later than January 1, 2011.</li> <li>Grants to states will be for a 5- year period, beginning by January 1, 2011.</li> <li>State initiatives will be carried out for at least a 3- year period.</li> <li>Amounts appropriated remain available until expended.</li> </ul>	
<i>Community Transformation Grants (page 1182, Section 4201)</i>	<ul style="list-style-type: none"> <li>Establishes competitive grant program for states and local governmental agencies and community-based organizations to promote evidence-based community preventive health activities intended to reduce chronic disease rates, address health</li> </ul>	<ul style="list-style-type: none"> <li>Authorization for such sums as may be necessary for each fiscal year 2010 through 2014.</li> </ul>	<ul style="list-style-type: none"> <li>Authorization of funding fiscal years 2010 through 2014.</li> </ul>	

<b>Program/ Initiative</b>	<b>Description</b>	<b>Funding</b>	<b>Availability</b>	<b>Limitation</b>
	disparities, etc.			
<i>Healthy Aging, Living Well public health grant program (page 1188, Section 4202)</i>	<ul style="list-style-type: none"> <li>• CDC to award grants to states or local health departments and Indian tribes for pilot programs to provide public health community interventions, screenings, etc. for individuals between ages of 55 and 64.</li> </ul>	<ul style="list-style-type: none"> <li>• Authorizes such sums as necessary.</li> </ul>	<ul style="list-style-type: none"> <li>• Authorization for funding for 5-year pilot programs, fiscal years 2010 through 2014</li> </ul>	
<i>Immunization Coverage Improvement Program (Page 1199, Section 4204)</i>	<ul style="list-style-type: none"> <li>• CDC demonstration program to award grants to states to improve immunization coverage for children, adolescents, and adults.</li> <li>• Grants for implementing interventions recommended by the Task Force on Community Preventive Services.</li> </ul>	<ul style="list-style-type: none"> <li>• Authorizes such sums as necessary.</li> </ul>	<ul style="list-style-type: none"> <li>• Authorization for funding for fiscal years 2010 through 2014.</li> </ul>	
<i>CHIP Obesity Demonstration Program (page 1242, Section 4306)</i>	<ul style="list-style-type: none"> <li>• Extends funding for the childhood obesity demonstration program established under CHIPRA (P.L. 111-3).</li> </ul>	<ul style="list-style-type: none"> <li>• Direct appropriation to HHS-CMS totaling \$25 million.</li> </ul>	<ul style="list-style-type: none"> <li>• Fiscal years 2010 through 2014.</li> </ul>	
<i>CHIP Outreach Grants (page 2161, Section 10203)</i>	<ul style="list-style-type: none"> <li>• Extends and increases funding for a program to award grants to states and other eligible entities to improve outreach and enrollment in the CHIP program, as established under CHIPRA (P.L. 111-3).</li> </ul>	<ul style="list-style-type: none"> <li>• Direct appropriation for \$140 million for fiscal years 2009 through 2015. CHIPRA originally appropriated \$100 million for fiscal years 2009 through 2013.</li> </ul>	<ul style="list-style-type: none"> <li>• Funding is extended for an additional two years, fiscal years 2014 and 2015.</li> </ul>	<ul style="list-style-type: none"> <li>• Maintenance of effort on state funding for outreach and enrollment activities, based on state spending in the fiscal year preceding the fiscal year of the grant award.</li> </ul>
<i>State Workforce</i>	<ul style="list-style-type: none"> <li>• Health care workforce</li> </ul>	<ul style="list-style-type: none"> <li>• Planning grants:</li> </ul>	<ul style="list-style-type: none"> <li>• Planning grants: available</li> </ul>	<ul style="list-style-type: none"> <li>• Planning grants require a</li> </ul>

Program/ Initiative	Description	Funding	Availability	Limitation
<i>Development Grants (page 1274, Section 5102)</i>	<p>development grant program for states to develop and implement workforce strategies at the state and local level.</p> <ul style="list-style-type: none"> <li>Administered by the Health Resources and Services Administration (HRSA) within HHS.</li> </ul>	<p>authorization for \$8 million for fiscal year 2010 and such sums as necessary thereafter. Up to \$150,000 per state partnership.</p> <ul style="list-style-type: none"> <li>Implementation grants: authorization for \$150 million for fiscal year 2010. Competitive grant award process.</li> </ul>	<p>starting federal fiscal year 2010. Grants awarded for activities for up to one year.</p> <ul style="list-style-type: none"> <li>Implementation grants: grants may be used for up to 2 years. HRSA may extend grant funding for one year for high performing grantees for eligible activities.</li> </ul>	<p>minimum 15% match (in cash or in kind). Match source may be from other federal, state, local or private sources.</p> <ul style="list-style-type: none"> <li>Implementation grants require a minimum 25% match (in cash or in kind). Match source may be from other federal, state, local or private sources.</li> <li>At least 60% of implementation grant funds must be used to make grants to address health care workforce development needs.</li> </ul>
<i>State and Regional Centers for Health Workforce Analysis (Page 1285, Section 5103)</i>	<ul style="list-style-type: none"> <li>HHS to award grants to states and eligible entities to support data collection and analysis and provide technical assistance to local entities for such activities. Data will be used by the National Center for Health Care Workforce Analysis.</li> <li>Eligible entities may also be selected to conduct longitudinal evaluation of individuals who have received education, training, or financial assistance from certain workforce programs.</li> </ul>	<ul style="list-style-type: none"> <li>Authorization for \$4.5 million per year for each of fiscal years 2010 through 2014.</li> <li>Authorization for such sums as necessary for longitudinal analysis for fiscal years 2010 through 2014.</li> </ul>	<ul style="list-style-type: none"> <li>Authorizes funding for fiscal years 2010 through 2014.</li> </ul>	<ul style="list-style-type: none"> <li>State/regional center must coordinate with national center.</li> </ul>
<i>Grants to Promote</i>	<ul style="list-style-type: none"> <li>CDC to award grants to</li> </ul>	<ul style="list-style-type: none"> <li>Authorization for such</li> </ul>	<ul style="list-style-type: none"> <li>Authorizes funding for</li> </ul>	

<b>Program/ Initiative</b>	<b>Description</b>	<b>Funding</b>	<b>Availability</b>	<b>Limitation</b>
<i>the Community Health Workforce (Page 1364, Section 5313)</i>	states and eligible state agencies to use of community health workers to promote positive health behaviors and outcomes in medically underserved communities.	sums as necessary.	fiscal years 2010 through 2014.	
<i>Primary Care Extension Program (Page 1404, Section 5405)</i>	<ul style="list-style-type: none"> <li>• AHRQ to administer a Primary Care Extension Program.</li> <li>• HHS will competitively award grants to states to establish state- or multistate-level Primary Care Extension Program State Hubs. States must develop a six year plan.</li> </ul>	<ul style="list-style-type: none"> <li>• Authorization for \$120 million for each of fiscal years 2011 and 2012, and such sums as may be necessary for fiscal years 2013 and 2014.</li> </ul>	<ul style="list-style-type: none"> <li>• Program grants would be awarded to state or multistate entities that submit fully-developed plans for the implementation of a Hub, for a period of six years.</li> <li>• Two-year planning grants are awarded to state or multistate entities with the goal developing a plan for a Hub.</li> <li>• States may receive additional assistance after the six year of support if they receive satisfactory evaluations.</li> </ul>	<ul style="list-style-type: none"> <li>• State may not use more than 10% of grant for admin.</li> <li>• Grant funds cannot be used for funding direct patient care.</li> </ul>
<i>Elder Justice Services (page 1763, Section 6701)</i>	<ul style="list-style-type: none"> <li>• Expands the permissible uses for grants under the Social Service Block Grant (SSBG) program to include elder justice related activities.</li> <li>• Creates Elder Justice Coordinating Council and an Advisory Board on Elder Abuse, Neglect, and Exploitation.</li> </ul>	<ul style="list-style-type: none"> <li>• Authorizes such sums as necessary for the Coordinating Council provisions.</li> </ul>	<ul style="list-style-type: none"> <li>• Not specified.</li> </ul>	
<i>Adult Protective</i>	<ul style="list-style-type: none"> <li>• Establishes program for</li> </ul>	<ul style="list-style-type: none"> <li>• Authorizes \$100 million</li> </ul>	<ul style="list-style-type: none"> <li>• Authorizes funding for</li> </ul>	<ul style="list-style-type: none"> <li>• Grants may not supplant</li> </ul>

Program/ Initiative	Description	Funding	Availability	Limitation
<i>Services (APS) Grant Program (page 1795, Section 2042)</i>	<p>HHS to award grants to states to enhance the provision of APS.</p> <ul style="list-style-type: none"> <li></li> </ul>	<p>for each of fiscal years 2011 through 2014 for adult protective services grants. Grant amount is based on appropriated funds multiplied by percentage of total number of elders in that state. Establishes a minimum grant amount for states and territories.</p>	<p>fiscal years 2011 through 2014</p>	<p>other federal, state and local resource for such purposes.</p>
<i>State Demonstration Program Concerning Elder Abuse (Page 1798, Section</i>	<ul style="list-style-type: none"> <li>Establishes grant program for states to conduct demonstration programs to test methods of elder abuse detection or prevention.</li> </ul>	<ul style="list-style-type: none"> <li>Authorizes \$25 million for each of fiscal years 2011 through 2014.</li> </ul>	<ul style="list-style-type: none"> <li>Authorizes funding for fiscal years 2011 through 2014.</li> </ul>	
<i>State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation (Page 2369, Section 10607)</i>	<ul style="list-style-type: none"> <li>HHS to award demonstration grants to states to develop alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.</li> </ul>	<ul style="list-style-type: none"> <li>Authorizes \$50 million for the five fiscal years beginning with 2011 for the demonstration projects and related provisions in this section.</li> <li>HHS may use part of the appropriated funds to provide initial planning grants to states, up to \$500,000 per state.</li> <li>Five percent of the amount appropriated each year is reserved for evaluation of the state demonstration programs.</li> </ul>	<ul style="list-style-type: none"> <li>Authorizes grant funding to be awarded for up to 5 years.</li> </ul>	



**Summary of PPACA Grants, Demonstration Projects and Other Funding Opportunities**

	Grant/Project  * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
<b>A. Federal, State and Local Governments and Indian Tribes</b>					
1.	<p><b>Services to Individuals with a Postpartum Condition and their Families</b></p> <p><u>Title II, Sec. 2952, Page 227</u></p>	<p>To establish, operate and coordinate the delivery of essential services to individuals with or at risk for postpartum conditions and their families</p>	<p>State and local governments</p> <p>Public-private partnerships</p> <p>Recipients of Healthy Start Initiative grants</p> <p>Public or nonprofit private hospitals</p> <p>Community-based organizations</p> <p>Hospices</p> <p>Ambulatory care facilities</p> <p>Community health centers</p> <p>Migrant health centers</p> <p>Public housing primary care centers</p> <p>Homeless health centers</p>	<p>Grants to be awarded in FYs 2010-2012</p> <p>\$3 million appropriated for FY 2010 with additional funding for FYs 2011-2012 as necessary</p>	<p>Hospitals</p> <p>Home health agencies</p> <p>Hospices</p> <p>Clinics</p> <p>Federally Qualified Health Centers ("FQHCs")</p> <p>School-based health centers</p> <p>Behavioral health providers</p> <p>Community-based organizations and centers</p>

	Grant/Project  * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
2.	<b>Competitive Grants for Regionalized Systems for Emergency Care Response</b>  <u>Title III, Sec. 3504, Page 400</u>	To support pilot projects that design, implement and evaluate models of regionalized emergency care and trauma systems	States or a partnership of 1 or more states and 1 or more local governments  Indian tribes	Department of Health and Human Services ("HHS") will award at least 4 contracts or grants  Funding amount not specified	Hospitals  Emergency medical services
3.	<b>Grants for Early Childhood Home Visitation Programs</b>  <u>Title II, Sec. 2951, Page 217</u>	To provide early childhood home visitation programs to promote maternal and prenatal health, infant health, child development, parenting skills, school readiness and reductions in child abuse	States  Indian tribes  Non-profit organizations with an established record of providing early childhood home visitation programs	Funding amount not specified	Home health agencies
4.	<b>State Option to Provide Health Homes for Enrollees with Chronic Conditions *</b>  <u>Title II, Sec. 2703, Page 201</u>	To develop a state plan amendment to provide Medicaid beneficiaries with chronic conditions who select a designated provider, a team of health care professionals or a health team as the individual's "health home" for purposes of providing the individual with health home services. "Health home" means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual to provide health home services	States	Total amount to be awarded to all states may not exceed \$25 million  Planning grants may be awarded beginning 1/1/11	Home health agencies  Physicians  Personal or home care agencies

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
5.	Establishing Community Health Teams to Support the Patient-Centered Medical Home  <u>Title III, Sec. 3502, Page 395</u>	To establish "health teams" to provide support services and capitated payments to primary care providers. A "health team" is a community-based, interdisciplinary, inter-professional team	States or state-designated entities  Indian tribes or tribal organizations	Funding amount not specified	Home health agencies  Physicians  FQHCs  Clinics
6.	Pregnancy Assistance Fund  <u>Title X, Sec. 10211-10214, Page 813</u>	To award competitive grants to states to assist pregnant and parenting teens and women. To award funding to establish, maintain and operate pregnant and parenting services. To improve services for pregnant women who are victims of domestic violence, sexual violence, sexual assault and stalking	States	\$25 million to be appropriated each FY 2010-2019  (funding cannot supplant existing funding for such services)  Eligible entity shall match 25% of funds received with non-federal funds (can be cash or in-kind)	Institutions of higher education  High schools  Community-based health prevention programs  State Attorneys General
7.	Medicaid Emergency Psychiatric Demonstration Project  <u>Title II, Sec. 2707, Page 208</u>	To permit a state to provide payments to mental health facilities to stabilize emergency mental conditions and review such stabilizations	States	3-year program  \$75 million is appropriated for FY 2011	Behavioral health facilities (not publically owned or operated and subject to the requirements of 42 U.S.C. 1395dd for the provision of medical assistance in emergency circumstances)

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
8.	<b>Trauma Service Availability - Grants to States</b>  <u>Title III, Sec. 3505, Page 407</u>	To promote universal access to trauma care services, particularly in underserved communities	States, which in turn may make grants to:  Hospitals in underserved areas;  Safety net public or nonprofit trauma centers; and  Certain other public or nonprofit trauma centers	\$100 million per FY from 2010-2015  At least 40% of any grant awarded must be directed to safety net trauma centers	Hospitals  Trauma centers
9.	<b>Trauma Care Centers and Service Availability</b>  <u>Title III, Sec. 3505, Page 404</u>	To defray uncompensated care costs, further the core missions of trauma centers and ensure the continued availability of trauma services	Public, nonprofit Indian Health Service, Indian tribal and urban Indian trauma centers	Maximum available grant is \$2 million per FY  \$100 million to be appropriated in FY 2009 and as needed for FYs 2010-2015	Public and Indian Health Service trauma centers
10.	<b>National Diabetes Prevention Program</b>  <u>Title X, Sec. 10501, Page 879</u>	To prevent adult-onset diabetes	State and local health departments  Tribal organizations  National networks of community-based non-profits focused on health and well being  Academic institutions	Funding amount not specified for 2010-2014	State and local health departments  Tribal organizations  National networks of community-based non-profits focused on prevention  Academic institutions

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
11.	<b>Incentives for Prevention of Chronic Diseases in Medicaid</b>  <u>Title IV, Sec. 4108, Page 443</u>	To encourage behavior modification by Medicaid beneficiaries and determine scalable solutions to prevent chronic diseases	States	Program shall begin 1/1/11 for 5-year period  \$100 million allocated to the program for the 5-year period	Hospitals Home health agencies FQHCs
12.	<b>Personal Responsibility Education Grants</b>  <u>Title II, Sec. 2953, Page 229</u>	To enable a state or local organization to carry out education programs to reduce teen pregnancy and to educate young people about abstinence, STDs, contraception, dating, marriage, healthy adult relationships, body image, diversity, financial literacy, parenting skills, career skills, life skills, goals and decision-making	States Indian tribes Local community organizations Faith-based organizations	Grants will be available in each FY from 2010-2014  \$75 million allocated per FY from 2010-2014  Must submit application by FY 2011 to be eligible	Hospitals Home health agencies Clinics FQHCs School-based health centers
13.	<b>Healthy Aging, Living Well Grant</b>  <u>Title IV, Sec. 4202, Page 448</u>	To carry out 5-year pilot programs to provide public health community interventions, screenings and clinical referrals for individuals who are between 55 and 64 years old	State and local health departments Indian tribes	Funding amount not specified for FYs 2010-2014	Hospitals Home health agencies FQHCs Community-based health prevention programs

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
14.	Community Transformation Grants  <u>Title IV, Sec. 4201, Page 446</u>	To implement, evaluate and disseminate evidence-based community preventive health activities to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities and develop stronger evidence-based prevention programming	State and local agencies  National networks of community-based organizations  State or local non-profit organizations  Indian tribes	Funding amount not specified	Hospitals  Home health agencies  FQHCs  Community-based health prevention programs
15.	Demonstration Program to Improve Immunization Coverage  <u>Title IV, Sec. 4204, Page 453</u>	To improve the provision of recommended immunizations for children, adolescents, and adults through the use of evidence-based, population-based interventions for high-risk populations	States	Funding amount not specified for FYs 2010-2014	Hospitals  Home health agencies  FQHCs  Community-based health prevention programs
16.	Demonstration Project to Evaluate Integrated Care Around a Hospitalization  <u>Title II, Sec. 2704, Page 205</u>	To evaluate the use of bundled payments for the provision of integrated care to a Medicaid beneficiary with respect to an episode of care that includes a hospitalization and concurrent physician services	States	Project to be conducted from 1/1/12-12/31/16  Funding amount not specified	Hospitals  Physicians
17.	Pediatric Accountable Care Organization Demonstration Project  <u>Title II, Sec. 2706, Page 207</u>	To allow certain providers of pediatric services to be recognized as accountable care organizations for purposes of receiving incentive payments	States	Project to be conducted from 1/1/12-12/31/16  Applicant must participate for at least 3 years Funding amount not specified	Hospitals  Physicians  Clinics  FQHCs

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
18.	Medicaid Global Payment System Demonstration Project  <u>Title II, Sec. 2705, Page 206</u>	To evaluate the adjustment of payments made to an eligible safety net hospital system or network from a fee-for-service structure to a global capitated payment model	Hospital must be a "large, safety net hospital system or network" (to be later defined by HHS) in a participating state	Project to be conducted in FYs 2010-2012  Funding amount not specified	Hospitals
19.	Medicare Payment Demonstration Project  <u>Title X, Sec. 10315, Page 828</u>	To test whether making adjustments for home health services would improve access to care for patients with high severity illness or for low-income or under-served beneficiaries	HHS	Project will occur over 4 years beginning no later than 1/1/2015  \$500 million appropriated for FYs 2015-2018	Home health agencies
<b>Providers</b>					
20.	Community Health Centers and the National Health Service CORPS Fund  <u>Title X, Sec. 10503, Page 886</u>	To expand and sustain national investment in community health centers by establishing a Community Health Center Fund to support health centers under Section 330 of the Public Health Service Act	HHS	Specific amounts appropriated for FYs 2011-2015	Community health centers
21.	State Health Care Workforce Development Grant Program  Planning Grants  <u>Title V, Sec. 5102, Page 481</u>	To enable state partnerships to complete comprehensive planning and to carry out activities leading to workforce development strategies at the state and local levels	State workforce investment board (board must be comprised of representatives from various sectors including, state, private and public entities)	Planning grants shall be awarded for 1 year  State required to match 15%  2010-\$8 million appropriated and such sums as may be necessary for each subsequent year	States and all providers dependent on health care workforce

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
22.	<p>State Health Care Workforce Development Grant Program</p> <p>Implementation Grants</p> <p><u>Title V, Sec. 5102, Page 481</u></p>	<p>To enable eligible partnerships to implement activities resulting in a plan for health workforce development addressing current and projected workforce demands within a state</p>	<p>Entities that receive a planning grant and complete all of the requirements of such grant or complete a satisfactory application</p> <p>Entities receiving an implementation grant must reserve at least 60% to make grants to encourage regional partnerships to address healthcare workforce development needs</p>	<p>Awarded for no more than 2 years (exception for 1 additional year for high performing grantees and grantees whose activities merit 1 more year)</p> <p>25% state match requirement</p> <p>\$150 million appropriated for FY 2010 and such sums as may be necessary thereafter</p>	<p>States and all providers dependent on health care workforce</p>
23.	<p>Demonstration Projects to Provide Low Income Individuals with Education, Training, and Career Advancement</p> <p><u>Title V, Sec. 5507, Page 545</u></p>	<p>To provide eligible individuals with education and training for occupations in health care fields that pay well and are expected to either experience labor shortages or be in high demand</p>	<p>States</p> <p>Indian tribes or tribal organizations</p> <p>Institutions of higher education</p> <p>Local workforce investment boards established under section 117 of the Workforce Investment Act of 1998</p> <p>Sponsors of an</p>	<p>\$85 million appropriated for each of FYs 2010-2014 for both this entry and entry 28 below</p> <p>HHS shall award at least 3 grants</p> <p>to an eligible entity that is an Indian tribe, tribal organization, or tribal college or university</p>	<p>States</p> <p>Indian tribes or tribal organizations</p> <p>Institutions of higher education</p> <p>Local workforce investment boards</p> <p>Sponsors of an apprenticeship program registered under the National Apprenticeship Act</p> <p>Community-based</p>

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
			apprenticeship program registered under the National Apprenticeship Act  Community-based organizations		organizations
24.	<b>Demonstration Project to Develop Training and Certification Programs For Personal or Home Care Aides</b>  <u>Title V, Sec. 5507, Page 547</u>	To conduct demonstration projects for purposes of developing core training competencies and certification programs for personal or home care aides	States	Grants must be awarded no later than 9/23/11 and project shall be for no less than 3 years  HHS shall use \$5 million for each of FYs 2010-2012 to carry out such projects	Home health agencies  Personal or home care agencies  Nursing homes
25.	<b>Grants to State and Regional Centers for Health Workforce Analysis</b>  <u>Title V, Sec. 5103, Page 486</u>	To allow for the collection, analysis and reporting of data related to health care workforce analysis to the National Center for Health Workforce Analysis and to provide technical assistance to local and regional entities on the collection, analysis and reporting of data	States  State workforce investment boards  Public health or health professions schools  Academic health centers  Public or private nonprofit entities	\$4.5 million appropriated for each of FYs 2010-2014	Academic health centers

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
26.	<b>Grants to States for Primary Care Extension Program</b>  <u>Title V, Sec. 5405, Page 532</u>	<p>To establish state or multi state level Primary Care Extension Program State Hubs for purpose of the Primary Care Extension Program established by PPACA to provide support/assistance to primary care providers)</p> <p>Hubs shall consist of (at a minimum) the state health department, the entity responsible for administering the state Medicaid program (if other than the state health department), the state-level entity administering the Medicare program, and the departments of 1 or more health professions schools in the state that train providers in primary care</p>	States or multi-state entities that submit fully-developed plans for either the implementation of a Hub or for developing a Hub	<p>Grants for implementation of a Hub is for 6 years</p> <p>Grants for planning a Hub is for 2 years</p> <p>\$120 million appropriated for FYs 2011-2012 and such sums as may be necessary for FYs 2013-2014</p>	Primary care providers
27.	<b>Epidemiology-Laboratory Capacity Grants</b>  <u>Title IV, Sec. 4304, Page 466</u>	To assist public health agencies in improving surveillance for, and response to, infectious diseases and other conditions of public health importance by strengthening epidemiology capacity, enhancing laboratory practice, improving information systems, and developing and implementing prevention and control strategies	<p>State and local health departments</p> <p>Indian tribes</p>	\$190 million for FYs 2010-2013	<p>State and local health departments</p> <p>Indian tribes</p>

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
28.	<b>Fellowship Training in Public Health, Epidemiology, Public Health Laboratory Science, Public Health Informatics, and Expansion</b>  <u>Title V, Sec. 5314, Page 518</u>	To address documented workforce shortages in state and local health departments in applied public health epidemiology and public health laboratory science and informatics through expansion of existing fellowship programs in these areas and expanding the Epidemic Intelligence Service	HHS to carry out	\$39.5 million appropriated for each of FYs 2010-2013	State and local health departments
29.	<b>Incentives For States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes</b>  <u>Title X, Sec. 10202, Page 805</u>	To provide states with incentives to offer long-term care services in home and community-based settings rather than in a nursing home	State in which Medicaid expenditures for long-term care services and supports provided in non-institutionally-based settings represent less than 50% of all Medicaid expenditures for long-term care services and supports	A state's Federal Medical Assistance percentage (i.e. Federal Matching) will increase by 2% or 5% depending on applicable category state falls into  Total payments by HHS to states during 10/1/2011-9/30/2015 up to \$3 billion	Home health agencies, and other community-based providers, such as adult day care and companion services

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
30	<b>Grants to Enhance Provisions of Adult Protective Services</b>  <u>Title VI, Sec. 6703, Page 676</u>	To enhance adult protective services provided by state and local governments	States and local governments	\$100 million appropriated for each of FYs 2011-2014  Amount paid to each state for a FY shall equal the amount appropriated for that year multiplied by the percentage of the total number of elders who reside in US who reside in the state (guaranteed minimum payment amount may also apply)	State and local adult protective agencies
31	<b>State Demonstration Projects for Purpose of Detecting &amp; Preventing Elder Abuse</b>  <u>Title VI, Sec. 6703, Page 677</u>	To improve detection and prevention of elder abuse at state and local levels	States	\$25 million appropriated for each of FYs 2011-2014	States
32.	<b>Grants to State Survey Agencies</b>  <u>Title VI, Sec. 6703, Page 681</u>	To protect residents of long-term care facilities by designing and implementing a complaint investigation system	State agencies that perform surveys of skilled nursing facilities or nursing facilities	\$5 million appropriated for each of FYs 2011-2014	State agencies

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
33.	<b>Funding for Local and Adult Protective Service Offices</b>  <u>Title VI, Sec. 6703, Page 676</u>	To provide funding for state and local adult protective services that perform certain specified functions including investigation of reports, research and dissemination of information related to elder abuse and neglect	State and local adult protective service offices	\$3 million appropriated for FY 2011 and \$4 million for each of FYs 2012-2014	State and local adult protective service offices
34.	<b>Grants for Establishment of Elder Abuse, Neglect and Exploitation Forensic Centers</b>  <u>Title VI, Sec. 6703, Page 672</u>	<p>To establish and operate stationary and mobile forensic centers and to develop forensic expertise regarding, and provide services relating to, elder abuse, neglect and exploitation</p> <p>Four grants to institutions of higher education with demonstrated expertise in forensics or commitment to preventing or treating elder abuse, neglect to establish and operate stationary forensic centers</p> <p>Six grants to establish and operate mobile forensic centers</p>	<p>The following entities if they have engaged in and have expertise in issues relating to elder justice or in a field necessary to promote elder justice efforts:</p> <p>State or local government agencies;</p> <p>Indian tribes or tribal organizations; and</p> <p>Other public or private entities</p>	\$4 million appropriated for 2011, \$6 million for 2012 and \$8 million for FYs 2013-2014	<p>State or local government agencies</p> <p>Indian tribes or tribal organizations</p> <p>Other public or private entities with expertise in elder justice</p>
35.	<b>Funds for Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers</b>  <u>Title VI, Sec. 6201, Page 606</u>	To help states carry out a nationwide program established by HHS for long-term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis	States	State match requirement - 3 times what state guarantees to make available for the program with max of \$3 million for newly participating states and \$1.5 million for previously participating states	<p>Long-term care facilities</p> <p>Nursing homes</p> <p>Assisted living service agencies</p> <p>Home health agencies</p> <p>Personal or home care agencies</p>

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
36.	<p>State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation</p> <p><u>Title X, Sec. 10607, Page 891</u></p>	<p>To provide grants to states to develop, implement and evaluate alternatives to current medical tort litigation</p>	<p>States</p>	<p>Grants shall only be provided for 5 years</p> <p>Funding amount not specified</p>	<p>States</p>
37.	<p>Community-Based Care Transitions Program</p> <p><u>Title III, Sec. 3026, Page 295</u></p>	<p>To provide funding to furnish improved care transition services to high-risk Medicare beneficiaries</p>	<p>Hospitals identified by HHS as having a high rate of readmission</p> <p>Community-based organizations that provide care transition services across a continuum of care through arrangements with eligible hospitals whose governing body includes representation of multiple health care stakeholders (including consumers)</p>	<p>Program shall begin on 1/1/2011 for a 5-year period</p> <p>\$500 million in the aggregate for FYs 2011-2015</p>	<p>Hospitals</p> <p>Home health agencies</p>

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
38.	<b>Pilot Testing Pay-For-Performance Programs For Certain Medicare Providers</b>  <u>Title X, Sec. 10326, Page 843</u>	To conduct a pilot program for eligible providers to test the implementation of a value-based purchasing program for Medicare payments	Psychiatric hospitals  Long-term care hospitals  Rehabilitation hospitals  PPS-exempt cancer hospitals  Hospice programs	Shall be established no later than 2016	Psychiatric hospitals  Long-term care hospitals  Rehabilitation hospitals  PPS-exempt cancer hospitals  Hospice programs
39.	<b>National Pilot Program on Payment Bundling</b>  <u>Title III, Sec. 3023, Page 281</u>	To establish a pilot program for integrated care during an episode of care provided to a Medicare Part A or B beneficiary around a hospitalization in order to improve the coordination, quality and efficiency of health care services	Hospitals  Physician groups  Skilled nursing facilities  Home health agencies	Program shall occur over a 5-year period  Program to be established no later than 1/1/2013	Hospitals  Physician groups  Skilled nursing facilities  Home health agencies
40.	<b>Independence at Home Demonstration Program</b>  <u>Title III, Sec. 3024, Page 286</u>	To test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes	Home health teams directed by a physician or, in accordance with state law, a physician assistant or nurse practitioner  The team may also be composed of nurses, pharmacists and other health and social services staff	Shall begin no later than 1/1/2012 and shall occur over a 3-year period  \$5 million allocated for each FY from 2010-2015	Home health agencies  Physicians  Physician assistants  Nurse practitioners

	Grant/Project <i>* Denotes funding is discretionary</i>	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
41.	<b>Demonstration Grants for Family Nurse Practitioner Training Programs</b>  <u>Title X, Sec. 10501, Page 877</u>	To establish a training demonstration program to employ and provide 1-year training to nurse practitioners for careers as primary care providers in FQHCs and Nurse-Managed Health Centers	FQHCs  Nurse-Managed Health Centers	Funds shall be appropriated to implement program for FYs 2011-2014  3-year grants  Priority given to those with ability to provide training to 3 nurse practitioners  Grant amounts shall be up to \$600,000 per grant per year  HHS may award technical assistance grants to grant recipients	FQHCs  Nurse-Managed Health Centers
42.	<b>Grants to Support Shared Decision making Implementation</b>  <u>Title III, Sec. 3506, Page 411</u>	To provide for the phased-in development, implementation and evaluation of shared decision making using patient decision aids to improve the understanding of patients of their medical treatment options	Health care providers	Funding amount not specified	Health care providers
43.	<b>Grants or Contracts to Implement Medication Management Services in Treatment of Chronic Diseases</b>  <u>Title III, Sec. 3503, Page 398</u>	To implement medication management services provided by licensed pharmacists as a collaborative, multidisciplinary, interprofessional approach to the treatment of chronic diseases	Entities that provide a setting appropriate for medication management services	Shall begin no later than 5/1/2010	Pharmacists  Hospitals  Clinics  Home health agencies

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
44.	<b>Grants or Contracts to Fund Development of Performance - Measures for Medication Therapy Management Services</b>  <u>Title III, Sec. 3503, Page 400</u>	To develop performance measures that assess the use and effectiveness of medication therapy management services	Entities that provide a setting appropriate for medication management services	Funding amount not specified	Pharmacists  Hospitals  Clinics
45.	<b>Incentive Payment Program for Major Surgical Procedures Furnished in Health Professional Shortage Area</b>  <u>Title V, Sec. 5501, Page 535</u>	To strengthen and expand access to general surgery services by providing financial incentives for surgeons to perform surgical procedures in shortage areas (10% additional payment for such services)	General surgeon who performs major surgical procedures in shortage areas	For major surgical procedure services on or after 1/1/2011 and before 1/1/2016  Funding amount not specified	Surgeons
46.	<b>Hospital Value-based Purchasing Program</b>  <u>Title III, Sec. 3001, Page 235</u>	To establish a hospital value-based purchasing program under which value-based incentive payments are made to hospitals that meet specified performance standards	Hospitals are eligible to participate unless the hospital is subject to certain payment reductions, has been cited for patient health or safety deficiencies that pose immediate jeopardy to the health or safety of patients, or lacks a minimum number of cases or measures, as determined by HHS	Shall apply to payments for discharges occurring on or after 10/1/2012  Funding amount not specified	Hospitals

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
47.	Value-based Purchasing Demonstration Program for Inpatient Critical Access Hospitals  <u>Title III, Sec. 3001, Page 244</u>	To test innovative methods of measuring and rewarding quality and efficient health care furnished by inpatient critical access hospitals	Critical access hospitals	Shall be established by 3/23/2012 and shall occur over a 3-year period  Funding amount not specified	Critical access hospitals
48.	Value-based Purchasing Demonstration Program for Hospitals Excluded from Hospital Value-based Purchasing Program as a Result of Insufficient Numbers of Measures and Cases  <u>Title III, Sec. 3001, Page 245</u>	To test innovative methods of measuring and rewarding quality and efficient health care furnished by hospitals excluded from value-based purchasing program	Hospitals excluded from the hospital value-based purchasing program as a result of an insufficient number of measures or cases as determined by HHS	Shall be established by 3/23/2012 and shall occur over a 3-year period  Funding amount not specified	Hospitals
49.	Medicare Hospice Concurrent Care Demonstration Program  <u>Title III, Sec. 3140, Page 322</u>	To determine if the use of a concurrent care system improves patient care, quality of life and cost-effectiveness	15 Medicare participating hospice programs from a mix of rural and urban areas	Program shall occur over a 3-year period	Hospices
50.	Research-Based Dental Caries Disease Management  <u>Title IV, Sec. 4102, Page 433</u>	To award grants to demonstrate the effectiveness of research-based dental caries management	Community-based providers of dental services, including:  FQHCs;	Funding amount not specified	Dentists  Hospitals  Clinics

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
			<p>Clinics of a state-owned or operated hospital</p> <p>Indian Health Service, Indian tribe or urban Indian dental service;</p> <p>Health system providers;</p> <p>Private providers of dental services;</p> <p>Medical, dental, public health, nursing or nutrition educational institutions; and</p> <p>National organizations involved in improving children's oral health</p>		FQHCs
51.	<p><b>Incentive Payments Program for Primary Care Physicians</b></p> <p><u>Title V, Sec. 5501, Page 534</u></p>	To expand access to primary care services (provides 10% additional payment on primary care services provided by primary care practitioners)	<p>The following practitioners for whom primary care services accounted for at least 60% of the allowed charges for that practitioner:</p> <p>Practitioners who have primary specialty designations of family medicine, internal medicine, geriatric medicine, or pediatric</p>	<p>For primary care services on or after 1/1/2011 and before 1/1/2016</p> <p>Funding amount not specified</p>	Primary care physicians

	Grant/Project  * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
			medicine; or  Nurse practitioners, clinical nurse specialists or physician assistants		
52.	<b>Certified EHR Technology Grant Program</b>  <u>Title VI, Sec. 6703, Page 674</u>	To assist long-term care facilities by providing funds to offset costs related to purchasing, leasing, etc. certified electronic health records ("EHR")technology	Long-term care facilities  Community-based long-term care providers	Appropriated for FY 2011-\$20 million  FY 2012-\$17.5 million  FYs 2013-2014 \$15 million (includes funding for entries 53 and 54 below)	Long-term care facilities  Community-based long-term care entities
53.	<b>Grants and Incentives for Long-term Care Staffing</b>  <u>Title VI, Sec. 6703, Page 673</u>	To improve long-term care staffing by providing eligible entities funds to carry out programs which offer employees providing direct care in long-term care, continuing training, bonuses, commissions etc.	Long-term care facilities  Community-based long-term care providers	Shares same funding as entry 52 above.	Long-term care facilities  Community-based long-term care entities
54.	<b>Programs to Improve Management Practices in Long-term Care</b>  <u>Title VI, Sec. 6703, Page 673</u>	To enhance quality of long-term care by providing training and technical assistance to eligible entities regarding management practices using methods demonstrated to provide retention of individuals who provide direct care	Long-term care facilities  Community-based long-term care entities	Shares same funding as entry 52 and 53 above.	Long-term care facilities  Community-based long-term care entities

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
55.	<b>Long-term Care Ombudsman Program Grants and Training</b>  <u>Title VI, Sec. 6703, Page 678</u>	Support and improvement of state long-term care ombudsman programs-entities to conduct pilot programs with state long-term care ombudsman offices	Eligible entities with relevant expertise and experience in abuse and neglect in long-term care facilities or long-term care ombudsman programs and responsibilities	Appropriated \$5 million for FY 2011  \$7.5 million for FY 2012  \$10 million for FYs 2013-2014	Long-term care facilities  Community-based long-term care entities
56.	<b>National Independent Monitor Demonstration Project</b>  <u>Title VI, Sec. 6112, Page 598</u>	To develop, test, and implement an independent monitor program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities	Chains of skilled nursing facilities and nursing facilities	Shall begin no later than 3/23/2011 and the project must be conducted for a 2-year period  Skilled nursing facility chains are responsible for a portion of the costs associated with the appointment of the independent monitors associated with this demonstration project  Funding amount not specified	Skilled nursing facilities  Nursing facilities
57.	<b>Graduate Nurse Education Demonstration Project</b>  <u>Title V, Sec. 5509, Page 556</u>	To provide additional qualified clinical training to advance practice nurses by reimbursing eligible hospitals for the provision of such training	Up to 5 eligible hospitals  "eligible hospital" means a hospital or a critical access hospital that has a written agreement in place	\$50 million appropriated for each FY 2012-2015	Hospitals

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
			with (i) 1 or more applicable schools of nursing; and (ii) 2 or more applicable non-hospital community-based care settings		
58.	<p><b>Grants for Training in Family Medicine, General Internal Medicine, Pediatrics and Physician Assistantships *</b></p> <p><u>Title V, Sec. 5301, Page 497</u></p>	To enhance health care workforce education and training through support and development of primary care training programs, fellowships, demonstration programs and other efforts in areas of family medicine, general internal medicine or general pediatrics	<p>Accredited public or non profit private hospitals</p> <p>Schools of medicine or osteopathic medicine</p> <p>Academically affiliated physician assistant training programs or</p> <p>Public or private non profit entities deemed appropriate by HHS</p>	<p>Duration of award is 5 years</p> <p>\$125 million appropriated for FY 2010 and such sums as may be necessary for each of FYs 2011-2014</p> <p>15% of amount above is designated for physician assistant training programs that prepare students to practice in primary care</p>	<p>Hospitals</p> <p>Schools of medicine</p> <p>Physician assistant training programs</p> <p>Public or private non profit entities deemed appropriate by HHS</p>
59.	<p><b>Quality Improvement Technical Assistance Grant</b></p> <p><u>Title III, Sec. 3501, Page 393</u></p>	To provide technical support to institutions and providers so that such institutions and providers understand, adapt and implement the models and practices identified in research conducted by the Center for Quality Improvement and Patient Safety	The following entities which have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement:	<p>20% matching fund requirement</p> <p>Funding amount not specified</p>	<p>Hospitals</p> <p>Clinics</p> <p>Physicians</p> <p>FQHCs</p> <p>Home health agencies</p> <p>Nursing homes</p>

	Grant/Project  * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
			Health care providers Health care provider associations Professional societies Health care worker organizations Indian health organizations Quality improvement organizations Patient safety organizations Local quality improvement collaboratives The Joint Commission Academic health centers Universities Physician-based research networks Primary care extension programs		Behavioral health providers

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
			Federal Indian Health Service programs or programs operated by an Indian tribe		
60.	<b>Grants to Nurse-Managed Health Clinics</b>  <u>Title V, Sec. 5208, Page 495</u>	To fund operation of Nurse-Managed Health Clinics	Nurse-Managed Health Clinics	\$50 million appropriated for FY 2010 and such sums as shall be necessary thereafter  Grant amounts based on financial need of clinic	Nurse-Managed Health Clinics
61.	<b>Nurse Education, Practice, and Retention Grants *</b>  <u>Title V, Sec. 5309, Page 511</u>	To enhance the nursing workforce by initiating and maintaining nurse retention programs including career advancement initiatives	Accredited schools of nursing, health care facilities, or partnerships of such schools and facilities	Appropriated such sums as may be necessary for each of FYs 2010-2012	Accredited nursing education programs  Health care facilities  Partnerships of nursing education programs and health care facilities
62.	<b>Nurse Faculty Loan Program *</b>  <u>Title V, Sec. 5311, Page 514</u>	To increase the number of qualified nursing faculty by having HHS make payments on loans of nurses attaining certain levels of education and agreeing to be employed as faculty at accredited nursing schools	Individuals who:  (1) are a United States citizen, national, or lawful permanent resident;  (2) hold an unencumbered license as a registered nurse; and  (3) have either already completed a master's	Individuals completing masters in nursing or equivalent have a cap of \$10,000 per year and total payments during FYs 2010 and 2011 can not exceed \$40,000  Individuals completing doctorate in nursing or equivalent have a cap of \$20,000 per	Nurses

	Grant/Project  * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
			or doctorate nursing program at an accredited school of nursing or is currently enrolled	year and total payments during FYs 2010 and 2011 can not exceed \$80,000  Appropriated such sums as may be necessary for each of FYs 2010-2014	
63.	<b>Grants to Individuals to Enter Careers in Geriatrics</b>  <u>Title V, Sec. 5305, Page 506</u>	To provide career awards and comprehensive education to individuals in geriatric areas in exchange for minimum employment commitments	Advanced practice nurses, clinical social workers, pharmacists, or students of psychology pursuing doctorate or other advanced degrees in geriatrics or related fields in accredited health professions schools	\$10 million appropriated for FYs 2011-2013	Nurses  Social workers  Pharmacists  Students of geriatric studies
64.	<b>Pediatric Loan Repayment Program</b>  <u>Title V, Sec. 5203, Page 489</u>	Increasing the supply of the health care workforce by supporting efforts to recruit and retain individuals in pediatric specialties to service underserved areas	U.S citizen/permanent legal resident that:  (i) is a licensed physician entering or receiving training in an accredited pediatric medical sub specialty or pediatric surgical specialty, residency, or fellowship or has completed (but not before the end of 2010) training set forth in PPACA; or	HHS shall make a maximum of \$35,000 per year payment on education loans (undergraduate or GME education loans) for eligible professional for no more than 3 years  \$20 million appropriated for each of FYs 2010-2013 for child and adolescent mental	Health care or mental health professionals in pediatric specialties

	Grant/Project	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
	<p>* Denotes funding is discretionary</p>		<p>(ii) a health care professional who (a) has received specialized training or clinical experience in child and adolescent mental health the areas specified in PPACA, or (b) who has a license or certification in the state to practice allopathic medicine, osteopathic medicine, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family therapy, school counseling, or professional counseling; or</p> <p>(iii) is a mental health service professional who completed (but not before the 2010 calendar year) specialized training or clinical experience in child and adolescent</p>	<p>and behavioral health specialists</p> <p>\$30 million appropriated for each of FYs 2010-2014 for pediatric medical specialists and pediatric surgical specialists</p>	

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
65.	<b>Public Health Workforce Loan Repayment Program</b>  <u>Title V, Sec. 5204, Page 488</u>	To assure adequate supply of public health professionals to eliminate critical public health workforce shortages in Federal, state, local and tribal public health agencies	mental health specified in PPACA.  U.S. Citizen (i) enrolled in or accepted for enrollment in academic educational institutions for public health or health professions degree and meeting additional specifications set forth in PPACA; or  (ii) individuals who have graduated during a preceding 10-year period with a public health or health professions degree meeting additional specifications set forth in PPACA	For each year which an individual contracts to serve, HHS may pay a max of \$35,000 per year served with max of 1/3 of loan balance for individuals with less than \$105,000  \$195 million authorized for 2010 and such sums as may be necessary for each of FYs 2011-2015	Individuals in public health  Students  Recent graduates
66.	<b>Allied Health Loan Forgiveness Program</b>  <u>Title V, Sec. 5205, Page 493</u>	To assure an adequate supply of allied health professionals and to eliminate critical allied health workforce shortages in the Federal, state and local and tribal public health care agencies	Allied health professionals who have graduated and received allied health professions degrees or certificates and are employed with Federal, state, local or tribal public health agencies or in a setting where patients might require health care services, including acute care facilities,	Funding amount not specified	Allied health professionals

	Grant/Project <small>* Denotes funding is discretionary</small>	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
			ambulatory care facilities, personal residences and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations		
67.	<b>Quality Improvement Program for Hospitals with a High Severity Adjusted Readmission Rate</b>  <u>Title III, Sec. 3025, Page 294</u>	To make available a program for hospitals to improve their readmissions rate through the use of patient safety organizations	Hospitals with high readmission rates for patients with certain conditions that has not taken appropriate steps to reduce the readmissions rate and improve patient safety	Program shall begin no later than 3/23/2012  Funding amount not specified	Hospitals
<b>Community Health Centers</b>					
68.	<b>Co-Locating Primary And Specialty Care In Community-Based Mental Health Settings</b>  <u>Title V, Sec. 5604, Page 561</u>	To improve care to adults with mental illness who have co-occurring primary care conditions and chronic diseases through co-location of primary and specialty care services in community-based mental and behavioral health settings	Qualified community mental health programs defined under section 1913(b)(1) of the Public Health Act	\$50 million appropriated for FY 2010 and such sums as may be necessary for each of FYs 2011-2014	Community mental health programs

	Grant/Project <i>* Denotes funding is discretionary</i>	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
69.	<b>Program for Early Detection of Certain Medical Conditions Related to Environmental Health Hazards</b>  <u>Title X, Sec. 10323, Page 839</u>	To make competitive grants to eligible entities to (1) screen "at risk individuals" (exposed to environmental health hazards) for environmental health conditions including, but not limited to, asbestosis, pleural thickening/plaques, mesothelioma and malignancies of the lungs, colon, rectum, larynx, stomach, esophagus, pharynx or ovary; (2) develop and disseminate public information and education about screening availability, detection, prevention and treatment of environmental health conditions, and availability of Medicare benefits for certain people diagnosed with an environmental health condition	Community health centers  FQHCs  Indian tribal governments  National Cancer Institute designated cancer centers  State and local governments  Miscellaneous non-profit organizations	\$23 million for FYs 2010-2014 is appropriated for funding  \$20 million for each 5-FY period thereafter  Appropriated funds shall remain available until expended	Community health centers  FQHCs  Indian tribal governments  National Cancer Institute designated cancer centers  Miscellaneous non-profit organizations
70.	<b>Demonstration Project Concerning Individualized Wellness Plan</b>  <u>Title IV, Sec. 4206, Page 458</u>	To test the impact of providing at-risk populations who utilize community health centers an individualized wellness plan that is designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment, including weight, tobacco/alcohol use, exercise, nutrition and blood pressure	Community health centers	Funding amount not specified	Community health centers
<b>Aging and Disability Resource Centers / Area Agencies on Aging</b>					
71.	<b>Additional Funding for Aging and Disability Resource Centers</b>  <u>Title III, Sec. 3306, Page 352</u>	To increase funding for aging and disability resource centers for FYs 2009-2012	Aging and disability resource centers	FY 2009 - \$5 million  FYs 2010-2012 - \$10 million in the aggregate	Aging and disability resource centers

	Grant/Project <i>* Denotes funding is discretionary</i>	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
72.	<b>Funding to Expand State Aging and Disability Resource Centers</b>  <u>Title II, Sec. 2405, Page 187</u>	HHS will provide funds to (i) support and expand Aging and Disability Resource Centers, and (ii) support efforts of Aging and Disability Centers and other public and private state and community-based organizations, including faith-based organizations, to serve as benefit enrollment centers	Aging and disability resource centers	For FYs 2010-2014, an additional \$10 million per FY will be appropriated to fund the programs	Aging and disability resource centers
73.	<b>Increased Funding for Area Agencies on Aging</b>  <u>Title III, Sec. 3306, Page 352</u>	To increase funding for area agencies on aging for FYs 2009-2012	Area agencies on aging	FY 2009 - \$7.5 million  FYs 2010-2012 - \$15 million in the aggregate	Area agencies on aging
<b>Academic Institutions</b>					
74.	<b>Grants Related to Area Health Education Centers Infrastructure Development</b>  <u>Title V, Sec. 5403, Page 526</u>	To enable eligible entities to initiate or continue health care workforce education programs and to improve existing area health education programs (programs must use at least 1 area health education center)	Schools of medicine or osteopathic medicine, an incorporated consortium of such schools, or the parent institutions of such schools  In states where no center program is in operation, HHS may award this type of grant to a school of nursing	Entity receiving grant must match an amount that is equal to not less than 50% of the costs of operating the program. At least 25% of the total required non-Federal contributions shall be in cash. (Waivers of matching funds requirement may apply)  Awards based on number of health education centers included in the program (not less than \$250,000)	Medical or osteopathic schools, an incorporated consortium of schools, or parent institutions of schools  Schools of nursing (where above do not exist in state)

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
				annually per area health education center)  \$125 million appropriated for each of FYs 2010-2014 (limitations exist)	
75.	Grants for Training in Family Medicine, General Internal Medicine, General Pediatrics and Physician Assistantships *  <u>Title V, Sec. 5301(b), Page 498</u>	To have schools establish, maintain, or improve academic units or programs that improve (i) clinical teaching and research in the fields of family medicine, general internal medicine or general pediatrics; or (ii) programs that integrate academic administrative units in these fields to enhance interdisciplinary recruitment, training and faculty development	Schools of medicine or osteopathic medicine	\$750,000 appropriated per year for each FY 2010-2014	Schools of medicine or osteopathic medicine
76.	Establishment of United States Public Health Sciences Track  <u>Title V, Sec. 5315, Page 521</u>	To establish an education track which emphasizes team based service, public health, epidemiology and emergency preparedness (the "Track") to be located at existing and accredited, affiliated health professions education training programs at selected academic health centers. Surgeon general is provided with authority to set programs, fellowships, hiring, etc. for the Track	Medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students in the Track can enter into contract with the Surgeon General for tuition (or tuition remission) and a stipend in return for obligated service with the Commissioned Corps of the Public Health Service equal to 2 years for each	HHS shall transfer from the public health and social services emergency fund such sums as may be necessary to carry out establishment of the Track  Funding amount not specified	Track students

	Grant/Project  * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
			<p>school year enrolled at the college (reduction in time may apply as specified)</p> <p>Participating health profession institutions (selected by HHS) may be reimbursed for the cost of educational services provided by the institutions to the Track students</p>		
77.	<p>Area Health Education Centers Point of Service Maintenance and Enhancement Award</p> <p><u>Title V, Sec. 5403, Page 526</u></p>	<p>To maintain and improve the effectiveness and capabilities of existing area health education center programs</p>	<p>Entities that have received infrastructure development funds, operates in an area health education center program, including an area health education center or centers, and have a center or centers that are no longer eligible to receive infrastructure development grants (described directly above)</p>	<p>Entity receiving grant must match not less than 50% of the costs of operating the program (25% cash requirement applies). (Waivers of matching funds requirement may apply)</p> <p>Awards of not less than \$250,000 annually per area health education center included in the program apply</p>	<p>Schools of medicine or osteopathic medicine, an incorporated consortium of such schools, or the parent institutions of such schools</p> <p>Schools of nursing (where above do not exist in state)</p>

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
78.	<b>Rural Physician Training Grants</b>  <u>Title X, Sec. 10501, Page 882</u>	To increase the number of medical school graduates who practice in underserved rural communities (HHS shall issue regulations that will define the term "underserved rural communities")	Schools of allopathic or osteopathic medicine	60 days after enactment of this program, HHS shall issue regulations that will define underserved rural community  Priority will be given to applicants who meet certain criteria such as having a record of successfully training students who practice in underserved rural communities  \$4 million is appropriated for program for each FY from 2010-2013	Schools of allopathic or osteopathic medicine
79.	<b>Preventative Medicine and Public Health Training Grant Program</b>  <u>Title X, Sec. 10501, Page 883</u>	To provide training to graduate medical residents in preventive medicine specialties	Accredited schools of public health  Accredited schools of medicine or osteopathic medicine  Accredited private or public non-profit hospitals  State, local or tribal health departments	\$43 million for FY 2011 are appropriated and necessary amounts for FYs 2012-2015	Accredited schools of public health  Accredited medical and osteopathy schools  Accredited private or public non-profit hospitals  State, local or tribal health departments

	<b>Grant/Project</b> * Denotes funding is discretionary	<b>Purpose</b>	<b>Recipient Eligible for Funding</b>	<b>Important Dates &amp; Funding Amounts</b>	<b>Potential Providers to Benefit</b>
80.	<b>Grants for Training for Mid-Career Public and Allied Health Professionals *</b>  <u>Title V, Sec. 5206, Page 494</u>	To provide and give grants to eligible entities for entities to award scholarships to mid-career professionals in the public health and allied health workforce enabling such individuals to receive additional training in the field of public health and allied health	Accredited educational institutions that offer a course of study, certified program, or professional training program in public health or allied health or a related discipline	\$60 million appropriated for FY 2010 and such sums as are necessary for FYs 2011-2015  50% to allied health mid-career professionals and 50% to public health	Educational institutions  Mid-career professionals in public health and allied health
81.	<b>Grant for Support and Development of Training in General, Pediatric, and Public Health Dentistry</b>  <u>Title V, Sec. 5303, Page 500</u>	To support and develop dental related training programs (including financial assistance programs, training, fellowships, loan repayment program for faculty in dental program)	Schools of dentistry, public or non-profit private hospital, or other private non-profit entity as determined by HHS  Eligible entities includes entities that have programs in dental or dental hygiene schools, or approved residency or advanced education programs in the practice of general, pediatric or public health dentistry	Entity receiving grant gets grant for 5 years subject to annual approval  \$30 million appropriated for FY 2010 and such sums as may be necessary thereafter for FYs 2011-2015	Dental schools and their students  Hospitals  Other private non-profit entities as determined by HHS  Residents  Practicing dentists  Dental hygienists  Full-time faculty of general, pediatric or public health dentistry
82.	<b>Alternative Dental Health Care Providers Demonstration Project</b>  <u>Title V, Sec. 5304, Page 503</u>	To award 15 grants to eligible entities to allow entities to establish a demonstration program designed to increase access to dental health care services in rural and other underserved communities	Entities which are within a program accredited by the Commission of Dental Accreditation or within an accredited dental education program and are	Shall not begin later than 3/23/2012 and shall conclude not later than 7 years after enactment  Each grant is not less than \$4 million	Institutions of higher education (including community colleges)  Public-private partnerships

	Grant/Project  * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
			either:  Institutions of higher education (including community colleges)  Public-private partnerships;  FQHCs;  Indian Health Service facilities;  State or county public health clinics;  Health facilities operated by Indian tribes; or  Public hospitals or health systems	for the 5 year period during which the demonstration project being conducted  Cap on first year disbursement applies- 20% of the total funding distributed in first year and minimum of 15% of funding for each year after	FQHCs  Indian Health Service facilities or Indian Tribes  State or county public health clinics  Health facilities operated by Indian tribe  Public hospitals or health systems
83.	<b>Grants for Mental and Behavioral Health Education and Training*</b>  <u>Title V, Sec. 5306, Page, 508</u>	To support the recruitment of students for, and education and clinical experience of students in certain education tracks related to mental and behavioral health as described in PPACA	Institutions of higher education  (At least 4 grants to historically black colleges or universities or other minority institutions)	Authorized to be appropriated for FYs 2010-2013:  \$8 million for training in social work;  \$12 million for training in graduate psychology, of which not less than \$10 million shall be	Institutions of higher education

	Grant/Project  * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
				allocated for doctoral, postdoctoral, and internship level training;  \$10 million for training in professional child and adolescent mental health; and  \$5 million for training in paraprofessional child and adolescent work	
84.	<b>Depressive Disorder Grant Program</b>  <u>Title X, Sec. 10410, Page 866</u>	To award competitive grants to eligible entities to establish national centers of excellence for depression ("Centers") to conduct activities related to depressive disorder treatment	Institutions of higher education  Public and private research institutions	Not later than 03/23/2011, not more than 20 Centers may be established  Not later than 9/30/2016, not more than 30 Centers may be established  Grants are awarded to recipients for a 5-year period and 1 additional 5-year period  Grant priority will be given if meet	Institutions of higher education  Public and private research institutions

	Grant/Project  * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
				specified criteria  1 Grant provided to recipient to be the coordinating center of excellence for depression  Entities must match (with non-federal funds) \$1 for every \$5 awarded  Recipients may not be awarded more than \$5 million except for coordinating center gets \$10 million	
85.	<b>Demonstration Program to Integrate Quality Improvement and Patient Safety Training into Clinical Education of Health Professionals</b>  <u>Title III, Sec. 3508, Page 412</u>	To develop and implement academic curricula that integrates quality improvement and patient safety in the clinical education of health professionals	Health professions schools  Schools of public health  Schools of social work  Schools of nursing  Schools of pharmacy  Graduate medical education programs  Schools of health care administration	Funding amount not specified	Academic institutions

	Grant/Project  * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
86.	Program for Education and Training in Pain Care  <u>Title IV, Sec. 4305, Page 468</u>	To develop and implement programs to provide education and training to health care professionals in pain management	Health care professions schools  Hospices  Other public and private entities	Funding amount not specified	Academic institutions  Hospices  Hospitals  Home health agencies  Nursing homes  Physicians
87.	Grants for Training for Direct Care Workers  <u>Title V, Sec. 5302, Page 499</u>	To allow entities to provide new training opportunities for direct care workers who are employed in long-term care settings such as nursing homes, assisted living facilities and skilled nursing facilities, intermediate care facilities for individuals with mental retardation, home and community-based settings and any other setting HHS determines to be appropriate	Institutions of higher learning who are accredited and have established a public-private educational partnership with a nursing home or skilled nursing facility, agency or entity providing home and community-based services to individuals with disabilities, or other long-term care provider	\$10 million appropriated for FYs 2011-2013  (Eligible entity provides funding to eligible individuals to offset cost of tuition and other fees for enrollment in programs provided by the eligible entity)	Institutions of higher learning  Nursing homes  Assisted living service agencies  Home health agencies
<b>Sponsors of School-Based Health Centers</b>					
88.	Grants for the Establishment of School-based Health Centers  <u>Title IV, Sec. 4101, Page 428</u>	To establish and operate school-based health centers	School based health centers or sponsors including hospitals, public health departments, community health centers, nonprofit health care agencies and Indian tribal governments	\$50 million per FY from 2010-2013	Schools with school-based health centers and listed sponsors

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
89.	Grants for the Operation of School-based Health Centers  <u>Title IV, Sec. 4101, Page 429</u>	To support the operation of school-based health centers	School-based health centers or sponsors including hospitals, public health departments, community health centers, nonprofit health care agencies and Indian tribal governments	Funding amount not specified	Schools with school-based health centers
<b>Miscellaneous Grants and Opportunities</b>					
90.	Programs Relating to Breast Health and Cancer  <u>Title X, Sec. 10413, Page 873</u>	To increase awareness of breast health and education for young women (ages 15-44) and provide assistance to young women diagnosed with breast cancer and pre-neoplastic breast diseases	HHS shall award grants to (1) entities to establish national multimedia campaigns oriented towards breast health and education for young women; and (2) any organization or institution who will provide assistance and information directed to young women with breast cancer and pre-neoplastic breast disease	\$9 million appropriated for each FY from 2010-2014  Priority shall be given to applicants that deal specifically with young women diagnosed with breast cancer and pre-neoplastic breast disease	Hospitals Physicians Clinics Community-based health prevention programs
91.	National Congenital Heart Disease Surveillance System  <u>Title X, Sec. 10411, Page 870</u>	To track and organize the epidemiology of congenital heart disease ("CHD") information into 1 population based national surveillance system that compiles data concerning actual occurrences of CHD	Public or private non-profit entity with specialized experience with CHD	Funding amount not specified	Hospitals Clinics FQHCs

	Grant/Project <small>* Denotes funding is discretionary</small>	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
92.	<b>Grants or Contracts for Quality Measure Development</b>  <u>Title III, Sec. 3013, Page 264</u>	To develop quality measures that allow the assessment of health outcomes, coordination of care, decision making, meaningful use of health information technology, patient safety, effectiveness of care, patient-centeredness of care, efficiency, health disparities or patient satisfaction	Entities that:  Have demonstrated expertise and capacity in the development and evaluation of quality measures;  Have adopted certain procedures in the quality development process;  Collaborate with certain entities regarding quality measures; and  Have transparent governing and conflicts of interest policies	Funding amount not specified	Hospitals  Clinics  FQHCs  Academic institutions
93.	<b>Office on Women's Health Grants</b>  <u>Title III, Sec. 3509, Page 414</u>	To fulfill the mission of this new government agency including promoting and funding women's health initiatives, providing advice and consultation regarding women's health issues and facilitating the exchange of information about women's health	Public and private entities, agencies and organizations	Funding amount not specified	Hospitals  Government agencies  Clinics  Physicians

	Grant/Project  * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
94.	<p>Program Payments to Teaching Health Centers that Operate Graduate Medical Education Programs</p> <p><u>Title V, Sec. 5508, Page 552</u></p>	<p>Expansion of existing or establishment of new approved graduate medical residency training programs at qualified teaching health centers</p>	<p>Qualified teaching health centers that are listed as sponsoring institutions by the relevant accrediting bodies</p>	<p>Amounts appropriated are not to exceed \$230 million for FYs 2011-2015</p>	<p>Teaching health centers</p>
95.	<p>Teaching Health Centers Development Grants</p> <p><u>Title V, Sec. 5508, Page 550</u></p>	<p>Establishing or expanding primary care residency training programs (family medicine, internal medicine, pediatrics, internal medicine pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics) at teaching health centers</p>	<p>Teaching health centers (entities that are community-based, ambulatory patient care centers and operate a primary care residency program (includes federally qualified health centers, community mental health center, rural health clinic and health center operated by Indian Health Service, an Indian tribe or tribal organization or an urban Indian organization))</p>	<p>Grants shall be for a term of not more than 3 years and the maximum award may not be more than \$500,000</p> <p>\$25 million appropriated for FY 2010</p> <p>\$50 million appropriated for FY 2011</p> <p>\$50 million appropriated for FY 2012</p> <p>and such sums as may be necessary for each FY thereafter</p> <p>No more than \$5 million annually may be used for technical assistance program grants</p>	<p>Qualified teaching health centers</p> <p>Federally qualified teaching health centers</p> <p>Community mental health centers</p> <p>Rural health clinics</p> <p>Indian health centers</p>

	Grant/Project  * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
96.	<p><b>Cures Acceleration Network Grant Program</b></p> <p><u>Title X, Sec. 10409, Page 860</u></p>	<p>National Institute of Health to award competitive grants, cooperative agreements and contracts to eligible entities to accelerate the development of high need cures</p>	<p>Private or public research institutions</p> <p>Institutions of higher education</p> <p>medical center</p> <p>Biotechnology/ pharmaceutical companies</p> <p>Disease or patient advocacy organizations</p> <p>Academic research institutions</p>	<p>Each award shall not be more than \$15 million per project for the 1<sup>st</sup> FY and may receive \$15 million in subsequent years</p> <p>Appropriated \$500 million for FY 2010 and necessary amounts for subsequent FYs</p>	<p>Private or public research institutions</p> <p>Institutions of higher education medical centers</p> <p>Biotechnology/ Pharmaceutical companies</p> <p>Disease or patient advocacy organizations</p> <p>Academic research institutions</p>
97.	<p><b>\$100 Million FY 2010 Appropriation</b></p> <p><u>Title X, Sec. 10502, Page 885</u></p>	<p>To be used for debt service on, or direct construction or renovation of, a health care facility that provides research, inpatient tertiary care, or outpatient clinical services</p>	<p>Facility must be affiliated with an academic health center at a public research university in the U.S. that contains a state's sole public academic medical and dental school</p>	<p>To remain available for obligation until 09/30/2011</p> <p>\$100 million available</p> <p>Federal support represents not more than 40% of total cost of the proposed new facility</p>	<p>Academic institutions</p>

	Grant/Project * Denotes funding is discretionary	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
98.	Establishment of National Training Institute for Surveyors  <u>Title VI, Sec. 6703, Page 680</u>	To protect residents of long-term care facilities by establishing and operating a national training institute for federal and state surveyors of long-term care facilities	Entities chosen by HHS	\$12 million appropriated for HHS to enter into contract with an entity for purpose of establishing and operating this entity	Entities chosen by HHS
99.	Grants for Geriatric Workforce Development  <u>Title V, Sec. 5305, Page 504</u>	Enhancing health care workforce education and training in the area of geriatrics by providing awards allowing entities that operate geriatric education centers for such entities to, among other things, run a faculty fellowship program focused on geriatrics, chronic care and long-term care	Entities that operate geriatric education centers	Awards of \$150,000 with max of 24 geriatric centers to receive award  \$10.8 million appropriated for FYs 2011-2014	Academic institutions
100.	Grants for Small Businesses to Provide Comprehensive Workplace Wellness Programs  <u>Title X, Sec. 10408, Page 859</u>	To award grants to eligible employers to provide their employees with access to workplace wellness programs	For or non-profit employers that employ less than 100 employees who work 25 hours or more per week and does not provide a workplace wellness program as of 03/23/2010	The grant program shall only be conducted for a 5-year period  Appropriated \$200 million in the aggregate for FYs 2011-2015	Small businesses
101.	Demonstration Project To Provide Access to Affordable Care  <u>Title X, Sec. 10504, Page 886</u>	To establish a 3-year demonstration project in up to 10 states to provide comprehensive health care services to the uninsured at reduced fees	States	HHS shall establish the demonstration project no later than September 23, 2010  Each state in which the entity is located shall receive not more than \$2 million for the 3-year period	State-based, non-profit public-private partnership that provides access to comprehensive health care services to the uninsured at reduced fees

	Grant/Project <i>* Denotes funding is discretionary</i>	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
102.	Grants or Contracts for Data Collection  <u>Title III, Sec. 3015, Page 269</u>	To support new, or improve existing, efforts to collect and aggregate quality and resource use measures	Entities that are:  Multi-stakeholder entity that coordinates the development of methods and implementation plans for the consistent reporting of summary quality and cost information;  capable of submitting summary data for a particular population and providers; or  Federal Indian Health Service program or a health program operated by an Indian tribe	20% matching fund requirement	Multi-stakeholder entities as described  Federal Indian Health Service programs or health programs operated by an Indian tribe
103.	Community-Based Collaborative Care Network Program  <u>Title X, Sec. 10333, Page 852</u>	To support community-based collaborative care networks, which are a consortium of health care providers with a joint governance structure that provides comprehensive/ coordinated care to low income populations	Unless specific exceptions apply, the network shall include a hospital and all FQHCs in the community	HHS shall give priority to networks that include (1) the capability to provide broad range of services to low-income individuals; (2) the broadest range of providers that serve a high volume of low income individuals; and (3) a county or municipal department of health	Hospitals  Community health centers  FQHCs

	Grant/Project <small>* Denotes funding is discretionary</small>	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
104.	<b>Grants To Promote Positive Health Behaviors and Outcomes</b>  <u>Title V, Sec. 5313, Page 516</u>	To promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers	Public or nonprofit private entities, including:  States  Public health departments  Free health clinics  Hospitals  FQHCs  A consortium of any of the above entities	Appropriated such sums as may be necessary to carry out this section for each of FYs 2010-2014	Public or private entity using community health workers  FQHCs  Hospitals  Health care provider consortium
105.	<b>Pilot Programs For Care of Certain Individuals Residing In Emergency Declaration Areas</b>  <u>Title X, Sec. 10323, Page 836</u>	To establish one mandatory and one optional pilot program to develop and provide innovative approaches to reimburse providers and to furnish comprehensive, coordinated and cost effective care to eligible individuals suffering from conditions caused by environmental conditions or public health hazards such as asbestosis, pleural thickening, pleural plaques, mesothelioma and other malignancies	Individual's suffering from environmentally caused conditions  Any medical provider providing services to such individuals	Funding amount not specified	Providers

	Grant/Project <i>* Denotes funding is discretionary</i>	Purpose	Recipient Eligible for Funding	Important Dates & Funding Amounts	Potential Providers to Benefit
106.	Minority Health Program  <u>Title X, Sec. 10334, Page 853</u>	To award grants, contracts, enter into memoranda of understanding and inter or intra agency agreements to assure the improved health status of racial and ethnic minorities and to develop measures to evaluate the effectiveness of activities aimed at reducing health disparities and supporting the local community	Public and non-profit entities and agencies  Departmental and cabinet agencies and organizations  Organizations that are indigenous human resource providers in communities of color	Funds appropriated as necessary for FYs 2011-2016	Public and non-profit entities and agencies  Departmental and cabinet agencies and organizations  Indigenous human resource providers in communities of color

Modifications/Amendments to Existing Grants, Demonstration Projects and Other Funding Opportunities

The following amendments were made to existing programs:

	<b>Grant/Project</b>	<b>Purpose</b>	<b>Amendments/Modifications</b>
1.	<b>Post-partum Depression Research</b> <u>Title II, Sec. 2952, Page 226</u>	HHS currently provides grants and other funding to research post-partum depression	HHS is "encouraged" to increase research, education and public outreach
2.	<b>Abstinence Education Funding</b> <u>Title II, Sec. 2954, Page 234</u>	Grants to states to provide abstinence education, and at the option of the state, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out-of-wedlock. The program was last funded in 2003.	Funding to be appropriated for FYs 2010-2014
3.	<b>Gainsharing Demonstration</b> <u>Title III, Sec. 3027, Page 297</u>	Program to allow eligible hospitals and physicians to investigate the effectiveness and efficiency of hospital gainsharing arrangements	Extends the program to 9/30/11, increases funding and requires a final report on the program by 3/31/2013
4.	<b>Childhood Obesity Demonstration Project</b> <u>Title IV, Sec. 4306, Page 469</u>	To conduct a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity	Extends \$25 million in aggregate funding for FYs 2010-2014
5.	<b>School-Based Sealant Program</b> <u>Title IV, Sec. 4102, Page 433</u>	To provide grants to states and Indian tribes for school-based oral health and dental sealant programs	Grants must now be awarded to each of the 50 states
6.	<b>Rural Community Hospital Demonstration Program</b> <u>Title III, Sec. 3128, Page 305</u>	Program to test the feasibility and advisability of establishing rural community hospitals to furnish covered inpatient hospital services	Extends the program for 5 years and provides that not more than 20 rural community hospitals may participate in the program during the extended period
7.	<b>Medicare Rural Hospital Flexibility Program</b> <u>Title III, Sec. 3129, Page 308</u>	To provide grants to states to establish a Medicare rural hospital flexibility program to create 1 or more rural health networks, promote regionalization of rural health services and improve access to hospital and other health services for rural residents. Also provides grants to hospitals assist eligible small rural hospitals in meeting the costs of implementing data systems and programs under PPACA including value-based purchasing programs, accountable care organization programs and the National Pilot Program on Payment Bundling.	Extends the availability of grants from an original end date of FY 2010-2012

	Grant/Project	Purpose	Amendments/Modifications
8.	<b>Demonstration Project on Community Health Integration Models in Certain Rural Counties</b>  <u>Title III, Sec. 3126, Page 307</u>	<p>To develop and test new models for the delivery of health care services in eligible counties for the purpose of improving access to, and better integrating the delivery of, acute care, extended care, and other essential health care services to Medicare beneficiaries</p> <p>Eligible entities must be located in a state in which at least 65% of the counties have 6 or less residents per square mile</p>	<p>An eligible entity selected for this project may now choose up to 8 counties in the state in which they are located, rather than the previous limit of 6 counties</p>
9.	<b>Additional Funding for National Health Services Corps</b>  <u>Title V, Sec. 5207, Page 494</u>	<p>National Health Services Corps is a part of HHS and its members are health professionals serving in underrepresented communities who receive loan repayment assistance and scholarships in exchange for services in these communities</p>	<p>Increases appropriations for existing National Health Services Corps</p> <p>2010- \$320,461,632  2011- \$414,095,394  2012- \$535,087,442  2013- \$691,431,432  2014- \$893,456,433  2015- \$1,154,510,336  2016 and thereafter- amount is based on prior FY adjusted as set forth in Act</p>
10.	<b>Public Health Service Act/Longitudinal Evaluations</b>  <u>Title V, Sec. 5103, Page 486</u>	<p>Provides for grants to state and state workforce investment board, public health or health professions schools, academic health centers or appropriate public or private entities for longitudinal evaluation of individuals who have received education, training, or financial assistance from programs under Public Health Service Act (42 U.S.C. 294m)</p>	<p>Increases amounts available for longitudinal studies to "such sums as may be necessary for FYs 2010-2014"</p>
11.	<b>Expansion of Eligibility for Geriatric Academic Career Awards</b>  <u>Title V, Sec. 5305, Page 506</u>	<p>Makes awards to faculty in areas of geriatrics to promote careers as academic geriatricians</p>	<p>Replaces definition of eligible individual who can receive grants under Section 753(c) of the Public Health Service Act 294(c).</p>

## STATE HEALTH POLICY

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

This *State Health Policy Briefing* identifies and describes ten aspects of federal health reform that states *must* get right if they are to be successful in implementation. These ten areas are:

1. Be Strategic with Insurance Exchange
2. Regulate the Commercial Health Insurance Market Effectively
3. Simplify and Integrate Eligibility Systems
4. Expand Provider and Health System Capacity
5. Attend to Benefit Design
6. Focus on the Dually Eligible
7. Use Your Data
8. Pursue Population Health Goals
9. Engage the Public in Policy Development and Implementation
10. Demand Quality and Efficiency from the Health Care System

This *State Health Policy Briefing* is a product of the State Consortium on Health Care Reform Implementation—a collaboration among the National Governors Association, the National Academy for State Health Policy, the National Association of Insurance Commissioners, and the National Association of State Medicaid Directors. This product has been reviewed by the Consortium and found to be consistent with its mission to add value to state policymakers and stakeholders in health reform implementation. Responsibility for the contents of this brief rests with the National Academy for State Health Policy.

**NATIONAL ACADEMY**  
for STATE HEALTH POLICY

# Briefing

A PUBLICATION OF THE NATIONAL ACADEMY FOR STATE HEALTH POLICY

MAY 2010

## State Policymakers' Priorities for Successful Implementation of Health Reform

BY ALAN WEIL

States that adopt a coordinated, strategic approach to implementing federal health reform will find that the new law contains many provisions that support significant improvements in their health care systems. At the same time, states will face significant challenges implementing the new law—in part due to the many tasks they must complete, and in part due to the extremely constrained financial and staff resources available to them.

There is a natural tendency to focus the implementation discussion on the most immediate issues—for example the state's choice regarding the high risk pool. Indeed, states must tackle these issues, but it is equally important that states begin thinking about and planning for the many aspects of implementation that occur in later years, particularly in 2014, when many of the law's provisions take effect.

At an April 26, 2010, meeting of the NASHP executive committee, the group identified ten aspects of federal health reform that states *must* get right if they are to be successful in their implementation. These ten areas are:

## I. BE STRATEGIC WITH THE INSURANCE EXCHANGE

The insurance exchange will be the exclusive vehicle for individuals and families to obtain subsidized insurance coverage, and it may also become a place where many individuals and firms purchase coverage without subsidies. As such, the insurance exchange presents each state with the opportunity to organize the chaotic and inefficient small group and individual insurance markets. A better-functioning market can improve choice and value for individuals, families, and small businesses, all of which are struggling to afford health insurance.

States have many choices with respect to the exchange. They may create separate exchanges for individuals and small businesses, or they may combine the two. They may create a statewide exchange, subdivide the state regionally, or join together with other states. States also may elect not to create an exchange at all, in which case the federal government will carry out these functions. Any one of these may be a reasonable choice for a state depending upon its own capacity and the nature of the insurance market. Beyond the number and size of the exchange(s), states must make choices about exchange governance, including whether the exchange is inside or outside state government, and, if inside, whether it resides in an existing agency, a new agency, or has an independent status.

Structural choices regarding the exchange will affect the state's ability to integrate the exchange into its overall implementation strategy. Critical exchange functions include selection of participating health plans and review of their rates, standardized presentation of information on benefits so people can make informed choices, standardized data collection across plans and holding plans to high standards in providing access to services and achieving health outcomes, and an effective risk adjustment mechanism to avoid incentives for risk selection and to assure that plans have sufficient resources to provide services to enrollees with high health needs. How the state approaches these functions—in particular how active or aggressive a role it plays in defining health insurance options within the exchange—will have a significant effect on the ultimate shape of the health insurance marketplace. An effective exchange will be a force for efficiency and an orientation toward quality in the insurance and health delivery sectors.

## 2. REGULATE THE COMMERCIAL HEALTH INSURANCE MARKET EFFECTIVELY

The federal law creates many new standards for health insurance underwriting and rating practices. Primary responsibility for enforcing most of those standards falls to the states. While insurance regulation is not a new state function, most states will be expected to dramatically increase their scrutiny of insurance rates and rate increases. Insurance regulation requires a significant number of resources, including highly technical skills. It also requires a range of enforcement tools.

Effective regulation is essential to assure availability of affordable coverage, to avoid risk selection between the exchange and the external market, and to focus the health insurance industry on delivery system improvements. The transition to new rating rules for small group and individual insurance must be handled carefully, as the existing market is fragile and subject to instability, and the amount of change in this market that will occur over a short period involves significant uncertainty.

States will also have a significant new role regarding review of health insurance premium increases. States must scrutinize rating and marketing practices carefully inside and outside the exchange. States must monitor the status of grandfathered plans to assure that they do not become an opportunity for risk selection or risk segmentation. Regulation will also be necessary to determine if new benefits such as preventive services are being delivered.

Effective commercial health insurance regulation will be critical to the success of the overall reform endeavor.

## 3. SIMPLIFY AND INTEGRATE ELIGIBILITY SYSTEMS

Dramatic simplification of eligibility is the only way to achieve the promise of near-universal coverage embodied in the federal law. To put it bluntly, 36 million Americans cannot be enrolled in Medicaid or the new exchanges by relying upon what in most states is a county-based eligibility platform designed around the cumbersome and intrusive processes of the welfare eligibility system. Eligibility systems in most states rely upon outdated technology and are expensive and slow to modify.

The federal law effects a tremendous simplification in Medicaid eligibility—moving to standards based on modified adjusted gross income as defined in the tax code. This simplification meshes nicely—at least in theory—with the simplified income tests for exchange-based subsidies. To make this work in practice, states must work out myriad issues that coordinate the flow of eligibility and enrollment information among Medicaid, CHIP, and the exchange. They must develop and refine data sharing between these entities and the federal government for information on income and citizenship. These information streams must come together in real time to provide potential enrollees with clear choices regarding their coverage options.

States have learned a great deal about effective outreach, enrollment, and retention of people eligible for coverage—but part of what they have learned is that those tools are only effective in the context of an improved eligibility system.

With guidance from the federal government, states must completely redesign their eligibility systems and processes to assure seamless transitions as families' incomes rise and fall; families are formed, grow, or dissolve; part time, seasonal, and migrant workers change status; and people move from one part of the state to another—or to another state entirely. This redesign must account for the need to continue administering fairly complex eligibility standards for some categories, such as people with disabilities, and for the efforts many states have made in recent years to offer single entry points for access to a broad range of social services, including the Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps) and child care subsidies. This is a massive undertaking. If done well, it holds the promise of incredible efficiencies and dramatic improvements in customer service and, ultimately, access to care.

#### 4. EXPAND PROVIDER AND HEALTH SYSTEM CAPACITY

On average, people without health insurance use about 60 percent of the health care services as people with coverage. Expanding coverage will increase demand for services, which will strain the capacity of those parts of the health care system that are already under pressure. Particular challenges will arise in the areas of primary care, culturally competent and linguistically accessible care, and highly specialized care. Coverage expansions will occur at the same time as some institutions—community clinics, health centers and public

and other safety net hospitals—are experiencing significant changes in their financing.

Expanding capacity is a long-term endeavor, so states must start now. The federal law provides some important opportunities. There are grant funds to support community health workers. There are opportunities for innovative payment and delivery models associated with telehealth in the areas of behavioral health and treatment of people with chronic illnesses, in particular by non-medical providers. There are significant changes in the allocation of graduate medical education training slots to emphasize primary care and outpatient settings and increased requirements on nonprofit hospitals to identify and meet community needs. There are a number of new funding streams designed to expand provider supply in underserved areas, promote a more diverse workforce, expand the number of oral health professionals and expand nursing capacity in federally qualified health centers. Federal grants to states to support alternatives to the current medical liability system may affect supply. And, while the new federal law does not make any changes in this area, now would be an excellent time to revisit state scope of practice laws and the state's approach to training and credentialing medical professionals.

Health coverage expansions will not create a provider supply problem, but they will highlight the problems states already have. The goals of health reform will not be met if the newly insured find that their coverage is a hollow promise.

#### 5. ATTEND TO BENEFIT DESIGN

Benefit design has a powerful effect on access to and utilization of services—particularly for the low and moderate-income people most affected by health reform. Traditional design features such as copayments, deductibles, and benefit limits are blunt instruments. Newer concepts of evidence-based benefit design are more sophisticated. For example, some plans have eliminated cost sharing for medications designed to treat chronic conditions on the basis that use of these drugs should be encouraged, not discouraged through copayments. At the same time, new benefit designs under development increase cost-sharing for procedures that do not have an evidence base to support their effectiveness.

While the federal law establishes parameters for insurance coverage, and those standards may be further explicated through regulations, a significant number of benefit design

issues remain with the states. For example, the new Medicaid coverage for people with incomes below 133 percent of the federal poverty level is for so-called "benchmark" coverage, which can be designed more akin to a commercial plan than to the traditional Medicaid benefit structure. The broad authority states have to select plans to participate in the insurance exchange could be used to affect benefit design. Many states operate premium assistance programs for workers who have access to employer-sponsored insurance, and the standards for those programs could include certain criteria regarding benefit design. States retain control over their benefit mandates in the individual and small group markets—although they must reimburse the federal government for some subsidy expenses associated with those benefits. And, of course, states continue to purchase coverage for their own workers and retirees.

While benefit design initially affects how the enrollee interacts with the health care system, when considered across purchasers, effective benefit design can push the entire health care system toward an emphasis on prevention and coordination and away from services and procedures that have limited value.

## 6. FOCUS ON THE DUALY ELIGIBLE

People eligible for both Medicare and Medicaid account for 42 percent of total Medicaid spending. This group of frail elders and a subset of people with disabilities experiences poorly coordinated care and high costs. Improvements in care for those who are dually eligible has long been a priority for states.

The federal law creates new challenges and opportunities for states. On the challenge side, the changes to the Medicare Advantage program will have implications for existing Special Needs Plans, which, despite their limitations, have been one source for coordination between Medicaid and Medicare. It is not yet clear how this will play out. States will also need to figure out how to integrate the new CLASS Act—a voluntary long-term care insurance program—into their overall strategy for meeting the long-term care needs of their citizens.

On the opportunity side, the law extends and expands the Money Follows the Person demonstration program to provide enhanced matching funds to help residents of institutions move back into the community, and creates new options for supports for people with disabilities. The law also establish-

es a competitive rebalancing incentive program that provides enhanced Medicaid matching payments for home and community-based services if states adopt certain delivery system reforms. The federal law creates a new office within CMS that focuses exclusively on the dually eligible, and the dually eligible are a target population for reforms that can be implemented by the new Center for Medicare and Medicaid Innovation. These two offices have not yet taken shape, but they offer unique vehicles for states to pursue models of integration between Medicaid and Medicare that have never before been available.

## 7. USE YOUR DATA

Data is the engine of improvement. The American health care system stands out relative to other sectors of the economy and relative to the health systems of other nations as operating with limited data. Its roots are paper medical records, payment methods that are treated as trade secrets, and fragmented delivery systems and payers, each of which owns its own data.

There are myriad provisions in the health reform law that call for the collection of new data. Data elements include race, ethnicity and language, price and utilization, program enrollment, and quality metrics. New data will be collected on, among other things, consumer complaints, wellness programs, the prevalence of chronic diseases, and the health care workforce.

Effective use of data requires a commitment to collect it, a strategy to combine data that come from different sources, and selection of priority areas for analysis. Under the provisions of the American Recovery and Reinvestment Act, each state has already developed health information exchange strategic and operational plans. These plans should be updated to reflect the new data provisions and to refine the approach to placing appropriate subsets of the data in the public domain where it can become a force for improvement. Purchasers—individuals, employers, public purchasers and the exchange—can use data to drive improvement in outcomes and quality. Doctors, hospitals, and health systems can use data to achieve the same ends. The state can aggregate data across systems to monitor population health, identify priorities for improvement, and track progress toward improvement goals.

## 8. PURSUE POPULATION HEALTH GOALS

The ultimate goal of the health care system is to improve and maintain people's health and functional status. Population health goals create a bridge between public health and personal health, because population health goals are only attainable through the coordinated efforts of both systems.

The prevention and public health components of the federal law represent a fundamental shift from public health as an afterthought, subject to annual appropriations in competition with the more visible personal health services, to a core, sustained investment. In addition to the creation of the National Prevention, Health Promotion, and Public Health Council, which will coordinate federal strategy, the law includes a large number of grants to address topics including surveillance, public health laboratories, childhood obesity, and racial and ethnic disparities. States will need to consider how closely the criteria for these grants match the priorities and programs in the state.

On the personal health side, the law expands coverage for preventive services, promotes employee wellness programs, and increases payment levels to primary care providers through Medicaid.

The combination of expanded insurance coverage, appropriate benefit design, improved data collection and monitoring, and the increased investment in public health make it realistic for a state to pursue targeted and substantial improvements in the health of the population.

## 9. ENGAGE THE PUBLIC IN POLICY DEVELOPMENT AND IMPLEMENTATION

The public remains confused about how health reform will affect them. The large number of people eligible for Medicaid and CHIP but not enrolled demonstrates that simply creating opportunities for coverage does not mean people will take advantage of them. Fundamentally, health reform can only succeed if it is more about culture and norms than it is about mandates and penalties.

The public also includes the large health sector and employers, who will also face significant changes. The most successful efforts to improve the performance of the health system have been multi-sector, public and private initiatives that set goals and plans for concrete improvements. This framework is particularly essential when pursuing payment changes,

which can only have their intended effect if they are adopted across purchasers.

The sheer number and scale of the tasks to be accomplished means the resources of each state's people and institutions must be brought into the implementation discussion. No amount of talent and goodwill in the state capitol can develop answers and policies that work for an entire state. States must develop a clear approach to achieving effective information flow between an engaged public and their elected representatives to weigh in on options before one is chosen, and to provide information back on how things are going so they can be improved.

## 10. DEMAND QUALITY AND EFFICIENCY FROM THE HEALTH CARE SYSTEM

The American health care system is the most expensive in the world. While delivering technically excellent care in many instances, it also has tremendous documented failures, including overuse of certain procedures, poor management of chronic conditions, excessive and duplicative use of diagnostic tests, avoidable errors that lead to harm and death, and expensive, wasteful administrative processes. In that context, it is imperative that all of the forces of health reform align to squeeze out waste so resources can go toward the unmet needs so many people have and back into the pockets of families and businesses that have far better uses for their limited funds.

Health reform provides states with a broad array of new tools for improving the quality and efficiency of the health care system. These tools include pilots for the establishment of pediatric accountable care organizations, the promotion of medical homes for people with chronic conditions, demonstrations on bundling payments for hospital, post-acute and physician services, and the broad authority embodied in the Center for Innovation.

Far beyond these specific demonstration programs, states have the ability to align the purchasing power they have within Medicaid, CHIP, public employees and retirees, and the new exchange. That leverage, used in conjunction with Medicare and private purchasers, can, through payment reform, benefit design, using data, and setting ambitious population health goals, yield changes in how health care is delivered. Leading states already have in place public and private partnerships that are using payment reform, transparency

with respect to price and quality, and other tools to achieve targeted improvements in health system performance.

## CONCLUSION

States that pursue the ten critical elements identified in this brief will have the greatest chance of achieving the goals embodied in the federal health reform law. As discussed elsewhere, what states need to achieve effective implementation falls into five categories: information and analysis; strategic and implementation planning; topic-specific technical assistance; communications; and coordination across efforts and integration with existing efforts.<sup>1</sup> Among these needs, the

most critical are clarity regarding the substantive provisions of the legislation, analysis of the fiscal and programmatic implications for states, full engagement with the public, and, ultimately, an overall strategy and set of goals, discussed publicly and adopted by the executive and legislative branches, that guides the work of all implementing agencies.

Now is the appropriate time for states to develop a set of overall strategic objectives to guide health reform implementation. This must be done now, even as states await additional federal guidance and many states anticipate new governors arriving in 2011. The specifics of implementation will change over time, but the guiding principles for successful implementation are likely to remain stable.

## ENDNOTES

1 Alan Weil, Jackie Scott, Anne Gauthier and Sonya Schwartz, *Supporting State Policymakers' Implementation of Federal Health Reform*, (Portland, ME: National Academy for State Health Policy, November 2009).

### NATIONAL ACADEMY for STATE HEALTH POLICY

#### About the National Academy for State Health Policy:

The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: [www.nashp.org](http://www.nashp.org).

#### Acknowledgements:

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## State Structures for Implementing Health Reform – Updated October 13, 2010

State	Name of Initiative and Link to Resource	Duties	Members of Initiative
California	<p>Health Care Reform Task Force</p> <p><a href="#">Link to Press Release</a></p> <p><a href="#">Link to Press Release on Legislation</a></p>	<p>To implement key reform provisions, including health benefit exchange, and other legislation signed to enact portions of health reform in 2010 and the long term.</p> <p><a href="http://www.Healthcare.ca.gov">www.Healthcare.ca.gov</a> contains priorities for implementation, timelines for major changes, and updates on Task Force actions.</p> <p>With support of Task Force, Governor signed legislation on 10/1/10 making California the first state to enact legislation creating a health benefit exchange</p>	<p>Task Force is chaired by Health and Human Services Secretary Kim Belche.</p> <p>The Task Force includes members from the:</p> <ol style="list-style-type: none"> <li>1) Governor's Office;</li> <li>2) Department of Finance;</li> <li>3) Department of Health Care Services;</li> <li>4) Department of Public Health;</li> <li>5) Department of Managed Health Care;</li> <li>6) Office of Statewide Health Planning and Development;</li> <li>7) Managed Risk Medical Insurance Board;</li> <li>8) Office of Systems Integration.</li> </ol>
Colorado	<p>The Director of Health Reform Implementation</p> <p>Interagency Health Reform Implementing Board</p> <p><a href="#">Link to Executive Order</a></p>	<p><b>Director of Health Reform Implementation:</b> Responsible for the coordination of and facilitation between agencies in order to implement health care reform.</p> <p><b>Interagency Health Reform Implementing Board</b> The Board is to report quarterly to the Governor on the status of implementation. Its duties include:</p> <ul style="list-style-type: none"> <li>• Developing a strategic plan for implementation;</li> <li>• Coordinating agency efforts to implement and monitor health reform;</li> <li>• Providing leadership and being accountable for implementation of state and federal health reform;</li> <li>• Engaging stakeholders to advise and assist in implementation;</li> <li>• Collaborating with appropriate federal agencies, state agencies, and stakeholders when necessary regarding the establishment of new rules, regulations, or mechanisms for implementation;</li> <li>• Providing transparent access to information;</li> <li>• Launching and regularly updating a new website that will provide residents with information about health reform, the phases of implementation, and how changes may benefit them;</li> <li>• Identifying opportunities for collaboration within the State, as well as regionally and nationally;</li> <li>• Analyzing the impact of health reform on state departments and agencies;</li> <li>• Recommending executive action or legislation to effectively implement health reform; and</li> <li>• Pursuing federal and state grants to assist in implementing health reform.</li> </ul>	<p><b>Voting Members of Board</b></p> <ol style="list-style-type: none"> <li>1) Executive Director of the Department of Health Care Policy and Financing;</li> <li>2) Director of Health Reform Implementation;</li> <li>3) State's Chief Medical Officer. If there is no Chief Medical Officer, the Executive Director of the Department of Public Health and Environment;</li> <li>4) Executive Director of the Department of Human Services;</li> <li>5) Director of the Division of Human Resources in the Department of Personnel and Administration;</li> <li>6) Commissioner of Insurance in the Department of Regulatory Agencies;</li> <li>7) Executive Director of the Department of Revenue;</li> <li>8) Budget Director of the Governor's Office of State Planning and Budgeting;</li> <li>9) Director of the Office of Information Technology;</li> <li>10) Chief Legal Counsel to the Governor; and</li> <li>11) A representative of the Governor's Policy Office.</li> </ol> <p><b>Chair:</b> Executive Director of the Department of Health Care Policy and Financing</p>

<p><b>Connecticut</b> (July 8, 2009)</p>	<p>Connecticut Health Care Reform Advisory Board</p> <p><a href="#">Link to Executive Order</a></p>	<p>The Connecticut Health Care Reform Advisory Board shall prepare a set of proposed health care policies in response to federal health care reforms.</p> <p>The board must make interim recommendations on or before February 1, 2010 and final recommendations to the Governor and to the General Assembly on or before January 1, 2011.</p>	<ol style="list-style-type: none"> <li>1) The Comptroller, or her designee;</li> <li>2) The Secretary of the Office of Policy and Management, or his designee;</li> <li>3) A member appointed by the Governor, who shall be a representative of the nursing or allied health professions;</li> <li>4) A member appointed by the Governor, who shall be a representative of the health insurance industry;</li> <li>5) A member appointed by the Governor, who shall be a representative of the business community;</li> <li>6) A member appointed by the Governor, who shall be a representative of the hospital industry;</li> <li>7) A member appointed by the President Pro Tempore of the Senate, who shall be a primary care physician;</li> <li>8) A member appointed by the Speaker of the House of Representatives, who shall be a representative of organized labor;</li> <li>9) A member appointed by the Majority Leader of the Senate, who shall have expertise in the provision of employee health benefit plans for small businesses;</li> <li>10) A member appointed by the Majority Leader of the House of Representatives, who shall have expertise in health care economics or health care policy;</li> <li>11) A member appointed by the Minority Leader of the Senate, who shall have expertise in health information technology;</li> <li>12) A member appointed by the Minority Leader of the House of Representatives, who shall have expertise in the actuarial sciences or insurance underwriting; and</li> <li>13) The Commissioners of the Departments of Social Services and Public Health and the Office of Health Care Access, or their designees.</li> </ol> <p><b>Chair:</b> Governor shall appoint the chair</p>
<p><b>Connecticut</b> (April 14, 2010)</p>	<p>Health Care Reform Cabinet</p> <p><a href="#">Link to Executive Order</a></p>	<p>The Health Care Reform Cabinet is tasked with:</p> <ul style="list-style-type: none"> <li>• Providing transparent access to information;</li> <li>• Assessing insurance market reforms needed to prepare Connecticut for final implementation of national health reform in 2014;</li> <li>• Developing a plan to pursue federal funds for a temporary high-risk health insurance pool;</li> <li>• Creating a health insurance purchasing exchange that will: create a website where small business owners and individuals can find a comparison of insurance policies including costs incurred and benefits provided; provide a point of access for all eligible residents and businesses to choose</li> </ul>	<p>The Cabinet is comprised of the commissioners or their designees from the following agencies:</p> <ol style="list-style-type: none"> <li>1) The Office of Policy and Management;</li> <li>2) The Department of Insurance;</li> <li>3) The Department of Social Services;</li> <li>4) The Department of Public Health;</li> <li>5) The Department of Mental Health and Addiction Services;</li> <li>6) The Department of Developmental Disability Services;</li> <li>7) The Department of Children and Families;</li> <li>8) The Department of Revenue Services;</li> <li>9) The Department of Economic and Community Development;</li> <li>10) The Department of Information Technology; and</li> <li>11) The Connecticut Health and Educational</li> </ol>

		<p>their insurance; and be structured to promote the highest quality and most cost-effective health care providers and insurers.</p> <ul style="list-style-type: none"> <li>• Pursue federal funding and/or foundation funding opportunities to assist in developing the exchange and implementing any other aspects of health care reform.</li> </ul> <p>Also, the Department of Public Health, on behalf of the Cabinet, shall launch and regularly update a website that will provide Connecticut residents with information about national health care reform, the phases of implementation and how changes may benefit them.</p>	<p>Facilities Authority.</p> <p><b>Chair:</b> Deputy Commissioner of the Department of Public Health</p>
Delaware	State Health Care Reform Steering Committee	<p>Will analyze the effects of and plan for the implementation of health care reform legislation, engage in a planning process to support informed decision-making about the most appropriate Exchange option for Delaware, and make recommendations regarding legislation versus regulatory action to address issues pertaining to PPACA.</p>	<p>Chaired by Secretary of Department of Health &amp; Social Services. Includes representation from:</p> <ol style="list-style-type: none"> <li>1) Department of Insurance</li> <li>2) Delaware Health Care Commission</li> <li>3) Office of Management and Budget</li> <li>4) Department of Technology and Information</li> </ol>
Illinois	<p>Illinois Health Reform Implementation Council</p> <p><a href="#">Link to Executive Order</a></p>	<p>The Council shall make recommendation on, but not limited to, opportunities and responsibilities in the Affordable Care Act to:</p> <ul style="list-style-type: none"> <li>• Establish a health insurance exchange and related consumer protection reforms;</li> <li>• Reform Medicaid services structures and enrollment systems;</li> <li>• Develop an adequate workforce;</li> <li>• Incentivize delivery systems to assure high quality health care and achieve desired outcomes;</li> <li>• Identify federal grants, pilot programs, and other non-state funding sources to assist with implementation of the Affordable Care Act; and</li> <li>• Foster the widespread adoption of electronic medical records and participation in the Illinois Health Information Exchange.</li> </ul>	<p>Members of the Council shall be appointed by the Governor and include the following individuals or their designees:</p> <ol style="list-style-type: none"> <li>1) A designee of the Office of the Governor;</li> <li>2) Director of the Department of Healthcare and Family Services;</li> <li>3) Director of the Department of Insurance;</li> <li>4) Director of the Department of Public Health;</li> <li>5) Director of the Department of Aging;</li> <li>6) Secretary of the Department of Human Services;</li> <li>7) Director of the Office of Health Information Technology;</li> <li>8) Director of Central Management Services;</li> <li>9) Director of the Governor's Office of Management and Budget;</li> <li>10) Director of the Department of Labor;</li> <li>11) Secretary of the Department of Financial and Professional Regulation.</li> </ol> <p><b>Chair:</b> The designee of the Office of the Governor  <b>Vice-Chairs:</b> Directors of the Department of Insurance and the Department of Healthcare and Family Services</p>

<p><b>Maine</b></p>	<p>Health Reform Implementation Steering Committee</p> <p><a href="#">Link to press release and Executive Order</a></p>	<p>In Conjunction with the Governor's Office of Health Policy and Finance, the Health Reform Implementation Steering Committee shall report to the Governor monthly. They shall immediately:</p> <ul style="list-style-type: none"> <li>• Conduct an in-depth analysis of the new federal legislation;</li> <li>• Identify the steps necessary to produce an implementation plan;</li> <li>• Develop a plan to pursue funds pursuant to the national temporary high risk pool;</li> <li>• Plan for the creation of the State Health Exchange; and</li> <li>• Plan for the implementation of all other components of National Health Reform, including specific action steps, timelines, and assignment of lead responsibility.</li> </ul> <p>They shall also:</p> <ul style="list-style-type: none"> <li>• Advise the Governor and provide coordination and leadership for implementation across all departments and agencies of the executive branch;</li> <li>• Assure information sharing and coordination of efforts with the Legislative Joint Select Committee on Health Care Reform Opportunities and Implementation;</li> <li>• Assure stakeholder engagement by consulting the Advisory Council on Health Systems Development to ensure open dialogue; and</li> <li>• Ensure the State Health Plan is consistent with implementation efforts, which must include a chapter outlining issues and options for National Health Reform implementation.</li> </ul>	<p>1) The Director of the Governor's Office of Health Policy &amp; Finance;</p> <p>2) Commissioner of the Department of Health and Human Services;</p> <p>3) Commissioner of the Department of Professional and Financial Regulation;</p> <p>4) Superintendent of Insurance; and</p> <p>5) Executive Director of the Dirigo Health Agency.</p> <p>Other members may be invited on an as needed basis</p> <p><b>Chair:</b> The Director of the Governor's Office of Health Policy and Finance</p>
<p><b>Maryland</b></p>	<p>Maryland Health Care Reform Coordinating Council</p> <p><a href="#">Link to Executive Order</a></p>	<p>By July 15, 2010, the Council must submit to the Governor a comprehensive evaluation of the federal health reform legislation and identify critical decision points that must be considered by the State.</p> <p>By January 1, 2011, the Council must submit to the Governor a comprehensive document with policy recommendations and implementation strategies.</p>	<p>1) The Governor or Governor's designee</p> <p>2) The Lieutenant Governor;</p> <p>3) Secretary of the Department of Health and Mental Hygiene;</p> <p>4) Secretary of the Department of Budget and Management;</p> <p>5) The Insurance Commissioner;</p> <p>6) The Attorney General or the Attorney General's Designee;</p> <p>7) The Chair of the Health Services Cost Review Commission or the Chair's designee;</p> <p>8) The Chair of the Maryland Health Care Commission or the Chair's designee;</p> <p>9) Two members of the Maryland Senate (appointed by the President of the Senate); and</p> <p>10) Two Members of the Maryland House of Delegates (appointed by the Speaker of the House).</p> <p><b>Co-Chairs:</b> The Secretary of the Department of Health and Mental Hygiene and the Lieutenant Governor</p>
<p><b>Michigan</b></p>	<p>The Health Insurance Reform Coordinating</p>	<p>The Council was not given a specific deadline to report recommendations. The Council is tasked with:</p>	<p>1) The Director of the Department of Community Health;</p> <p>2) The Director of the Department of Human</p>

	<p>Council</p> <p><a href="#">Link to Executive Order</a></p>	<ul style="list-style-type: none"> <li>• Conducting a comprehensive evaluation health reform laws to identify decision points or state action items necessary to comply with the law or to further enhance access to health care, reduce costs, and improve quality;</li> <li>• Identifying and recommending mechanisms to assure a coordinated and efficient state implementation;</li> <li>• Engaging stakeholders to develop implementation recommendations;</li> <li>• Facilitating collaboration with federal agencies regarding the establishment of new rules, regulations, or mechanisms for implementation;</li> <li>• Developing recommendations for implementation of a health insurance exchange;</li> <li>• Analyzing the impact of health reform on state departments and agencies, including budgetary impacts;</li> <li>• Identifying federal grants, pilot programs, and other non-state funding sources to assist with implementation;</li> <li>• Recommending executive action or legislation to effectively and efficiently implement health reform;</li> <li>• Submitting to the Director of the Department and to the Governor a strategic plan for the effective and efficient implementation of health reform;</li> <li>• Performing other functions related to implementation as requested by the Director of the Department or the Governor.</li> </ul>	<p>Services, or his or her designee from within the Department of Human Services;</p> <p>3) The Director of the Department of Technology, Management, and Budget, or his or her designee from within the Department of Technology, Management, and Budget;</p> <p>4) The State Budget Director, or his or her designee from within the State Budget Office;</p> <p>5) The State Personnel Director, or his or her designee from within the Civil Service Commission;</p> <p>6) The Director of the Office of the State Employer, or his or her designee from within the Office of the State Employer;</p> <p>7) The Commissioner of Financial and Insurance Regulation, or his or her designee from within the Office of Financial and Insurance Regulation; and</p> <p>8) The Director of the Medical Services Administration within the Department of Community Health.</p> <p><b>Chair:</b> Director of the Department of Community Health</p>
<b>Minnesota</b>	<p>Health Care Reform Task Force</p> <p><a href="#">Link to Signed Legislation</a> (Article 22, Section 4)</p>	<p>The Task Force shall develop and present to the governor and legislature a preliminary report and recommendations on state implementation of federal health care reform legislation by December 15, 2010.</p> <p>The report must include recommendations for state law and program changes to comply with federal health care reform, recommendations for implementing optional provisions for states, considerations to maximize federal funding to the state, and a timeline for future reports on state implementation.</p>	<p>The governor will appoint 13 voting members to the Task Force, and the legislature will appoint 4 members. Appointments by the governor will include:</p> <ol style="list-style-type: none"> <li>1) Two persons representing the governor and state agencies;</li> <li>2) Three persons with demonstrated leadership in health care organizations, health plan companies, or health care trade or professional associations;</li> <li>3) Three persons with demonstrated leadership in employer and group purchaser activities (1 from the business community and 2 from labor organizations); and</li> <li>4) Five persons with demonstrated expertise in areas of health care financing, access, and quality.</li> </ol>
<b>Mississippi</b>	<p>Health Insurance Exchange Study Committee</p> <p><a href="#">Link to Signed Legislation</a></p>	<p>The Committee will conduct an extensive study of health insurance exchanges as proposed at the federal level. The study will include, but is not limited to, the following issues:</p> <ul style="list-style-type: none"> <li>• The participation of insurance carriers in the exchange, the benefits offered by carriers, the rules and standards for the insurance products and the rating standards that the state will establish for the products;</li> <li>• The pool of eligible individuals to mitigate any selection effects on the small group</li> </ul>	<ol style="list-style-type: none"> <li>1) Two members who represent insurance companies, appointed by the Governor, one of which shall be a domestic insurer, and one of which shall be the insurer for the Mississippi Children's Health Insurance Program (CHIP);</li> <li>2) Two health insurance underwriters named by the Mississippi Health Underwriters Association;</li> <li>3) A business owner named by the Mississippi Manufacturer Association;</li> <li>4) A licensed independent insurance agent named by the Independent Insurance Agents of Mississippi;</li> <li>5) A business owner named by the National</li> </ol>

		<p>market;</p> <ul style="list-style-type: none"> <li>• The review of all applicable ERISA, HIPAA and COBRA laws to ensure plans meet the requirements for rating, guarantee issue, imposition of preexisting condition exclusions and continuation of coverage, and potential liability of carriers if the exchange is negligent in applying the laws;</li> <li>• The role of insurance agents in the exchange, the compensation of the agents, and to ensure that all applicable state and federal laws are followed;</li> <li>• The necessity of duplicate costs from dual regulations of health insurance plans in the State of Mississippi;</li> <li>• Thorough review of other states' results and implementation of similar plans;</li> <li>• The ability to reduce the number of uninsured;</li> <li>• The effect of adverse selection;</li> <li>• The funding requirements and fiscal notes;</li> <li>• The projected fees paid by employees and employers;</li> <li>• The methodology used to establish the cost of the projected fees;</li> <li>• Study of other states' successes and failures;</li> <li>• Analysis and documentation of the uninsured population in this state; and</li> <li>• Analysis of the individuals outlined above to determine emergency room utilization and costs.</li> </ul>	<p>Federation of Independent Business;</p> <ol style="list-style-type: none"> <li>6) Two members of the House of Representatives appointed by the Speaker of the House, one of which shall be the Chairman of the House Insurance Committee;</li> <li>7) Two members of the Senate appointed by the Lieutenant Governor, one of which shall be the Chairman of the Senate Insurance Committee;</li> <li>8) A member named by the Division of Medicaid; and</li> <li>9) The Commissioner of Insurance or his designee.</li> </ol>
<p><b>New Mexico</b></p>	<p>New Mexico Health Care Reform Leadership Team</p> <p><a href="#">Link to Executive Order</a></p>	<p>The Leadership Team is responsible for developing a strategic plan, coordinating across state agencies, being accountable for recommendations, and overseeing planning, development, and implementation.</p> <p>The strategic plan is to be presented to the Governor no later than July 1, 2010 and shall include:</p> <ul style="list-style-type: none"> <li>• Measures to implement health reform, including proposals for statutory and regulatory changes, resource allocation, budgeting, and personnel management;</li> <li>• An analysis of how health reform will impact the state budget;</li> <li>• Identification of funding sources, including federal grants and existing state resources, as well as potential gaps in funding;</li> <li>• An analysis of data necessary for implementation;</li> <li>• An analysis of existing state agency capacities and consideration of any necessary structural changes within state government;</li> <li>• A timeline for implementation;</li> <li>• A communication plan for stakeholders, the public, and state agencies.</li> </ul>	<ol style="list-style-type: none"> <li>1) The Secretary of the Human Services Department;</li> <li>2) The Secretary of the Department of Health;</li> <li>3) The Secretary of the Department of Workforce Solutions;</li> <li>4) The Secretary of Taxation and Revenue Departments;</li> <li>5) The Secretary of the Department of Information Technology;</li> <li>6) The Superintendent of the PRC Division of Insurance;</li> <li>7) The Secretary of the Children, Youth, and Families Department;</li> <li>8) The Secretary of the Aging and Long Term Services Department;</li> <li>9) The Secretary of the Indian Affairs Department;</li> <li>10) The Behavioral Health Collaborative CEO; and</li> <li>11) A representative of the Governor's Office.</li> </ol> <p><b>Chair:</b> The Secretary of the Human Services Department</p>

<p>New York</p>	<p>Governor's Health Care Reform Cabinet</p> <p><a href="#">Link to Press Release</a></p>	<p>The Health Care Reform Cabinet is charged with the following tasks:</p> <ul style="list-style-type: none"> <li>• Identifying deadlines for the completion of interim or final steps necessary or desired to comply with the provisions of federal health care reform;</li> <li>• Identifying those provisions of federal health care reform with which the State must comply and those that are optional, and evaluating whether participation in optional programs is appropriate;</li> <li>• Assessing the State's capacity to carry out those provisions of federal health care reform that affect or potentially affect the State;</li> <li>• Identifying any changes needed to State statute, regulation, policy or procedure in order to implement such provisions and facilitating the achievement of such changes as necessary;</li> <li>• Communicating with the federal government, local governments, other states, health care providers, and other stakeholders as advisable or necessary; and</li> <li>• Providing for outreach to the public to educate them on the implementation of reforms as necessary.</li> </ul>	<p>The Health Care Reform Cabinet will have representatives from the following state agencies and offices:</p> <ol style="list-style-type: none"> <li>1) Department of Health</li> <li>2) Department of Insurance</li> <li>3) Division of the Budget</li> <li>4) Department of Civil Service</li> <li>5) Department of Taxation and Finance</li> <li>6) Department of Labor</li> <li>7) Office for Technology</li> <li>8) Office of Temporary and Disability Assistance</li> <li>9) Office of Mental Health</li> <li>10) Office of Mental Retardation and Developmental Disabilities</li> <li>11) Office of Alcoholism and Substance Abuse Services</li> <li>12) Office for Aging</li> <li>13) Office of the Medicaid Inspector General</li> <li>14) Office of Children and Family Service</li> <li>15) Deputy Secretary for Human Services, Technology and Operations</li> <li>15) Deputy Secretary for Intergovernmental Affairs</li> <li>16) Counsel to the Governor</li> </ol> <p><b>Chair:</b> Director of State Operations  <b>Vice-Chairs:</b> Deputy Secretary for Health, Medicaid and Oversight; Deputy Secretary for Labor and Financial Regulation</p> <p>The Governor will also name an external advisory group representing health care providers, consumers, businesses, organized labor, local governments, health insurers, and health policy experts to assist and advise the Cabinet and ensure stakeholder and public engagement.</p>
<p>Nevada</p>	<p>Nevada Health Care Reform Teams</p> <p><a href="#">Link to Website</a></p>	<p>Founded by the Director of the Nevada Department of Health &amp; Human Services under the direction of the Governor, the Health Care Reform Policy Planning Group and the Health Care Reform Implementation Working Group are the two teams that will provide information and advice on matters of health care reform.</p> <p>The priorities of the Policy Planning Group are to monitor issues related to health care reform and inform the Governor's office of decisions and that must be made and provide advice as to those decisions. The Implementation Working Group and its subcommittees will develop white papers on key issues of healthcare reform, particularly what the state must do to prepare for full implementation. Both teams will work in an ongoing basis as long as necessary, without a specific deadline.</p>	<p>The Health Care Reform Policy Planning Group will have one or more representatives from the following offices and agencies:</p> <ol style="list-style-type: none"> <li>1) Director of Nevada's Department of Health and Human Services</li> <li>2) Nevada Insurance Commissioner</li> <li>3) Administrator of Nevada's Division of Health Care Financing &amp; Policy</li> <li>4) Nevada State Insurance Division</li> <li>5) Office of the Attorney General</li> <li>6) Nevada Risk Management</li> <li>7) Nevada Public Employees Benefits Program</li> <li>8) Director of Governor's Office of Consumer Health Assistance</li> <li>9) Administrator of Nevada Division of Welfare &amp; Supportive Services</li> </ol> <p><b>Chair:</b> Director of Nevada's Department of Health and Human Services</p> <p>The Health Care Reform Implementation Working Group will have administrators and staff representatives from the following offices and agencies:</p>

			<ol style="list-style-type: none"> <li>1) Division of Health Care Financing &amp; Policy</li> <li>2) Aging and Disability Services Division</li> <li>3) Division of Mental Health &amp; Developmental Services</li> <li>4) Division of Welfare &amp; Supportive Services</li> <li>5) Division of Child &amp; Family Services</li> <li>6) Nevada State Health Division</li> <li>7) DHHS Director's Office</li> </ol> <p><b>Chair:</b> Administrator of Nevada's Division of Health Care Financing &amp; Policy</p>
<b>Ohio</b>	<p>Ohio Health Care Reform Stakeholder Forum</p> <p><a href="#">Link to Executive Order</a></p>	<p>Interagency group with regular public meetings to monitor and work towards implementation PPACA provisions.</p>	<p>This group includes representation from:</p> <ol style="list-style-type: none"> <li>1) The Governor's Office</li> <li>2) Department of Insurance</li> <li>3) Health Care Coverage and Quality Council</li> <li>4) Department of Health</li> <li>5) Department of Mental Health</li> <li>6) Department of Aging</li> <li>7) Department of Alcohol and Drug Addiction Services</li> <li>8) Department of Job &amp; Family Services</li> <li>9) Department of Administrative Services</li> <li>10) Department of Developmental Disabilities</li> <li>11) Board of Regents</li> </ol>
<b>Pennsylvania</b>	<p>Commonwealth Health Care Reform Implementation Committee</p> <p><a href="#">Link to Executive Order</a></p>	<p>The Commonwealth Health Care Reform Implementation Committee shall:</p> <ol style="list-style-type: none"> <li>1) Design the optimal programmatic model for the commonwealth's High Risk Pool.</li> <li>2) Design the optimal organizational model to support a customer-friendly and efficient health benefit exchange.</li> <li>3) Identify all technology, organization and process improvements necessary to support the implementation of all state obligation under the Act.</li> <li>4) Prepare a strategic plan for the implementation of the Act.</li> <li>5) Identify legislative action necessary to enable full implementation of the Act and draft legislation for discussion with appropriate members of the legislature.</li> <li>6) Create, as needed, inter-agency teams comprised of key staff to assist the Health Care Reform Implementation Committee's decision making process.</li> <li>7) Engage members of the Commonwealth's Health Care Reform Implementation Advisory Committee and seek public input as necessary to accomplish its charge.</li> </ol>	<p>The members of the Commonwealth Health Care Reform Implementation Committee shall be appointed by the Governor and shall include the following individuals or their designees:</p> <ol style="list-style-type: none"> <li>1) Governor's Chief of Staff</li> <li>2) Secretary of Administration</li> <li>3) Secretary of Aging</li> <li>4) Secretary of the Budget</li> <li>5) Director of the Governor's Budget Office</li> <li>6) Secretary of Health</li> <li>7) Executive Director of the Office of Health Care Reform</li> <li>8) Insurance Commissioner</li> <li>9) Secretary of Legislative Affairs</li> <li>10) Secretary of Planning and Policy</li> <li>11) Secretary of Public Welfare</li> <li>12) Deputy Secretary of Public Welfare for Medical Assistance</li> </ol> <p><b>Chair:</b> The Governor shall designate the Chair of the Health Care Reform Implementation Committee</p> <p>The Governor shall also appoint members to the Health Care Reform Implementation Advisory Committee which will provide feedback, inform best practices, and advise the Commonwealth Health Care Reform Implementation Committee.</p>

<p><b>Vermont</b></p>	<p>Governor's Health Care Cabinet</p> <p><a href="#">Link to Executive Order</a></p>	<p>The Cabinet was not given a specific deadline to report findings. Rather, the Cabinet reports to the Governor periodically on how to better integrate health care delivery, improve communication, and provide strategic responses to federal health care reform.</p>	<p>The Health Care Cabinet shall consist of ex-officio representatives from State agencies and departments to include:</p> <ol style="list-style-type: none"> <li>1) Secretary of Civil and Military Affairs; 2) The Secretary of the Agency of Human Services;</li> <li>3) Commissioner and Deputy Commissioners of the Department of Health;</li> <li>4) Commissioners of the Departments of Mental Health, Children and Families, Disabilities, Aging &amp; Independent Living, Labor and Human Resources;</li> <li>5) Commissioner of the Department of Banking, Insurance, Securities and Health Care Administration and the Deputy Commissioner of Health Care Administration;</li> <li>6) Director of the Office of Vermont Health Access;</li> <li>7) Director and Deputy Director of Health Care Reform; and</li> <li>8) Director of the Vermont Blueprint for Health</li> </ol> <p><b>Chair:</b> The Governor shall appoint Co-Chairs</p>
<p><b>Virgin Islands</b></p>	<p>Health Care Reform Implementation Task Force</p> <p><a href="#">Link to Executive Order</a></p>	<p>The Health Care Reform Implementation Task Force shall:</p> <ul style="list-style-type: none"> <li>• Review and research all aspects of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 and their impact on the Territory;</li> <li>• Provide guidance and specific recommendations with respect to implementation of health initiatives, and involve key stakeholders and groups;</li> <li>• Provide short and long range detailed plans including actions and timelines;</li> <li>• Identify funding sources with which the Territory could utilize in implementing health care reform initiatives;</li> <li>• Recommend legislation or executive action to improve access to health care for residents;</li> <li>• Perform such other functions as may be directed by the Governor.</li> <li>• Submit to the Governor quarterly written reports and complete a Master Implementation Plan no later than 180 days after the first meeting of the Task Force.</li> </ul>	<ol style="list-style-type: none"> <li>1) Governor or his designee;</li> <li>2) Lieutenant Governor;</li> <li>3) Commissioner of Health;</li> <li>4) Director of Personnel;</li> <li>5) Director of the Office of Management and Budget;</li> <li>6) Attorney General;</li> <li>7) CEO of the Schneider Regional Medical Center;</li> <li>8) CEO of the Governor Juan F. Luis Hospital;</li> <li>9) Executive Director of the St. Thomas East End Medical Center Corp.;</li> <li>10) CEO of Frederiksted Health Care, inc.;</li> <li>11) Director of VI Equicare;</li> <li>12) Chair of the GES/Health Insurance Board of Trustees; and</li> <li>13) Chairman of the Legislature's Committee on Health.</li> </ol> <p><b>Chair:</b> Lieutenant Governor</p>

<p>Virginia</p>	<p>Health Care Reform Initiative</p> <p><a href="#">Link to Press Release</a></p>	<p>The Health Care Reform Initiative will examine best practices for Medicaid programs, pursue reforms to improve safety and quality, and examine the impact of the requirements of the Patient Protection and Affordable Care Act including Medicaid, insurance, and delivery system reforms.</p> <p>The Initiative will submit findings that impact the development of the Executive Budget by September 30, 2010. Reports of the Initiative's activities, findings, and recommendations will be submitted to the Governor on January 10, 2011 and every following year until 2014.</p>	<p>The Health Care Reform Initiative will be staffed and supported with existing resources from the following offices and agencies:</p> <ol style="list-style-type: none"> <li>1) Office of the Secretary of Health and Human Resources;</li> <li>2) Department of Planning and Budget; and</li> <li>3) Department of Medical Assistance Services.</li> </ol> <p>The Secretary of Health and Human Resources will establish an advisory group of stakeholders and interested parties to provide input and advice.</p>
<p>Washington</p>	<p>Health Care Cabinet</p> <p><a href="#">Link to Executive Order</a></p>	<p>By August 1, 2010, the Health Care Cabinet will submit to the Governor a plan identifying:</p> <ul style="list-style-type: none"> <li>• Short and long range opportunities, issues, and gaps created by the enactment of national health reform;</li> <li>• Structures and processes needed by state agencies to orchestrate reform implementation including those to appropriately assist the private health care sector in its implementation efforts;</li> <li>• Work force capacity and training needs in the public and private sectors; and</li> <li>• Specific action steps, timelines, and assignment of lead responsibility.</li> </ul> <p>The work plan must contain recommendations from the Administrator of the Health Care Authority and Secretary of the Department of Social and Health Services, in coordination with the Office of Financial Management and Executive Policy Office, identifying specific actions and timelines to implement uniform policies and to consolidate duties, functions and powers related to state agencies' health care purchasing under the Health Care Authority.</p>	<p><b>Permanent Members</b></p> <ol style="list-style-type: none"> <li>1) Administrator of the Health Care Authority;</li> <li>2) Secretary of the Department of Health;</li> <li>3) Secretary of the Department of Social and Health Services;</li> <li>4) Director of the Executive Policy Office; and</li> <li>5) Director of the Office of Financial Management.</li> </ol> <p><b>Invited on a "As Needed" Basis</b></p> <ol style="list-style-type: none"> <li>1) Secretary of Corrections;</li> <li>2) Director of the Department of Retirement Systems;</li> <li>3) Director of the Department of Veterans Affairs;</li> <li>4) Director of the Department of Labor and Industries; and</li> <li>5) Office of the Insurance Commissioner.</li> </ol> <p><b>Chair:</b> Director of the Executive Policy Office</p>
<p>Wisconsin</p>	<p>Office of Health Care Reform</p> <p><a href="#">Link to Executive Order</a></p>	<p>Although no specific date is given by which the new office should complete these tasks, the executive order puts forth goals for the Office of Health Care including:</p> <ul style="list-style-type: none"> <li>• Developing a plan that uses national health care reform to build on Wisconsin's existing programs;</li> <li>• Providing transparent access to information;</li> <li>• Assessing insurance market reforms needed to prepare Wisconsin for final implementation of national health reform in 2014;</li> <li>• Developing a plan to pursue federal funds for a temporary high risk health insurance pool;</li> <li>• Creating a health insurance purchasing exchange. Exchange must create a website to</li> </ul>	<p>The new Office of Health Care Reform is to be led by the Secretary of the Department of Health Services and the Commissioner of Insurance.</p>

		<p>aid price/quality transparency, provide a single point of access for all eligible residents and businesses to choose their insurance, promote consumer choice by providing easy comparability of health plans, lower health care premium costs by creating a large pool of employees to increase consumer purchasing and bargaining power, and reward the highest quality/cost-effective health care providers and insurers;</p> <ul style="list-style-type: none"> <li>• Pursuing federal grants to assist in developing the exchange and implementing any other aspects of health care reform; and</li> <li>• Directing the Department of Health Services, on behalf of the Office of health care reform, to launch and regularly update a new website – <a href="http://www.healthcarereform.wisconsin.gov">www.healthcarereform.wisconsin.gov</a> – that will provide Wisconsin residents with information about national health care reform, the phases of implementation, and how changes may benefit them.</li> </ul>	
<b>Wyoming</b>	<p>State Agency Leadership Team</p> <p><a href="#">Link to Press Release</a></p>	<p>The team will determine how national health care reform will affect state programs and the people they serve. The team will draft a short-term work plan that will set out necessary considerations and actions through January 1, 2011.</p>	<p>The State Agency Leadership Team will consist of representative from the following agencies and departments:</p> <ol style="list-style-type: none"> <li>1) Director of the Department of Health</li> <li>2) Director of the Department of Insurance</li> <li>3) Director of the Department of Family Services</li> <li>4) Director of the Department of Education</li> <li>5) Director of the Department of Workforce Services</li> <li>6) Administration and Information's Group Health Insurance Program</li> <li>7) Office of the State's Chief Information Officer</li> <li>8) Attorney General's Office</li> </ol> <p>Other state agencies will be added to the team as necessary for analysis and implementation.</p>

## **State Decision-Making in Implementing National Health Reform**

The federal government may soon pass legislation that will significantly reform our health care system. The complexity and breadth of federal health reforms will pose a significant challenge to states. The preparation and planning will require a thorough review of the reforms and the impact—individually and combined—each will have on the states' health care systems.

There are major components to the bill that address health insurance and coverage, as well as some immediate actions and longer-term system reforms. Governors will have to plan strategically to implement these new programs and expansions—a process that will likely take several years and a great deal of effort and negotiation. Additionally, governors must prepare to ensure the immediate and ongoing coordination of agencies and other stakeholders, consider the timing and interactions among key components, and develop a plan for communicating with the public. This brief provides states with an initial guide on approaching critical aspects of decision-making in health reform implementation.

### **Reform Provisions Affecting States**

The federal health reform bill includes provisions that affect major aspects of the health care system, including a Medicaid expansion, an insurance exchange, insurance market reforms, and delivery system improvements.

#### Medicaid Expansion

The Medicaid expansion will extend coverage to all individuals under age 65 up to 133 percent FPL by 2014. The expansion is fully federally funded for the first three to four years. The state matching portion is phased in over the following two to three years, ultimately resulting in state fund contributions of about 10 percent.

#### Exchange

Private health insurance exchanges, a mechanism for connecting individuals with insurance products, will be implemented by 2014. The current legislation calls for the creation of exchanges in each state that can be operated as a non-profit entity or as a quasi-governmental unit. States also have the option to establish regional exchanges both within and between other states.

#### Insurance Reforms

The bill includes changes to the small group and individual insurance markets such as, requirements for guaranteed issue and renewability; a prohibition on pre-existing conditions; the creation of a national program to fund state high-risk pools; and rating bands that include age (maximum of 3:1), family structure, geography, actuarial value of the benefit, and tobacco use (maximum of 1.5:1). States retain the authority to go beyond the measures.

### Delivery System Reforms

The bill contains delivery system reforms to achieve better health outcomes through a more efficient system. The Obama Administration is supporting fully federally funded reimbursement of Medicaid primary care providers at 100 percent of Medicare rates, but this is not currently in the Senate bill. The legislation also provides grants to states for prevention and wellness initiatives.

The legislation creates a Federal Office of Dual Eligibles, as well as a Medicaid medical home option. The bill also includes multiple options for payment reform including accountable care organization pilot programs, bundled payments, and the establishment of a Federal Innovation Center to test payment and service delivery models. In addition, there are incentive payments for alternative medical liability laws and the option for chronic care medical homes.

### Near-Term Federal Requirements

There are certain aspects of the federal health reform legislation that will go into effect immediately or shortly after enactment. Governors should review these specific requirements and make decisions quickly. The immediate issues that are likely to be most important to governors are:

- *High-risk pools.* If a state does not already have one in place, the state will need to set one up, use an approved alternative state health program to act as a high-risk pool, or the federal government will step in to run one. In many states, existing high-risk pools will need to accommodate more people.
- *Web portal for insurance options.* A national program will be established to provide standardized information on all insurance products being offered on the small group and individual markets. States will need to work with the federal government to provide the standardized information.
- *Medicaid maintenance of effort (MOE).* The legislation continues the MOE on Medicaid that was enacted by ARRA. As a result, states will be unable to decrease eligibility rates or benefits. They will have to remain at their current levels until the Medicaid expansion becomes law. As a result, states may need to revisit their Medicaid state plans and budget.

Implementation planning will be vital in moving forward with each reform effort and in ensuring coordination among the components. There will be several opportunities for states to receive federal money for implementing reforms, and it will be important to consider all options as governors are determining if and how to approach implementation.

### **State Preparations and Planning**

If national health reform legislation is signed into law, states quickly should begin preparations for implementation. Due to the significant and varied roles states will play in making federal reforms operational, governors will need to develop a strategic plan for implementation. This is likely to be a substantial undertaking for states because of the extent of the reforms and the coordination that will need to take place.

As part of the strategic plan, governors must recognize the action steps they need to take to ensure success in implementing reforms. They will need to identify the immediate, short-term, and long-term steps in order to make the appropriate decisions in a timely matter. Specifically, governors should include the following in their strategic plans:

- Identify and organize their state leadership team to develop the strategic plan and establish coordination across state agencies on cross-cutting issues.
- Determine the gaps and resources that currently exist in state government as they relate to reforms to better plan for implementation.
- Evaluate their existing infrastructure to consider where new programs may be housed and consider establishing new offices or agencies for reform programs.
- Examine the timing of their legislative and regulatory processes to ensure ample time for both bill passage and the following regulations to meet federal deadlines for implementation.
- Develop a communications plan for stakeholders, the general public, and state agencies to educate these groups on the effects of health reform and the state's role in implementation.

Aspects of this strategic plan are discussed further in the following sections. Having such a plan will help states assess their current situation, as well as determine when and whether to adopt the federal reforms.

#### Identify and Convene State Leadership Team

One of the first steps governors need to take is to identify the appropriate state leaders that will guide national health reform implementation. Governors should form a health reform cabinet that reports directly to the governor, develops the strategic plan for reform implementation, and is held accountable for its recommendations. Specifically, the governor should give the cabinet responsibilities for the following activities:

- Articulating a clear purpose and operations plan for the cabinet;
- Oversee planning, development and implementation of reforms;
- Identify ways to build on existing infrastructures and programs, or to create a new entity within state government to house governance and oversight functions;
- Ensure appropriate coordination and collaboration across state agencies; and
- Engage with relevant stakeholders to get their buy-in and insight for implementing reforms.

States have used this cross-agency model to coordinate programs and improve on the existing system. Previously, states have created children's cabinets to improve the management of children's issues across health, education, and social service programs. Many of the same themes apply in creating a similar group of senior state officials to organize and manage federal health reforms. For example, Governor Jim Douglas of Vermont issued an executive order establishing a health care cabinet to improve the coordination of national health reform implementation.

### Form a Public/Private Advisory Commission

It will be beneficial for governors to engage stakeholders in the planning and implementation processes to ensure success and broad-based support, as well as to solicit assistance and strategies for approaching reforms. To begin, the health reform cabinet discussed above should identify major, relevant stakeholders to participate in the commission, such as:

- Private insurance companies operating in the state;
- State medical society;
- State hospital group;
- Other direct service providers (i.e., community clinics);
- Major employers;
- Advocacy groups;
- Insurance brokers;
- Other private sector stakeholders; and
- State legislators.

As part of getting them invested in the process, the cabinet should work with the commission to establish the purpose and goals for the group. The commission may have the following responsibilities:

- Solicit experiences and advice on similar programs outside of state government;
- Provide strategies and feedback on implementation plans and establish networks for outreach;
- Create a communications and outreach plan to educate the public on the reforms;
- Discuss potential partnerships between the state and stakeholders for implementation; and
- Discuss potential financial support for aspects of implementation.

For example, Connecticut created an advisory group to respond to federal health reforms. The group consists of fifteen stakeholders from state government and the private sector. The group is charged with examining state-based delivery system reforms, emphasizing cost containment, and increasing access to coverage in the state.

States have used a similar model for other types of advisory groups that have public and private sector interactions, such as infrastructure projects, federal recovery project planning, climate change, and the development of statewide health information exchanges.

### Determine Available Gaps and Resources

States are facing difficult financial situations, and their budget gaps are likely to increase before they begin to decline slowly over several years. It is important for governors to thoroughly analyze their states' situation and agency needs to understand how national reforms will further impact state budgets and their ability to integrate reforms.

If federal grants will be available for states to implement reforms, governors will need to identify existing state resources and where there may be gaps in funding to know which federal grant opportunities would suit their needs.

*Governance and Oversight.* States will need to examine existing state agency capacities, data resources, and leadership to determine what immediate and more long-term changes need to be made to ensure a smooth transition to a reformed system. It will be critical for governors to identify the governance and oversight needs of their state to find gaps that may exist as they approach implementation.

For example, there is likely to be a lack of personnel to not only complete new work associated with reforms, but also that have the professional experience and training necessary for some of the tasks required. It is important for the state to identify those areas and develop a plan for increasing personnel and leadership across these areas. Additionally, for the Medicaid expansion, states will need to develop an online application process and analyze the capacity of their eligibility system infrastructure to ensure compliance with the federal law.

A critical issue for governors to consider is the infrastructure changes that will be necessary within state government. States will need to establish where new programs will be housed and organize how they will be run within new or existing agencies and programs. This infrastructure planning will be a crucial step in phasing in the reforms and having the appropriate mechanisms, personnel and systems in place to incorporate reforms, especially as states already have reduced programs to a minimum and stretched personnel in an effort to balance their budgets.

*Modeling the Distribution of Individuals' Insurance Status.* Governors will also want to analyze current programs, such as Medicaid, CHIP, and insurance offerings, to determine the effects of increased enrollment across many insurance options. States will need to conduct a simulation of where they think people are going to enter the health insurance market – maintaining current coverage, enrolling in their employer's insurance, purchasing individual coverage, buying insurance through the exchange (including who qualifies for subsidies), qualifying for Medicaid or CHIP, or choosing not to purchase coverage.

This modeling will help states estimate their increased caseload for public programs and help to gauge the strength and resilience of existing insurance offerings in the individual and small group markets. It will also assist governors in determining the best ways to handle the influx of uninsured residents entering the system through public programs, the exchange, or into other private or employer coverage. Because budgets are already tight and Medicaid costs are continuing to rise, these estimates will be important in determining the potentially significant impact these reforms will have on the state budget.

## **Determine the Synchronization and Intersection of Reforms**

The timing of launching various health reforms will play a large role in the success of reforms and the strength of the insurance market. Although the federal reform legislation will have deadlines for implementation, there are numerous factors of timing and synchronization that can ease the transition and avoid unintended consequences. It will be crucial for states to consider the structural and administrative outcomes of implementation, market impacts in existing and new insurance products, as well as their effects on existing state programs and private sector stakeholders.

Governors should consider timing and staging of reforms and their impacts on: the insurance marketplace, stakeholders, and state infrastructure and agencies. Gradual phase-in and transition periods will ensure adequate preparation and planning to redirect resources to address emerging needs. Unsynchronized implementation of reform components could result in a significantly weakened insurance market and major gaps in coverage for individuals. The order in which the reforms are implemented and how they are phased in will be a key factor to ensure that each reform has the support and functionality needed, and that reform efforts run in a complementary fashion.

### Market impacts and timing of insurance reforms

It is vital that states' small group and individual markets remain strong and viable as new regulations are put into effect, and as exchange mechanisms become operational. Dramatic shifts could create market instability or consumer concern. By planning reforms in a synchronized manner, states can ease market pressures and alleviate consumer disruption.

*Insurance Reforms.* It will be important for governors to ensure that the timing of new insurance market regulations is given appropriate consideration. Governors may want to strongly consider phasing in the reforms to maintain the integrity of the markets. For instance, if a state with little existing regulation in its individual insurance market were to implement all of their insurance reforms simultaneously, it could dramatically increase participation by unhealthy, previously uninsured individuals, thereby driving up premiums and resulting in insurance carriers pulling out of the market. However, if the regulations are phased in and slowly change the market, the risk pool is likely to be more diverse and keep the markets stabilized.

*Health Insurance Exchange.* As states set up insurance exchanges for those in the small group and individual markets, it will be crucial to plan its creation and launch in concert with the other reforms being implemented. For instance, it will be important to the integrity of the exchange that the insurance regulations are substantially in place before the exchange is functioning. It will also be important to plan the set-up of the exchange so that those who qualify for Medicaid or federal subsidies are notified of their eligibility and given appropriate instruction. It will be the exchange's responsibility to be able to provide this information and the subsequent instructions to ensure people are enrolled. In most states, no current government entity exists to handle all of these responsibilities, and it will be crucial for governors to consider the structure of the exchange and linkages to other programs.

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*Individual Mandate.* Requiring most residents to have health insurance is a critical piece in synchronizing among reforms. Because an individual mandate will bring more people into the market, particularly those who may be healthy and otherwise uninsured, it will be key to ensure that the market can handle all newcomers. The insurance reforms will need to be in place before the individual mandate takes effect, mainly to prevent people from being denied coverage when they are required to have it. In addition, people should have access to insurance through the exchange if they are not able to purchase it through their employer. The Medicaid expansion will also need to be in place to ensure those who are eligible receive Medicaid coverage. The system will also need to be in place to ensure those who are exempt from the individual mandate are identified and not penalized for not having insurance.

#### Intersection of Existing State Programs and New Functions

It will be vital that governors consider the intersection among aspects of the new law, as well as existing state programs and regulations. Several of the reforms are dependent on the implementation of others, and therefore their implementation will need significant planning. Governors will need to map out the reforms with state programs and other new initiatives to ensure a comprehensive view of the outcomes of implementing these changes.

*Medicaid Expansion.* The Medicaid expansion will take extensive planning to build on top of the existing Medicaid program. Governors will need to have their systems and personnel prepared and in place before the transition date. They should also consider in which Medicaid plans they are going to enroll newly eligible populations. In addition, states may want to consider expanding early to prevent a rush of enrollees. An important lesson learned from the federal government in implementing Medicare Part D was that a “turn-on” date for all beneficiaries at once was extremely problematic. States can use this experience to strategically plan and perform a “dry run” of their systems, phase in their expansion, or prepare local staff to assist in enrollment as the deadline approaches.

*Coordination within state agencies.* Because of the complexity and many components of the reforms, governors will need to assign designated roles to state agencies. They will also need to make certain that agencies are coordinating across state programs, and internally within each division to maximize the efficacy of programs and the use of state personnel and funding. Governors will need to involve state programs, such as:

- **Budget and Tax.** Income eligibility determinations for Medicaid and federal subsidies may involve the state’s budget and tax office. In addition, this state office may participate in income exemption determinations for the individual mandate.
- **Medicaid.** The state’s Medicaid agency will no doubt lead the Medicaid expansion. The agency may also play a role in income eligibility determinations with the exchange.
- **Insurance.** The department of insurance will likely have a large role in oversight and certification of plans in the exchange, as well as the regulation of rate bands.

- **Public Health.** Involvement by the health department will be important for the development of benefit designs, workforce issues, the interaction of reforms with community health centers, and delivery system reforms.
- **Health Information Technology.** Those overseeing health information technology initiatives should be closely involved in the development of the reform infrastructure, as well as coordinating with the state's electronic health record implementation.
- **State Employees/Retirees.** The state's office of personnel management may need to analyze the reforms to determine what requirements they have to meet as a large employer. They may also need to examine the actuarial value of state employee benefits to determine whether they would be considered a "high-cost plan," and therefore would place a fee on the insurance carrier who would pass the cost along to the state.

*Establishing Programs.* Action steps and timing for establishing a new program, such as an exchange, should be thoroughly analyzed and the impacts on existing programs and reforms efforts assessed. The placement of new programs or offices should also be examined, in addition to whether they are needed at all. If a similar program in the state exists or an office is responsible for the same health policies, it may not be necessary to set up a new program. Rather, the existing office's mission could be transformed to meet the needs of the new reforms while also maintaining its previous purpose.

However, some of the reforms may be significantly unique so that the only option for the state is to set up a new program or office. For instance, most states do not currently operate an exchange or have any similar programs. Thus, a new program or office will likely need to be created to meet the federal guidelines for running an exchange. However, existing responsibilities will still play a role in the new entity. Insurance commissioners, for examples, will likely play a significant part in certifying plans that can be offered through exchanges.

In addition, the timing and interaction of reforms, including when new state government offices become operational, will be a key element in successful implementation. It will be necessary for governors to task their state leaders with mapping out the infrastructure of the reforms, as well as the timing to ensure that the systems that need to work together and depend on each other for data, benefits information, and consistent messaging to the public are able to meet their goals.

There will be many instances of key timing and interaction factors that will have to be considered. One example is the interaction of the exchange, increased Medicaid enrollment and the individual mandate. Due to the Medicaid expansion, as well as the enforcement of an individual mandate, there will be an increase in Medicaid enrollment. Medicaid systems must be ready to handle the increase in beneficiaries. In addition, the exchange is likely to see a significant increase in usage when the individual mandate goes into effect, and the exchange will need to be fully equipped to handle the increased enrollment. It will also need to be ready to process those individuals who come to the exchange to buy health insurance, but are instead eligible for Medicaid. The timing and

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interplay of these various aspects of reform are crucial and will need to be thoroughly examined prior to implementation.

#### *Incorporating Existing Delivery System Reforms*

Governors can use their experiences from previously enacted state-based delivery reforms to incorporate new reforms into their existing system. Identification of initiative overlaps (e.g., states that already operate a medical homes system) will help states to further their efforts and to advise other states on best practices and lessons learned from these pilot programs.

An example of this is governors working with their public health departments to identify and implement prevention and wellness initiatives. States can also partner with insurance commissioners and attorneys general to revise their medical liability laws.

#### Impact on Relevant Stakeholders

While there are several changes that will occur within state government, it is also important for governors to understand and monitor the impact federal reforms will have on relevant stakeholders in their states. Through the creation of a public/private advisory commission discussed earlier, stakeholders will be able to provide feedback and strategies for approaching reform. States should also educate their stakeholders to ensure they have the knowledge they need to make informed decisions on reforms. As part of the initial strategic planning process, individual stakeholder impacts include:

- *State Legislators.* Because the reforms will require some dramatic changes, legislation will be required to implement the reforms on the state level. Governors will have to engage legislators to get their input on developing a plan for implementation. Political challenges may make legislative relations difficult. However, it is important for governors and legislators to realize that in order to meet federal deadlines in 2014, the state will have to pass legislation by 2012 at the latest to allow for timely implementation.
- *Employers.* It appears likely that the employer community will continue to play a large role in providing their employees with health insurance. There will be tax credits available for some small businesses that offer coverage. It will be important to track the levels of employer-sponsored insurance. For instance, benefit requirements may influence employers' offerings. Small and large businesses may have different perspectives on these reforms, and governors should engage with a broad range of employer representatives.
- *Insurance Companies.* With new insurance regulations and the establishment of an exchange as part of the larger reforms, it will be crucial to immediately engage with private insurance companies. The new insurance regulations in the small group and individual markets will have an enormous impact. Governors will need to engage with the private insurers to ensure that the transition is as smooth as possible and that the insurers do not decide to abandon the market, leaving few plan options. The establishment of an exchange will also create significant changes for the private

insurance markets, and states should communicate with the carriers to encourage a seamless transition. While these reforms will not be implemented immediately, the planning and legislation to create them will have to be determined in the near future.

- *Medical Providers.* An early impact on medical providers will involve interactions with their patients. Patients are likely to inquire with their providers about the changes and how it affects their treatment and insurance. It will be important for governors to engage with medical providers to enlist their assistance in helping patients understand how the federal reforms affect them and their insurance coverage. Involving providers in preparations and planning will be a key factor throughout implementation.
- *Community Groups.* The groups that will have the most interaction with individuals in explaining the reforms will be the community organizations – faith-based, grassroots, advocacy, and other groups where citizens generally get their information. Individuals may require help in understanding how the law affects them, and community groups will be important in providing this type of guidance. Thus, states should engage with these organizations to ensure they have the information and resources needed to be able to appropriately help individuals understand what the federal reforms mean to them. Outreach is going to be a crucial part of implementation, and the states should look to the community groups for their buy-in and support in educating the public.
- *Other stakeholders.* There are other important stakeholder groups that may be impacted by these reforms, including insurance brokers. In many states, insurance brokers play a major role in providing small businesses with their insurance options. Many of the federal reforms leave the role of the brokers undecided. It will be important for governors to have conversations with the brokers as a strategic plan for implementation is developed, especially in states where brokers play a large role in the small group market.

Other sectors may also be touched, such as the local health departments. It will be important for governors to reach out to these constituencies in the local areas to get a better sense of the issues that are likely to occur on the ground as people are seeking care.

### **Implications of Opting In or Opting Out of Programs**

States may have choices in deciding if and how they will participate in federal reforms. Governors need to weigh the consequences of opting in or opting out of certain programs to enable them to make decisions on what actions they will take.

There is an option in the legislation that allows for states to opt out of reforms while addressing the same issues through alternative state-based programs. They are permitted to use similar pathways to addressing the main issues in the bill without having to adhere to the federal guidelines. The benchmarks that states would have to meet and guidelines

they would have to follow are likely to be stringent. States are not permitted to exercise this option until after most of the reforms are to be implemented.

If governors decide not to implement federal reforms, the bill provides for the federal government to step in to implement those reforms in the state. At this time, it remains unclear as to how and when this default would take place. However, it will most likely involve preempting many state laws currently in existence. In addition, the state is likely to lose certain state authorities and responsibilities, which will be turned over to the federal government in administering reforms, or be splintered from existing authorities and oversight.

#### Health of Programs and Markets

When deciding whether to opt out of reforms, governors should review their current landscape and programs to determine what is best for their state. Important factors that could influence their decisions include (but are not limited to): budgetary, administrative and political impacts of opting in/out, population size, number of private insurers in the small group and individual markets, number of lives covered in the markets, existing state regulation of the marketplace, willingness of private insurers to work with the state, existing state programs, and past experiences with purchasing pools and regulations. All of these will influence a state's decision-making process and should help governors determine whether reforms are right for their state.

For example, states with fewer residents, fewer insurance options and a smaller risk pool may decide to default to a federally-run insurance exchange to be able to offer more options at a lower rate than if they set up their own exchange. If they make this choice, states will then be responsible for coordinating state programs with the federal exchange, which could prove to be arduous.

#### Financial Impacts

There will be funding available for states to assist with development and implementation efforts. States will need to consider whether the funding is sufficient to meet the needs of the state when implementing the reforms. In some states, it may take a significant effort to meet the standards of the federal reform requirements; and therefore will require increased spending for direct services and personnel to administer and operate certain programs, oversight, and other efforts. While it is assumed that states are going to have to pay a part of the federal reforms, governors will need to determine whether federal funding is sufficient and does not require state resources beyond what the state is willing and able to pay.

If a state decides to opt out of reforms, the governor should consider the financial penalties for doing so. The state should consider what penalties might be assessed as part of foregoing participation, including funding tied to already existing programs in the state. The governors will need to determine whether the penalties tied to non-participation, along with potential funding lost for existing programs, are significant enough to opt in or opt out of reforms.

### Coordination with Federal Government

If a governor is considering opting out of implementing federal reforms, it will be important to review the program coordination that would need to take place. The federal government and the state will have to coordinate existing programs run by the state with those the federal government is setting up. This may prove to be challenging for the state, as their existing programs may not be in a position to communicate with those the federal government is setting up and cannot be built on existing state systems. In addition, the federal government may have standards that the state will have to meet to ensure appropriate coordination between the programs and the systems on the federal level. Thus, governors will want to weigh the coordination issues and their impacts on the state when considering whether to opt out of federal reforms.

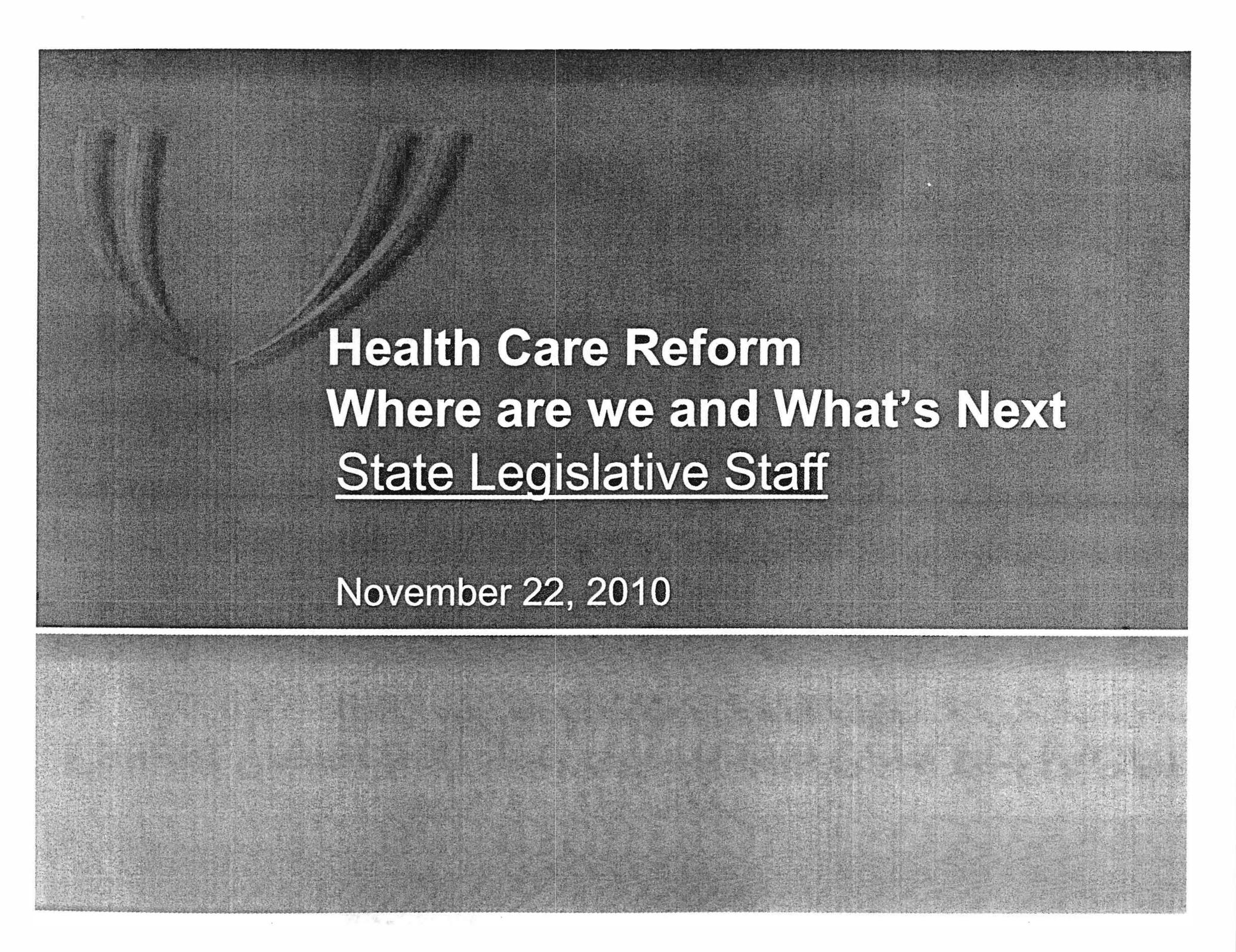
For instance, if a state decides not to set up an exchange and the federal government steps in to run an exchange for the state, the state will likely have to conform to the federal exchange's guidelines for Medicaid eligibility and low-income subsidy determinations, while the state is accustomed to using its existing eligibility determination system. This may pose some difficulties and extra processes for the state.

### **Conclusion**

Federal health reform will have a major effect on states' public insurance programs, the private insurance marketplace, and other health programs. It is vital that governors understand the reforms to be able to make the significant decisions that will be necessary in planning for implementation of national reforms.

Regardless of the level of a state's participation in these reforms, governors will need to begin planning for reform implementation shortly after the bill passes. Therefore, states' decisions as to whether to participate and the discussions that will need to take place with legislatures will be crucial to planning.

With state budgets already in dire shape and health care costs continuing to rise, governors need to make the decisions that are right for their states and will help improve the health of their states' residents while strengthening the health care system.

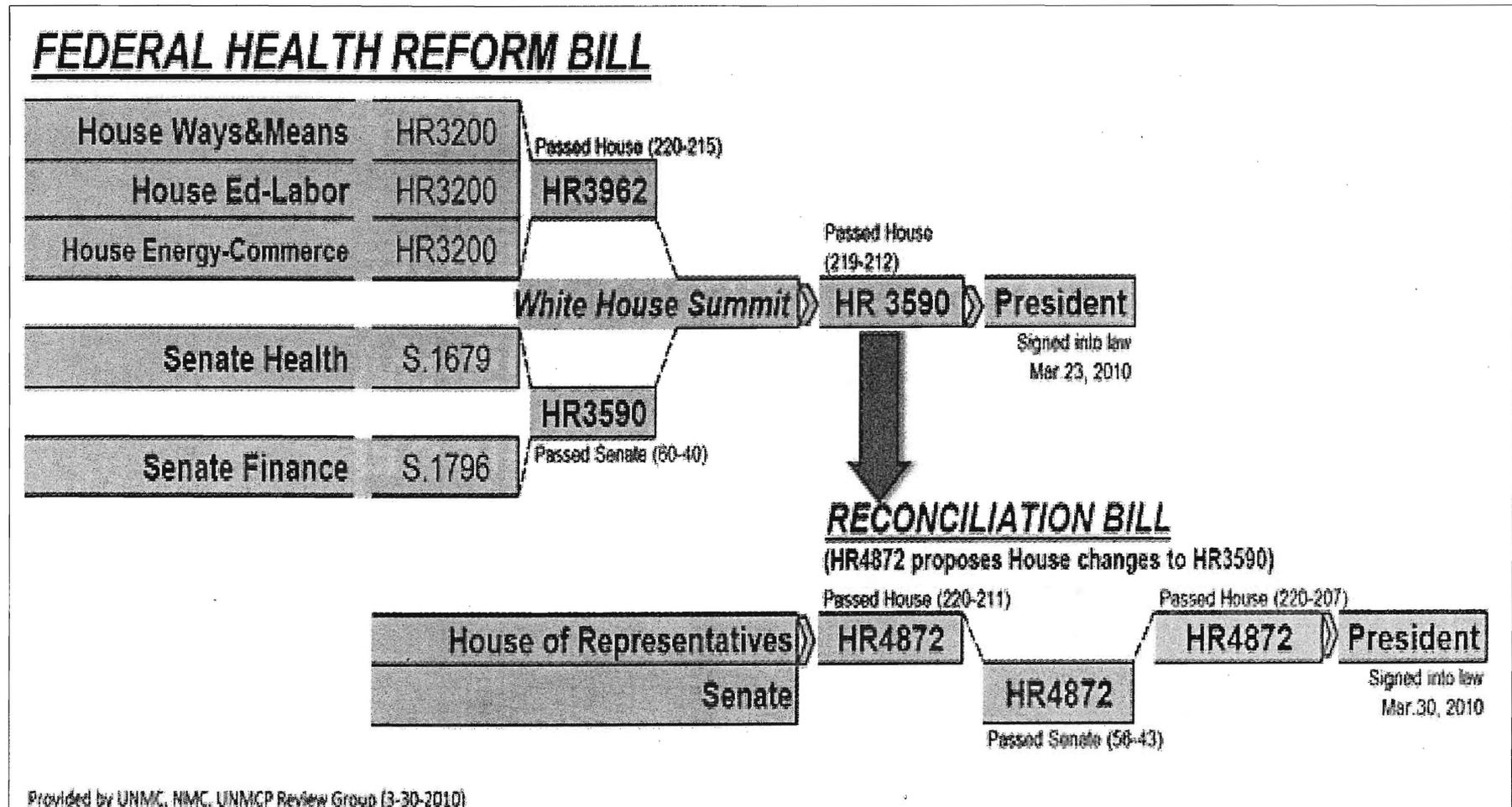


**Health Care Reform**  
**Where are we and What's Next**  
**State Legislative Staff**

November 22, 2010



# Patient Protection and Affordable Care Act (ACA) (How We Got to Where We Are)



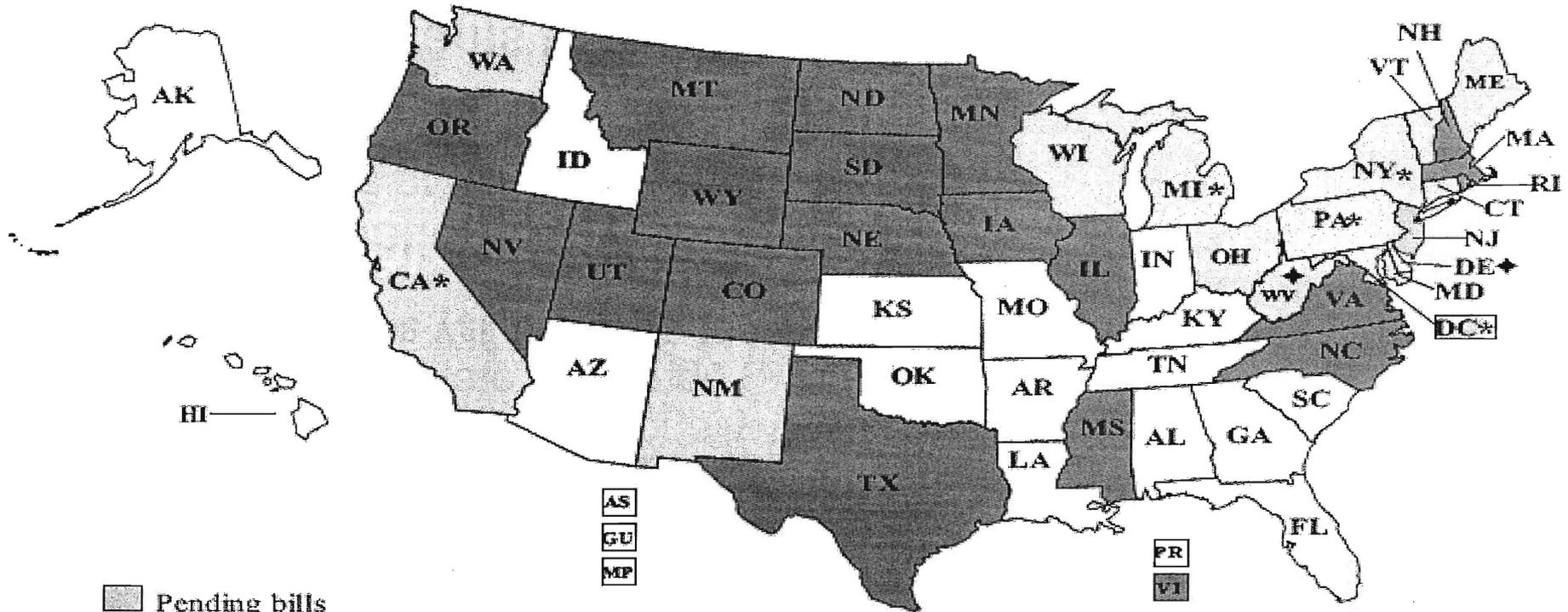


## The ACA Law: Highlights

- Health insurance for about 32 million additional citizens
  - About 15 million nationally to be added to Medicaid [est. @ 110,000 in Nebr]
  - About 15-16 million nationally to buy private insurance from an agent or through a state exchange (est @110,000-112,000 in Nebr)
  - Most citizens will continue to have employer-based private insurance
- New regulations governing insurance industry
  - Eliminate pre-existing conditions
  - Require coverage for preventive services
- Funds programs to test innovations in delivery of care, payment systems, malpractice reform, etc.
- Reforms beginning in 2010 include: Insurers can't rescind coverage; Dependents up to 26 can stay on parents plan; Children with pre-existing conditions covered; Tax credits for small businesses start; No lifetime limits on coverage.



# State Actions Implementing Health Reform



Updated 9/27/10

Source: NCSL, 2010

\* Introduced bills currently pending in the legislatures

◆ Legislative action/enacted law requires executive action by the state agency or governor



## Health Reform State Focus

- How will Legislature monitor ongoing changes?
- Workforce  
Distribution, Shortages & Incentives
- State Exchange  
Coverage & Operation
- State Medicaid  
Enrollment  
Participation in Demonstrations  
State Plan Amendments



## Health Care Reform: Workforce

- State could review of the state's student loan forgiveness and incentives programs for primary care providers to determine if they need updating in view of added federal incentives to train primary care providers.
- Consider state pilot programs that promote cost savings in delivery of care. State could consider offering relief from state regulations that do not affect quality controls.
- State could review the existing regulations governing physician assistants and nurse practitioners to determine if they should be updated to reduce costs of care, regulatory burden and improve access in underserved areas.



## Health Care Reform: State Exchanges

- By 2014 each state is to have an operating “Insurance Exchange” for uninsured individuals and small businesses (100 or less employees) to buy private insurance.
- Federal grants to states to fund plan an Exchange.
- States have great flexibility to design Exchange.  
If a state decides not to create an Exchange the federal government reserved the option to set up and operate an exchange in a state.
- Abortion - Each state decides if insurance plans will cover abortion. Federal law prohibits public subsidies from being used toward a premium that covers abortions. States can enact a state law to prohibit the offering of abortion insurance coverage through its Exchange.
- Exchanges to offer four levels of insurance coverage, plus two nationwide multi-state plans to ensure more competition.



## **Health Care Reform: State Medicaid**

- How will the Insurance Exchange Sign-up and Medicaid Sign-up interact?
- Consider whether it is advantageous for state to participate in Pediatric Accountable Care Organization Demonstration Program.
- Will the State seek state plan amendments or federal grants to participate in new healthy lifestyle programs?
- Will the state certify its projected budget shortfall to be exempt from the maintenance of effort requirements?
- The state will need to determine if it complies with the National Correct Coding Initiative.



## Useful Web Sites

### UNMC Health Care Reform

<http://www.unmc.edu/healthcarereform>

### Kaiser Family Foundation Summary

[http://www.kff.org/healthreform/upload/housesenatebill\\_final.pdf](http://www.kff.org/healthreform/upload/housesenatebill_final.pdf)

### Washington Post Calculator

<http://www.washingtonpost.com/wp-srv/special/politics/what-health-bill-means-for-you/>

### Fact Checking Web sites

[www.politifact.com](http://www.politifact.com)

[www.factcheck.org](http://www.factcheck.org)

November 17, 2010

Senator Tim Gay  
Legislative District #14  
State Capitol, P.O. Box 94604  
Lincoln, NE 68509-4604

Dear Senator Gay:

The Department of Health and Human Services hired an actuarial firm, Milliman, Inc. to provide an analysis of the impact of the federal Health Care Reform legislation on the Nebraska Medicaid program. The August 18, 2010 report included an estimate for a loss in pharmacy rebates. Since that time, the Centers for Medicare and Medicaid Services (CMS) changed its interpretation of the federal legislation relating to pharmacy rebates and issued revised guidance. The Department requested Milliman to review the changed guidance and assess its impact on the Nebraska Medicaid program.

Based on this change in interpretation by CMS, Milliman, Inc. has updated the estimated costs for Health Care Reform related to pharmacy rebates. The update eliminates the losses previously projected for pharmacy rebates. The fiscal impact of the Health Care Reform legislation to the Nebraska Medicaid program has been revised to \$458.2 Million for the Mid-Range Participation scenario and to \$691.5 Million for the Full Participation scenario. The revised report is enclosed for your convenience.

If you have any questions, please do not hesitate to contact me.

Sincerely,



Vivianne M. Chaumont, Director  
Division of Medicaid & Long-Term Care  
Department of Health and Human Services

Enclosure



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milliman.com

November 10, 2010

Ms. Vivianne Chaumont, Director  
Division of Medicaid & Long-Term Care  
Department of Health and Human Services  
State of Nebraska  
P.O. Box 95026  
Lincoln, NE 68509-5026

**RE: PATIENT PROTECTION AND AFFORDABLE CARE ACT WITH HOUSE  
RECONCILIATION – FINANCIAL ANALYSIS - UPDATE**

Dear Vivianne:

Milliman, Inc. (Milliman) has been retained by the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care (DHHS) to provide consulting services related to the financial review of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (Affordable Care Act) as they relate to the provisions impacting the State's Medicaid program and budget. This letter reflects an update to our analysis reflecting the instructions for the Federal offset of Medicaid prescription drug rebates, as outlined in the September 28, 2010 letter from Department of Health and Human Services October 2010 update to State Medicaid Directors.

**SUMMARY OF RESULTS**

Milliman has developed two estimates of the enrollment and fiscal impact associated with the Medicaid expansion and other related provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act. We have developed (1) a mid-range participation scenario and (2) a full participation scenario. We have prepared our fiscal analysis to reflect the state impact for state fiscal years 2011 through 2020. We have adjusted all data to reflect the three month offset between the federal fiscal year and the state fiscal year as appropriate.

Enclosures 1 and 2 provide the fiscal impact results of the Affordable Care Act under a mid-range participation scenario (Enclosure 1) and a full participation scenario (Enclosure 2). The total fiscal impact to the Nebraska Medicaid budget during the next 10 years would be estimated to be in the range of approximately \$458.2 million to \$691.5 million based upon the assumptions outlined in this document. Table 1 illustrates the anticipated expenditure impacts to the Nebraska Medicaid budget for the period of SFY 2011 through SFY 2020 under each scenario.

**Table 1**

**Nebraska Department of Health and Human Services**  
**Division of Medicaid and Long-Term Care**  
**4**  
**Patient Protection and Affordable Care Act**  
**as Amended by the Health Care and Education Reconciliation Act**  
  
**State Budget Fiscal Impact – SFY 2011 through SFY 2020**  
**(Values Illustrated in Millions)**

<b>Component</b>	<b>Estimated Fiscal Impact – State Only</b>	
	<b>Mid-Range Participation Scenario</b>	<b>Full Participation Scenario</b>
Adults and Parents Expansion to 138% FPL	\$179.3	\$250.6
Children – Enrollment due to ACA	285.8	366.7
Administration	82.4	106.8
Pharmacy Rebate Loss for Nebraska	0.0	0.0
Physician Fee Schedule Increase to Medicare Rates	0.0	56.8
Foster Children Coverage to Age 26	15.1	15.1
Medically Needy Expansion to 138% FPL	5.6	5.6
DSH Reduction	(18.8)	(18.8)
CHIP Enrollment Shift and FMAP Increase	(30.9)	(30.9)
State Disability Shift to Medicaid and Expansion to 138% FPL	(60.5)	(60.5)
<b>Total</b>	<b>\$458.2</b>	<b>\$691.5</b>

Note: Values have rounded

The results shown in Table 1 and the enclosures vary from our August 16, 2010 letter due to the impact of the pharmacy rebate loss being removed based on recent guidance from CMS. The Children population has also been shown separately from the Adult and Parent populations.

**Estimated Medicaid Enrollment Impact**

Table 2 illustrates the projected increase in Medicaid enrollment reflecting a 138% Federal Poverty Level (FPL) limit. The 138% FPL limit reflects the 133% FPL indicated in the Affordable Care Act with the 5% income disregard allowance. The values in Table 2 were derived from the 2009 Current Population Survey (2009 CPS) data from the U.S. Census Bureau collected in 2009 (representing 2008 insurance and income data) as well as Medicaid enrollment data provided by DHHS. Children were defined as ages 0 through 19. The Adult and Parent populations were defined as ages 20 through 64.

**Table 2**

**Nebraska Department of Health and Human Services**  
**Division of Medicaid and Long-Term Care**  
  
**Patient Protection and Affordable Care Act**  
**as Amended by the Health Care and Education Reconciliation Act**  
  
**State Budget Enrollment Impact – 2009 CPS Census Data**

<b>Population</b>	<b>FPL Range</b>	<b>Enrollment Full Participation Scenario</b>	<b>Mid-Range Participation Assumption</b>	<b>Enrollment Mid-Range Participation Scenario</b>
Uninsured Adults	0% - 138%	36,779	80%	29,423
Newly Eligible Parents	50% - 138%	20,510	85%	17,433
Woodwork Parents	< 50%	4,623	70%	3,236
Woodwork Children	<138%	23,119	80%	18,496
Insured Switchers – Adults	0% - 138%	23,916	50%	11,958
Insured Switchers – Parents	0% - 138%	21,429	75%	16,071
Insured Switchers – Children	0% - 138%	14,538	75%	10,903
State Disability <sup>(1)</sup>	0% - 138%	154	DHHS 133% FPL Assumption+ 5%	154
Medically Needy <sup>(2)</sup>	43% - 138%	229	DHHS 133% FPL Assumption +5%	229
Sub-total		145,297		107,903

Notes: (1) State Disability currently covered with state funds to 100% FPL. Enrollment reflects shift to Medicaid and FPL expansion estimated as of 2014.

(2) Enrollment reflects FPL expansion estimated as of 2014.

The mid-range participation rates in Table 2 were reviewed for consistency with participation in the Medicare program which exceeds 95% and the Medicaid/CHIP programs for children which exceeds 85%. Actual participation in the Medicaid program after the expansion may exceed the participation rates noted in these other programs, since there will be an individual mandate for health insurance coverage under federal health care reform legislation.

**Percentage increase in Medicaid in relation to the total number of Nebraskans**

- Calendar Year 2008 Nebraska Census Estimate 1,783,000
- Increase would be approximately 6.1% to 8.2% more Nebraska residents on Medicaid
- Increase from 11.6% to range of 17.7% - 19.8% - or nearly 1 in 5 Nebraskans

The remainder of this letter discusses each of the Medicaid components of health care reform as listed in Table 1.

**a. Adults/Parents/Children Expansion to 138% FPL**

The fiscal impact associated with the Adults, Parents, and Children expansion to 138% FPL includes both currently insured and uninsured individuals below the 138% FPL amount and children not currently covered under Medicaid, who are also below the 138% FPL limit. The 138% FPL limit reflects the 133% FPL indicated in the Affordable Care Act with the 5% income disregard allowance. The analysis presented in this report reflects full participation (full participation scenario) as well as an alternate participation assumption (mid-range participation scenario). The participation assumptions by population are presented in Table 2. The assumed average annual cost per enrollee by population as of State fiscal year 2009 is provided in Table 3.

**Table 3**

**Nebraska Department of Health and Human Services  
 Division of Medicaid and Long-Term Care**

**Patient Protection and Affordable Care Act  
 as Amended by the Health Care and Education Reconciliation Act**

**Average Cost per Enrollee as of SFY 2009**

<b>Population</b>	<b>Average Annual Cost</b>
Uninsured Adults	\$5,467
Newly Eligible Parents	\$4,881
Woodwork Parents	\$4,881
Woodwork Children	\$2,654
Insured Switchers – Adults	\$5,900
Insured Switchers – Parents	\$5,268
Insured Switchers – Children	\$2,950
State Disability <sup>(1)</sup>	\$78,107
Medically Needy – Disabled <sup>(1)</sup>	\$85,390
Medically Needy – Long-Term <sup>(1)</sup>	\$109,932

Notes: (1) State Disability and Medically Needy costs provided by DHHS for FFY 2014.

The cost estimates for the State Disability and Medically Needy populations were obtained from the health care reform projection provided by DHHS. All other annual cost estimates were developed from SFY 2009 enrollment and expenditures provided in the *Nebraska Medicaid Reform Annual Report* dated December 1, 2009 with appropriate adjustments. The values in Table 3 reflect the age/gender mix of each population based upon the 2009 CPS census data. For example, the insured switcher adult population does not have the same age distribution as the uninsured adult population which impacts expected average cost. Milliman additionally used internally available data from other Medicaid expansion analyses to develop the cost relationship between adults and parents. Milliman assumed a composite annual trend of 3.0% to project the claim cost for the expansion population into future years. The 3.0% trend reflects the impact of enrollment growth as well as projected trend for utilization and intensity of services.

The Affordable Care Act reflects the following Federal Medical Assistance Percentages (FMAP) for the expansion populations.

- 100% FMAP in CY 2014, 2015, and 2016
- 95% FMAP in CY 2017
- 94% FMAP in CY 2018
- 93% FMAP in CY 2019
- 90% FMAP in CY 2020+

Milliman assumed that the projected FFY 2012 FMAP rate of 57.64% for Medicaid and 70.35% for CHIP would continue through 2020 for non-expansion populations.

**b. Administration**

In addition to the expenditures associated with providing medical services, Nebraska will incur additional administrative expenditures. The expenditures for the initial modifications to the current administrative systems, as well as establishment of an Exchange, are estimated to be \$25 million (State and Federal) or \$12.5 million (State only). On-going costs for the coverage of the additional 108,000 to 145,000 Medicaid enrollees are estimated to be \$21.5 to \$29.0 million per year (State and Federal) or \$10.8 to \$14.5 million per year (State only). The on-going costs were developed assuming approximately \$200 per recipient per year or approximately 3.75% of total expected medical expenditures. Based on my experience with Medicaid programs, the state Medicaid administrative costs range from 3.5% to 6.0% of the total medical costs. The administrative expenses would be anticipated to be incurred in calendar years 2012 and 2013 for the initial administrative expenditures and in calendar year 2014 forward for the on-going expenditures.

**c. Pharmacy Rebate Loss for Nebraska**

The Affordable Care Act includes increased rebate percentages for covered outpatient drugs provided to Medicaid patients. The minimum rebate percentage is increased from 15.1% to 23.1% for most brand name drugs and from 11% to 13% for generic drugs effective January 1, 2010. However, the Affordable Care Act indicates that the impact will be accrued 100% to the Federal government. Based on instructions regarding the Pharmacy Rebate offset from Department of Health and Human Services to the state Medicaid Directors dated September 28, 2010, we have estimated that no impact will occur to the rebates currently accruing to the state budget.

The following provides additional details regarding the history of the anticipated pharmacy rebate losses and the resulting modification by CMS.

- In a September 28, 2010 letter, CMS modified the instructions originally outlined in an April 22, 2010 letter on how the increased pharmacy rebate will be captured from the total Medicaid rebates.
- April 22, 2010 State Medicaid Director Letter from Department of Health and Human Services RE: Medicaid Prescription Drug Rebates
  - Page 3, Changes in Non-Federal Share of Rebates: *“For brand name drugs subject to the 23.1 percent minimum rebates, we plan to offset an amount equal to the non-Federal*

*share of 8 percent of AMP (the difference between 23.1 percent of AMP and 15.1 percent of AMP), regardless of whether States received a rebate amount based on the difference between AMP and best price.”*

- **Initial Estimated Financial Impact August 16, 2010 Letter:** Since the State of Nebraska receives a significant portion of pharmacy rebates on brand name drugs at the difference between AMP and best price, the State of Nebraska would have lost 8 percent of AMP. The overall estimated impact ranged from 20.7% to 22.6% of pharmacy rebates received.
- May 18, 2010 letter from State Medicaid Directors to Ms. Cynthia Mann, Director, Center for Medicaid, CHIP and Survey & Certification
  - Letter outlined the Medicaid Directors’ concern regarding the treatment of the recapture of the non-Federal Share of Rebates
  - Page 2, *“The application of this provision to a rebate that is unaffected by the increase in the minimum rebate violates both the letter and the apparent intent thereof. By its terms, this provision applies only to ‘amounts received by the State ... that are attributable ... to the increase in the minimum rebate percentage.’ ”*
- CMS worked with State Medicaid Directors and other organizations, including the American Academy of Actuaries Medicaid Committee, to understand their concerns.
- September 28, 2010 State Medicaid Director Letter RE: Medicaid Prescription Drugs
  - Page 1 – 2, Revised Policy on Federal Offset of Rebates: *“ ... However, after further consideration of the offset provisions in section 2501 of the Affordable Care Act, we have decided to reconsider our instructions regarding the calculation of the offset provisions to reflect the lesser of the difference between the increased minimum rebate percentage and the AMP (Average Manufacturers Price) minus BP (Best Price). We plan to offset the amount equal to the increased amount of rebates resulting from the Affordable Care Act. ’ ”*
  - **Updated Financial Impact:** Since the federal offset will only be on the increased rebate value for brand name drugs, there will not be an expected loss of pharmacy rebates to the State of Nebraska.

#### **d. Physician Fee Schedule Increase to Medicare Rates**

According to an April 2009 report by the Urban Institute’s Health Policy Center, the current Nebraska Medicaid fee schedule reimburses at approximately 82% of the Medicare fee schedule for primary care services. The Affordable Care Act requires an increase in the Medicaid physician fee schedule for a limited set of primary and preventive care services to 100% of the Medicare physician fee schedule. 100% Federal funding is available for calendar years 2013 and 2014. No additional funding is available for other physician services.

##### *Full Participation Scenario –*

The full participation scenario assumes that DHHS will increase the fee schedule for the required services for both primary care and specialty care providers and will continue the increased fee schedule after calendar year 2014 to assure continued access to physician care. In addition to increasing the expected cost of corresponding existing expenditures by approximately 22%, the analysis reflects an additional \$120 per year for the dual eligible population since Medicare only pays 80% of the fee schedule for Part B services.

Under the full participation scenario, the increased cost would be an estimated \$27 million (State and Federal) per year for the current Medicaid program and expansion populations. During calendar years 2013 and 2014, the state would have to pay the standard state portion of the increase for specialty providers for the existing Medicaid population. Therefore, the state share in these two calendar years would be approximately \$2.8 million (State only) per year. In 2015, the State only cost for the fee schedule expansion would grow to an estimated \$9 million (State only).

*Mid-Range Participation Scenario –*

The mid-range participation scenario assumes that DHHS will only increase the fee schedule for primary care providers, not specialty care providers. The mid-range participation scenario further assumes that the fee schedule increase will only continue through calendar year 2014 and will terminate when the Federal funding level decreases. The annual cost would be approximately \$18 million and reflects 100% Federal funding for the calendar year 2013 and 2014 period.

**e. Foster Children Coverage to Age 26**

It is Milliman's understanding that Nebraska currently provides Medicaid eligibility coverage to Foster Children to age 19. The Affordable Care Act includes mandatory coverage for Foster Children to age 26 beginning on January 1, 2014. Milliman has estimated the annual cost at \$5.5 million per year (State and Federal) or approximately \$2.3 million per year (State only).

**f. Medically Needy Expansion to 138% FPL**

The Medically Needy population is currently covered to 43% FPL. The population is limited to non-Dual eligibles under age 65. Effective January 1, 2014, the population will be covered to 138% FPL including the 5% income disregard allowance. Milliman has utilized the DHHS expenditure estimate for the Medically Needy population for fiscal year 2014 assuming expansion to 133% FPL under the Medicaid enhanced FMAP rate. Our projection adjusts the DHHS estimate by a factor of 1.05 to reflect expansion to the 138% FPL level. We have additionally adjusted the estimate provided by DHHS from a Federal fiscal year basis to a State fiscal year basis. Although these individuals would theoretically be included in the 2009 CPS data, the cost intensity needs to be additionally reflected.

**g. DSH Reduction**

Based upon the aggregate Disproportionate Share Hospital (DSH) payment reductions indicated in the Affordable Care Act, Milliman developed average Federal fiscal year DSH reduction percentages. Milliman adjusted the Federal fiscal year percentages to a State fiscal year basis. The baseline DSH expenditures of \$44.0 million provided by DHHS were ultimately reduced to two-thirds of the National reduction percentage. The reduction was reduced to two-thirds of the National percentage to reflect that Nebraska is a low DSH state.

Federal Fiscal Year	DSH Percentage Reduction	
	National Percentage	Nebraska Percentage
2014	4.4%	2.9%
2015	5.3%	3.5%
2016	5.3%	3.5%
2017	15.9%	10.6%
2018	44.1%	29.4%
2019	49.4%	32.9%
2020	35.3%	23.5%

Note: Nebraska percentage reduction was estimated at 2/3 of National percentage reduction since Nebraska is a low DSH state.

**h. CHIP Enrollment Shift and FMAP Increase**

Under the Affordable Care Act, the CHIP program is required to continue to 2019. However, the legislation provides an additional Federal matching rate of 23% beginning on October 1, 2015 and ending September 30, 2019. The additional 23% FMAP will increase the total FMAP for the CHIP program to approximately 93.35%. The enhanced FMAP will decrease expenditures for Nebraska and increase expenditures for the Federal share.

The projection additionally reflects that approximately 30% of current CHIP program enrollees will shift to Medicaid eligibility effective January 1, 2014. The 30% reflects CHIP enrollees <138% FPL.

**i. State Disability Shift to Medicaid and Expansion to 138% FPL**

Nebraska currently covers the State Disability population to 100% FPL with 100% state funds. Milliman has utilized the DHHS expenditure estimate for the State Disability population for Federal fiscal year 2014 assuming expansion to 133% FPL under the Medicaid enhanced FMAP rate. Our projection adjusts the DHHS estimate by a factor of 1.05 to reflect expansion to the 138% FPL level. We have additionally adjusted the estimate provided by DHHS from a Federal fiscal year basis to a State fiscal year basis. Although these individuals would theoretically be included in the 2009 CPS data, the cost intensity needs to be additionally reflected.

**OTHER CHANGES TO CURRENT PROGRAMS**

Milliman anticipates potential savings from the following populations even if the programs are not discontinued. However, savings estimates have not been included in the total impact projection for either the full participation scenario or mid-range participation scenario.

***Pregnant Women above 138% FPL***

The State of Nebraska currently provides eligibility for pregnant women up to 185% FPL. It would be anticipated that the majority of pregnant women between 138% FPL and 185% FPL will receive care through the insurance exchange. We have estimated that approximately 10% of the current expenditures for the pregnant women population will no longer be incurred by the Nebraska Medicaid program. We have estimated the annual savings to be approximately \$3.4 million (State and Federal) per year or \$1.4 million (State only) per year beginning on January 1, 2014.

***Breast and Cervical Cancer Program***

The State of Nebraska currently provides eligibility under the Breast and Cervical Cancer program. The total annual expenditures under the program are approximately \$5.0 million (State and Federal) or \$1.5 million (State only). It is not anticipated that this program will be required to be continued with the expansion requirements below 138% FPL and insurance reforms for individuals above 138% FPL. Therefore, we have estimated that this program could be terminated beginning on January 1, 2014; although, some of these individuals will become eligible under the new Medicaid eligibility requirements.

**LIMITATIONS**

The information contained in this correspondence, including any enclosures, has been prepared for the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care and their advisors. These results may not be distributed to any other party without the prior consent of Milliman. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling that will allow appropriate use of the data presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for DHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by DHHS as well as enrollment and expenditure data obtained from the Medicaid Statistical Information System (MSIS) State Summary Datamart and the *Nebraska Medicaid Reform Annual Report* dated December 1, 2009 as retrieved from the DHHS website. The values presented in this correspondence are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented will need to be reviewed for consistency and revised to meet any revised data. The data and information included in the report has been developed to assist in the analysis of the financial impact of Nebraska Medicaid Assistance expenditures. The data and information presented may not be appropriate for any other purpose. It should be emphasized that the results presented in this correspondence are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this letter.



Ms. Vivianne Chaumont  
November 10, 2010  
Page 10



If you have any questions or comments regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

A handwritten signature in cursive script that reads "Robert M. Damler".

Robert M. Damler, FSA, MAAA  
Principal and Consulting Actuary

RMD/lrb  
Enclosures



**ENCLOSURE 1**

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Division of Medicaid and Long-Term Care  
 Health Care Reform Projection - Mid-Range Impact Scenario  
 (Values in Millions)

11/10/2010  
9:38 AM

EXPENDITURES	<u>SFY 2011</u>	<u>SFY 2012</u>	<u>SFY 2013</u>	<u>SFY 2014</u>	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	<u>SFY 2011 - SFY 2020</u>
<b>Current Programs</b>											
<b>Medicaid</b>											
Total (State and Federal)	\$1,745.1	\$1,792.5	\$1,841.2	\$1,891.3	\$1,942.7	\$1,995.5	\$2,049.7	\$2,105.4	\$2,162.6	\$2,221.4	\$19,747.6
Federal Funds	\$1,029.1	\$1,036.8	\$1,061.3	\$1,090.1	\$1,119.8	\$1,150.2	\$1,181.5	\$1,213.6	\$1,246.5	\$1,280.4	\$11,409.3
State Funds	\$716.0	\$755.7	\$780.0	\$801.2	\$822.9	\$845.3	\$868.3	\$891.9	\$916.1	\$941.0	\$8,338.3
<b>CHIP</b>											
Total (State and Federal)	\$63.2	\$65.1	\$67.0	\$69.0	\$71.1	\$73.3	\$75.4	\$77.7	\$80.0	\$82.4	\$724.4
Federal Funds	\$45.0	\$45.9	\$47.2	\$48.6	\$50.0	\$51.5	\$53.1	\$54.7	\$56.3	\$58.0	\$510.3
State Funds	\$18.1	\$19.2	\$19.9	\$20.5	\$21.1	\$21.7	\$22.4	\$23.0	\$23.7	\$24.4	\$214.1
<b>State Disability</b>											
Total (State and Federal)	\$8.1	\$8.4	\$8.6	\$8.9	\$9.2	\$9.4	\$9.7	\$10.0	\$10.3	\$10.6	\$93.3
Federal Funds	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
State Funds	\$8.1	\$8.4	\$8.6	\$8.9	\$9.2	\$9.4	\$9.7	\$10.0	\$10.3	\$10.6	\$93.3
<b>All Programs</b>											
Total (State and Federal)	\$1,816.4	\$1,866.0	\$1,916.9	\$1,969.2	\$2,023.0	\$2,078.2	\$2,134.9	\$2,193.2	\$2,253.0	\$2,314.4	\$20,565.3
Federal Funds	\$1,074.1	\$1,082.7	\$1,108.5	\$1,138.7	\$1,169.8	\$1,201.7	\$1,234.6	\$1,268.2	\$1,302.9	\$1,338.4	\$11,919.6
State Funds	\$742.3	\$783.3	\$808.5	\$830.5	\$853.2	\$876.5	\$900.4	\$924.9	\$950.1	\$976.0	\$8,645.7

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Division of Medicaid and Long-Term Care  
 Health Care Reform Projection - Mid-Range Impact Scenario  
 (Values in Millions)

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**EXPENDITURES**

	<u>SFY 2011</u>	<u>SFY 2012</u>	<u>SFY 2013</u>	<u>SFY 2014</u>	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	<u>SFY 2011 - SFY 2020</u>
<b>Health Care Reform</b>											
<b>Adults and Parents - Expansion to 138% FPL</b>											
Total (State and Federal) - Newly Eligible				\$142.6	\$293.7	\$302.5	\$311.6	\$320.9	\$330.5	\$340.5	\$2,042.2
Total (State and Federal) - Woodwork				\$9.2	\$18.9	\$19.4	\$20.0	\$20.6	\$21.2	\$21.9	\$131.2
Total (State and Federal) - Insured Switchers				\$90.0	\$185.3	\$190.9	\$196.6	\$202.5	\$208.6	\$214.9	\$1,288.9
Federal Funds				\$237.8	\$489.9	\$504.6	\$507.0	\$506.5	\$516.3	\$520.7	\$3,282.9
State Funds				\$3.9	\$8.0	\$8.2	\$21.2	\$37.5	\$44.0	\$56.5	\$179.3
<b>Children - Impact due to ACA</b>											
Total (State and Federal) - Newly Eligible				\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total (State and Federal) - Woodwork				\$28.5	\$58.6	\$60.4	\$62.2	\$64.0	\$66.0	\$67.9	\$407.6
Total (State and Federal) - Insured Switchers				\$18.6	\$38.4	\$39.6	\$40.8	\$42.0	\$43.2	\$44.5	\$267.1
Federal Funds				\$27.1	\$55.9	\$57.6	\$59.3	\$61.1	\$62.9	\$64.8	\$388.9
State Funds				\$20.0	\$41.1	\$42.3	\$43.6	\$44.9	\$46.3	\$47.6	\$285.8
<b>Administrative Expenses</b>											
Total (State and Federal)		\$6.3	\$12.5	\$17.0	\$21.5	\$21.5	\$21.5	\$21.5	\$21.5	\$21.5	\$164.8
Federal Funds		\$3.1	\$6.3	\$8.5	\$10.8	\$10.8	\$10.8	\$10.8	\$10.8	\$10.8	\$82.4
State Funds		\$3.1	\$6.3	\$8.5	\$10.8	\$10.8	\$10.8	\$10.8	\$10.8	\$10.8	\$82.4
<b>Pharmacy Rebate Loss for Nebraska</b>											
Total (State and Federal)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Federal Funds	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
State Funds	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
<b>Physician Fee Schedule Increase to Medicare Rates</b>											
Total (State and Federal)			\$7.2	\$18.3	\$9.4	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$34.9
Federal Funds			\$7.2	\$18.3	\$9.4	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$34.9
State Funds			\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
<b>Foster Children Coverage to Age 26</b>											
Total (State and Federal)				\$2.8	\$5.5	\$5.5	\$5.5	\$5.5	\$5.5	\$5.5	\$35.8
Federal Funds				\$1.6	\$3.2	\$3.2	\$3.2	\$3.2	\$3.2	\$3.2	\$20.6
State Funds				\$1.2	\$2.3	\$2.3	\$2.3	\$2.3	\$2.3	\$2.3	\$15.1
<b>Medically Needy Expansion to 138% FPL</b>											
Total (State and Federal)				\$10.6	\$21.8	\$22.5	\$23.2	\$23.9	\$24.6	\$25.3	\$151.9
Federal Funds				\$10.6	\$21.8	\$22.5	\$22.6	\$22.6	\$23.0	\$23.2	\$146.2
State Funds				\$0.0	\$0.0	\$0.0	\$0.6	\$1.3	\$1.6	\$2.2	\$5.6

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Division of Medicaid and Long-Term Care  
 Health Care Reform Projection - Mid-Range Impact Scenario  
 (Values in Millions)

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EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
<b>DSH Reductions</b>											
Total (State and Federal)				(\$1.0)	(\$1.5)	(\$1.6)	(\$3.9)	(\$10.9)	(\$14.1)	(\$11.4)	(\$44.3)
Federal Funds				(\$0.6)	(\$0.9)	(\$0.9)	(\$2.2)	(\$6.3)	(\$8.1)	(\$6.6)	(\$25.5)
State Funds				(\$0.4)	(\$0.6)	(\$0.7)	(\$1.7)	(\$4.6)	(\$6.0)	(\$4.8)	(\$18.8)
<b>CHIP Enrollment Shift and FMAP Increase</b>											
Total (State and Federal)				\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Federal Funds				(\$1.3)	(\$2.7)	\$6.1	\$9.3	\$9.5	\$9.8	\$0.2	\$30.9
State Funds				\$1.3	\$2.7	(\$6.1)	(\$9.3)	(\$9.5)	(\$9.8)	(\$0.2)	(\$30.9)
<b>State Disability Shift to Medicaid and Expansion to 138% FPL</b>											
Total (State and Federal)				\$1.6	\$3.4	\$3.5	\$3.6	\$3.7	\$3.8	\$3.9	\$23.6
Federal Funds				\$6.1	\$12.6	\$12.9	\$13.0	\$13.0	\$13.2	\$13.3	\$84.0
State Funds				(\$4.4)	(\$9.2)	(\$9.4)	(\$9.4)	(\$9.3)	(\$9.4)	(\$9.4)	(\$60.5)
<b>All Programs - After Expansion</b>											
Total (State and Federal)	\$1,816.4	\$1,872.2	\$1,936.6	\$2,307.3	\$2,678.0	\$2,742.4	\$2,815.9	\$2,886.9	\$2,963.9	\$3,049.0	\$25,068.7
Federal Funds	\$1,074.1	\$1,085.8	\$1,121.9	\$1,446.9	\$1,769.7	\$1,818.4	\$1,857.4	\$1,888.6	\$1,934.0	\$1,968.0	\$15,964.8
State Funds	\$742.3	\$786.4	\$814.7	\$860.5	\$908.3	\$923.9	\$958.5	\$998.3	\$1,029.9	\$1,081.0	\$9,103.9
<b>All Programs - Fiscal Impact</b>											
Total (State and Federal)	\$0.0	\$6.3	\$19.7	\$338.1	\$655.0	\$664.2	\$681.0	\$693.8	\$710.9	\$734.5	\$4,503.4
Federal Funds	\$0.0	\$3.1	\$13.5	\$308.1	\$599.9	\$616.7	\$622.9	\$620.3	\$631.1	\$629.6	\$4,045.2
State Funds	\$0.0	\$3.1	\$6.3	\$30.0	\$55.1	\$47.5	\$58.1	\$73.4	\$79.8	\$105.0	\$458.2
<b>Pregnant Women (133% - 185%)</b>											
Total (State and Federal)				(\$1.6)	(\$3.3)	(\$3.4)	(\$3.5)	(\$3.6)	(\$3.7)	(\$3.8)	(\$22.8)
Federal Funds				(\$0.9)	(\$1.9)	(\$2.0)	(\$2.0)	(\$2.1)	(\$2.1)	(\$2.2)	(\$13.2)
State Funds				(\$0.7)	(\$1.4)	(\$1.4)	(\$1.5)	(\$1.5)	(\$1.6)	(\$1.6)	(\$9.7)
<b>Breast &amp; Cervical Cancer</b>											
Total (State and Federal)				(\$2.4)	(\$5.0)	(\$5.2)	(\$5.3)	(\$5.5)	(\$5.6)	(\$5.8)	(\$34.8)
Federal Funds				(\$1.7)	(\$3.5)	(\$3.6)	(\$3.7)	(\$3.8)	(\$3.9)	(\$4.0)	(\$24.4)
State Funds				(\$0.7)	(\$1.5)	(\$1.5)	(\$1.6)	(\$1.6)	(\$1.7)	(\$1.7)	(\$10.3)



**ENCLOSURE 2**

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Division of Medicaid and Long-Term Care  
 Health Care Reform Projection - Maximum Impact Scenario  
 (Values in Millions)

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EXPENDITURES	<u>SFY 2011</u>	<u>SFY 2012</u>	<u>SFY 2013</u>	<u>SFY 2014</u>	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	<u>SFY 2011 - SFY 2020</u>
<b>Current Programs</b>											
<b>Medicaid</b>											
Total (State and Federal)	\$1,745.1	\$1,792.5	\$1,841.2	\$1,891.3	\$1,942.7	\$1,995.5	\$2,049.7	\$2,105.4	\$2,162.6	\$2,221.4	\$19,747.6
Federal Funds	\$1,029.1	\$1,036.8	\$1,061.3	\$1,090.1	\$1,119.8	\$1,150.2	\$1,181.5	\$1,213.6	\$1,246.5	\$1,280.4	\$11,409.3
State Funds	\$716.0	\$755.7	\$780.0	\$801.2	\$822.9	\$845.3	\$868.3	\$891.9	\$916.1	\$941.0	\$8,338.3
<b>CHIP</b>											
Total (State and Federal)	\$63.2	\$65.1	\$67.0	\$69.0	\$71.1	\$73.3	\$75.4	\$77.7	\$80.0	\$82.4	\$724.4
Federal Funds	\$45.0	\$45.9	\$47.2	\$48.6	\$50.0	\$51.5	\$53.1	\$54.7	\$56.3	\$58.0	\$510.3
State Funds	\$18.1	\$19.2	\$19.9	\$20.5	\$21.1	\$21.7	\$22.4	\$23.0	\$23.7	\$24.4	\$214.1
<b>State Disability</b>											
Total (State and Federal)	\$8.1	\$8.4	\$8.6	\$8.9	\$9.2	\$9.4	\$9.7	\$10.0	\$10.3	\$10.6	\$93.3
Federal Funds	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
State Funds	\$8.1	\$8.4	\$8.6	\$8.9	\$9.2	\$9.4	\$9.7	\$10.0	\$10.3	\$10.6	\$93.3
<b>All Programs</b>											
Total (State and Federal)	\$1,816.4	\$1,866.0	\$1,916.9	\$1,969.2	\$2,023.0	\$2,078.2	\$2,134.9	\$2,193.2	\$2,253.0	\$2,314.4	\$20,565.3
Federal Funds	\$1,074.1	\$1,082.7	\$1,108.5	\$1,138.7	\$1,169.8	\$1,201.7	\$1,234.6	\$1,268.2	\$1,302.9	\$1,338.4	\$11,919.6
State Funds	\$742.3	\$783.3	\$808.5	\$830.5	\$853.2	\$876.5	\$900.4	\$924.9	\$950.1	\$976.0	\$8,645.7

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Division of Medicaid and Long-Term Care  
 Health Care Reform Projection - Maximum Impact Scenario  
 (Values in Millions)

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EXPENDITURES	<u>SFY 2011</u>	<u>SFY 2012</u>	<u>SFY 2013</u>	<u>SFY 2014</u>	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	<u>SFY 2011 - SFY 2020</u>
<b>Health Care Reform</b>											
<b>Adults and Parents - Expansion to 138% FPL</b>											
Total (State and Federal) - Newly Eligible				\$174.6	\$359.6	\$370.4	\$381.5	\$393.0	\$404.8	\$416.9	\$2,500.8
Total (State and Federal) - Woodwork				\$13.1	\$26.9	\$27.8	\$28.6	\$29.4	\$30.3	\$31.2	\$187.4
Total (State and Federal) - Insured Switchers				\$147.2	\$303.3	\$312.4	\$321.8	\$331.4	\$341.4	\$351.6	\$2,109.1
Federal Funds				\$329.3	\$678.5	\$698.8	\$702.2	\$701.5	\$715.1	\$721.2	\$4,546.6
State Funds				\$5.5	\$11.4	\$11.8	\$29.7	\$52.3	\$61.3	\$78.6	\$250.6
<b>Children - Impact due to ACA</b>											
Total (State and Federal) - Newly Eligible				\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total (State and Federal) - Woodwork				\$35.6	\$73.3	\$75.5	\$77.7	\$80.1	\$82.5	\$84.9	\$509.5
Total (State and Federal) - Insured Switchers				\$24.9	\$51.2	\$52.8	\$54.3	\$56.0	\$57.6	\$59.4	\$356.1
Federal Funds				\$34.8	\$71.7	\$73.9	\$76.1	\$78.4	\$80.8	\$83.2	\$498.9
State Funds				\$25.6	\$52.7	\$54.3	\$55.9	\$57.6	\$59.3	\$61.1	\$366.7
<b>Administrative Expenses</b>											
Total (State and Federal)		\$6.3	\$12.5	\$20.8	\$29.0	\$29.0	\$29.0	\$29.0	\$29.0	\$29.0	\$213.5
Federal Funds		\$3.1	\$6.3	\$10.4	\$14.5	\$14.5	\$14.5	\$14.5	\$14.5	\$14.5	\$106.8
State Funds		\$3.1	\$6.3	\$10.4	\$14.5	\$14.5	\$14.5	\$14.5	\$14.5	\$14.5	\$106.8
<b>Pharmacy Rebate Loss for Nebraska</b>											
Total (State and Federal)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Federal Funds	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
State Funds	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
<b>Physician Fee Schedule Increase to Medicare Rates</b>											
Total (State and Federal)			\$10.1	\$27.3	\$28.1	\$28.9	\$29.7	\$30.5	\$31.3	\$32.2	\$218.0
Federal Funds			\$8.9	\$24.5	\$22.7	\$20.3	\$20.6	\$20.9	\$21.4	\$21.8	\$161.3
State Funds			\$1.2	\$2.8	\$5.4	\$8.6	\$9.0	\$9.5	\$9.9	\$10.4	\$56.8
<b>Foster Children Coverage to Age 26</b>											
Total (State and Federal)				\$2.8	\$5.5	\$5.5	\$5.5	\$5.5	\$5.5	\$5.5	\$35.8
Federal Funds				\$1.6	\$3.2	\$3.2	\$3.2	\$3.2	\$3.2	\$3.2	\$20.6
State Funds				\$1.2	\$2.3	\$2.3	\$2.3	\$2.3	\$2.3	\$2.3	\$15.1
<b>Medically Needy Expansion to 138% FPL</b>											
Total (State and Federal)				\$10.6	\$21.8	\$22.5	\$23.2	\$23.9	\$24.6	\$25.3	\$151.9
Federal Funds				\$10.6	\$21.8	\$22.5	\$22.6	\$22.6	\$23.0	\$23.2	\$146.2
State Funds				\$0.0	\$0.0	\$0.0	\$0.6	\$1.3	\$1.6	\$2.2	\$5.6

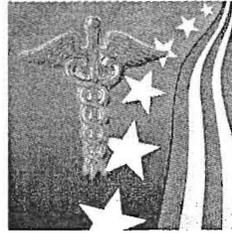
NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Division of Medicaid and Long-Term Care  
 Health Care Reform Projection - Maximum Impact Scenario  
 (Values in Millions)

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EXPENDITURES	<u>SFY 2011</u>	<u>SFY 2012</u>	<u>SFY 2013</u>	<u>SFY 2014</u>	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	<u>SFY 2011 - SFY 2020</u>
<b>DSH Reductions</b>											
Total (State and Federal)				(\$1.0)	(\$1.5)	(\$1.6)	(\$3.9)	(\$10.9)	(\$14.1)	(\$11.4)	(\$44.3)
Federal Funds				(\$0.6)	(\$0.9)	(\$0.9)	(\$2.2)	(\$6.3)	(\$8.1)	(\$6.6)	(\$25.5)
State Funds				(\$0.4)	(\$0.6)	(\$0.7)	(\$1.7)	(\$4.6)	(\$6.0)	(\$4.8)	(\$18.8)
<b>CHIP Enrollment Shift and FMAP Increase</b>											
Total (State and Federal)				\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Federal Funds				(\$1.3)	(\$2.7)	\$6.1	\$9.3	\$9.5	\$9.8	\$0.2	\$30.9
State Funds				\$1.3	\$2.7	(\$6.1)	(\$9.3)	(\$9.5)	(\$9.8)	(\$0.2)	(\$30.9)
<b>State Disability Shift to Medicaid and Expansion to 138% FPL</b>											
Total (State and Federal)				\$1.6	\$3.4	\$3.5	\$3.6	\$3.7	\$3.8	\$3.9	\$23.6
Federal Funds				\$6.1	\$12.6	\$12.9	\$13.0	\$13.0	\$13.2	\$13.3	\$84.0
State Funds				(\$4.4)	(\$9.2)	(\$9.4)	(\$9.4)	(\$9.3)	(\$9.4)	(\$9.4)	(\$60.5)
<b>All Programs - After Expansion</b>											
Total (State and Federal)	\$1,816.4	\$1,872.2	\$1,939.5	\$2,426.7	\$2,923.6	\$3,004.8	\$3,085.9	\$3,164.7	\$3,249.7	\$3,343.0	\$26,826.5
Federal Funds	\$1,074.1	\$1,085.8	\$1,123.6	\$1,554.2	\$1,991.2	\$2,053.0	\$2,093.8	\$2,125.6	\$2,175.7	\$2,212.4	\$17,489.3
State Funds	\$742.3	\$786.4	\$815.9	\$872.5	\$932.4	\$951.8	\$992.1	\$1,039.1	\$1,074.0	\$1,130.7	\$9,337.2
<b>All Programs - Fiscal Impact</b>											
Total (State and Federal)	\$0.0	\$6.3	\$22.6	\$457.4	\$900.7	\$926.6	\$951.0	\$971.5	\$996.7	\$1,028.6	\$6,261.2
Federal Funds	\$0.0	\$3.1	\$15.1	\$415.5	\$821.4	\$851.3	\$859.2	\$857.3	\$872.8	\$874.0	\$5,569.7
State Funds	\$0.0	\$3.1	\$7.5	\$42.0	\$79.2	\$75.3	\$91.7	\$114.2	\$123.8	\$154.6	\$691.5
<b>Pregnant Women (133% - 185%)</b>											
Total (State and Federal)				(\$1.6)	(\$3.3)	(\$3.4)	(\$3.5)	(\$3.6)	(\$3.7)	(\$3.8)	(\$22.8)
Federal Funds				(\$0.9)	(\$1.9)	(\$2.0)	(\$2.0)	(\$2.1)	(\$2.1)	(\$2.2)	(\$13.2)
State Funds				(\$0.7)	(\$1.4)	(\$1.4)	(\$1.5)	(\$1.5)	(\$1.6)	(\$1.6)	(\$9.7)
<b>Breast &amp; Cervical Cancer</b>											
Total (State and Federal)				(\$2.4)	(\$5.0)	(\$5.2)	(\$5.3)	(\$5.5)	(\$5.6)	(\$5.8)	(\$34.8)
Federal Funds				(\$1.7)	(\$3.5)	(\$3.6)	(\$3.7)	(\$3.8)	(\$3.9)	(\$4.0)	(\$24.4)
State Funds				(\$0.7)	(\$1.5)	(\$1.5)	(\$1.6)	(\$1.6)	(\$1.7)	(\$1.7)	(\$10.3)

## The 2011 State Legislators' Check List for Health Reform Implementation

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DECEMBER 2010

Rachel Morgan RN, BSN, Health Committee Director

*National Conference of State Legislatures 444 North Capitol Street, N.W., Suite 515 Washington, D.C. 20001*

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#### American Health Benefits Exchanges

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FY2011 Actions

#### ISSUE

#### PLANNING FOR STATE EXCHANGE IMPLEMENTATION IN FY2014

The Affordable Care Act (ACA) establishes a plan to facilitate the purchase and sale of qualified health coverage in the individual market, and to provide options for small business through American Health Benefit Exchanges. The ACA directs states to establish and implement the operation of an exchange no later than January 1, 2014. State-established government or nonprofit entities will certifying plans and identify individuals eligible for Medicaid, CHIP, and premium and cost-sharing credits. States have several options to structure their exchanges and many of these decisions will be either made by state legislators or dependent upon actions they take in session from 2011 through to 2014.

#### INITIAL GUIDANCE TO STATES ON EXCHANGES

The Department of Health and Human Services released guidance November 18<sup>th</sup> to assist states in the development of their exchanges. The secretary plans to release regulations for public comment in 2011, but has provided this guidance to assist states and territories with their overall planning, including the legislative plans for 2011. This guidance is the first in a series of documents that will be released by HHS over the next three years. The categories of information in this document cover the following:

- Principles and Priorities
- Outline of Statutory Requirements
- Clarifications and Policy Guidance, and
- Federal Support for the Establishment of State based exchanges.

The exchanges have been defined as a mechanism for organizing the health insurance marketplace to help consumers and small business shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality.

LINK TO INITIAL GUIDANCE DOCUMENT— <http://www.ncsl.org/documents/health/1118ExchGuid.pdf>

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## FY 2011 TASKS

### AMERICAN HEALTH BENEFITS EXCHANGES

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY2011 Actions	<p><b>PLANNING FOR STATE EXCHANGE IMPLEMENTATION IN FY2014</b> <i>(continued)</i></p> <p><b>LEGISLATIVE CONSIDERATIONS [Based on recommendations from the NAIC model act]</b></p> <ul style="list-style-type: none"> <li>▪ State options for consideration relating to exchange structure:               <ol style="list-style-type: none"> <li>1. Designation of the oversight authority within:                   <ul style="list-style-type: none"> <li>▪ a new or existing state agency, or</li> <li>▪ an independent public agency, or quasi-governmental agency,</li> </ul> </li> <li>2. Whether to establish a regional or interstate exchange, and</li> <li>3. Whether to operate a unified exchange by merging the SHOP Exchange<sup>1</sup> and the exchange for the individual market.</li> </ol> </li> <li>▪ Determine governance mechanisms if the exchange is not located within a state agency including:               <ol style="list-style-type: none"> <li>1. a governing board, it's size, composition and terms,</li> <li>2. determine the process of appointments to the board, their powers and duties,</li> <li>3. designation of committees or other entities involved in day-to-day responsibilities, and</li> <li>4. licensure requirements.</li> </ol> </li> <li>▪ If the state exchange will require certain health benefits that exceed the essential benefits package established by the Department of Health and Human Services. <i>(States must develop a mechanism to defray the cost of additional benefits in relation to premium and cost-sharing assistance for enrollees.)</i></li> <li>▪ Duties of the exchange.</li> <li>▪ Designate state authority responsible for health benefit plan certification.</li> <li>▪ Conform all state law to Federal ERISA fiduciary duties.</li> <li>▪ Grant necessary rule making authority to appropriate state entities responsible for implementing state law related to exchanges.</li> <li>▪ Determine budget for exchange, Medicaid, and CHIP information technology systems needs capable of meeting interoperability requirement, (refer to resource documents, <b>Guidance for Exchange and Medicaid IT Systems, Version 1.00</b>).</li> </ul>

<sup>1</sup> "SHOP Exchange" is defined as meaning the Small Business Health Options Program.

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### AMERICAN HEALTH BENEFITS EXCHANGES

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<p><b>FY2011 Actions</b> <b>GUIDANCE FOR STATUTORY REQUIREMENT (BASED ON HHS GUIDANCE RELEASED NOVEMBER 17, 2010)</b>            According to the ACA there are two basic types of federal requirements for exchanges which include 1) minimum functions exchanges must undertake directly or, in some cases, by contract; and 2) oversight responsibilities the exchanges must exercise in certifying and monitoring the performance of Qualified Health Plans (QHPs). Plans participating in the exchanges must also comply with state insurance laws and federal requirements in the Public Health Service Act.</p> <p><b>I. EXCHANGE FUNCTIONS</b></p> <ul style="list-style-type: none"> <li>▪ <b>Core functions that an exchange must meet:</b> <ol style="list-style-type: none"> <li>1. Certification, recertification and decertification of plans,</li> <li>2. Operation of a toll-free hotline,</li> <li>3. Maintenance of a website for providing information on plans to current and prospective enrollees,</li> <li>4. Assignment of a price and quality rating to plans,</li> <li>5. Presentation of plan benefit options in a standardized format,</li> <li>6. Provision of information on Medicaid and CHIP eligibility and determination of eligibility for individuals in these programs,</li> <li>7. Provision of an electronic calculator to determine the actual cost of coverage taking into account eligibility for premium tax credits and cost sharing reductions,</li> <li>8. Certification of individuals exempt from the individual responsibility requirement,</li> <li>9. Provision of information on certain individuals and to employers,</li> <li>10. Establishment of a Navigator program that provides grants to entities assisting consumers.</li> </ol> </li> <li>▪ <b>Additional Exchange functions include:</b> <ol style="list-style-type: none"> <li>1. Presentation of enrollee satisfaction survey results,</li> <li>2. Provision for open enrollment periods,</li> <li>3. Consultation with stakeholders, including tribes, and</li> <li>4. Publication of data on the exchange's administrative costs.</li> </ol> </li> </ul>

## FY 2011 TASKS

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## AMERICAN HEALTH BENEFITS EXCHANGES

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	FY2011 Actions	GUIDANCE FOR STATUTORY REQUIREMENT (BASED ON HHS GUIDANCE RELEASED NOVEMBER 17, 2010) (CONTINUED)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		I. OVERSIGHT RESPONSIBILITIES	<ul style="list-style-type: none"> <li>▪ HHS is required to develop regulatory standards in five areas that insurers must meet in order to be certified as QHP by an Exchange:               <ol style="list-style-type: none"> <li>1. Marketing</li> <li>2. Network adequacy</li> <li>3. Accreditation for performance measures</li> <li>4. Quality improvement and reporting</li> <li>5. Uniform enrollment procedures</li> </ol> </li>   <li>▪ Additional areas where exchanges must ensure plan compliance with regulatory standards established by HHS include:               <ol style="list-style-type: none"> <li>1. Information on the availability of in-network and out-of-network providers, including provider directories and availability of essential community providers,</li> <li>2. Consideration of plan patterns and practices with respect to past premium increases and a submission of the plan justifications for current premium increases,</li> <li>3. Public disclosure of plan data identified, including claims handling policies, financial disclosures, enrollment and disenrollment data, claims denials, rating practices, cost sharing for out of network coverage, and other information identified by HHS,</li> <li>4. Timely information for consumers requesting their amount of cost sharing for specific services from specified providers,</li> <li>5. Information for participants in group health plans,</li> <li>6. Information on plan quality improvement activities.</li> </ol> </li> </ul>

# The 2011 State Legislators' Check List for Health Reform Implementation

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### AMERICAN HEALTH BENEFITS EXCHANGES

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>FY2011 Actions</b>    <b>CLARIFICATION AND POLICY GUIDANCE (BASED ON HHS GUIDANCE RELEASED NOVEMBER 17, 2010) (CONTINUED)</b></p> <p>States should consider the following issues in establishing an Exchange.</p> <ul style="list-style-type: none"> <li>▪ <b>Organizational Form.</b> States have the option to establish their exchange as a governmental agency or nonprofit entity. Within the governmental agency category, the exchange could be housed within an existing state office, or it could be an independent public authority. Regardless of its organizational form, the exchange must be publicly accountable, transparent, and have technically competent leadership, with the capacity and authority to meet federal standards, including the discretion to determine whether health plans offered through the exchange are “in the interests of qualified individuals and qualified employers”. Exchanges also must have security procedures and privacy standards necessary to receive tax data and other information needed for enrollment.</li> <li>▪ <b>Operating Model.</b> States have options to operate their exchange from an “<i>active purchaser</i>” model, in which the exchange operates as large employers often do in using market leverage and the tools of managed competition to negotiate product offerings with insurers, to an “<i>open marketplace</i>” model, in which the exchange operates as a clearinghouse that is open to all qualified insurers and relies on market forces to generate product offerings. States should provide comparison shopping tools that promote choice based on price and quality and enable consumers to narrow plan options based on their preferences.</li> <li>▪ <b>Small Business (SHOP) Exchanges.</b> Federal rules will provide a framework for SHOP Exchanges, including options for how employers can provide contributions toward employee coverage that meet standards for small business tax credits. States are permitted to define “small employers” as employers with one to 50 employees for plan years beginning before January 1, 2016. States with differing legal standards for counting employer size should review their definitions for consistency with federal law.</li> <li>▪ <b>Risk Adjustment.</b> Federal rules in 2011 will outline <i>risk adjustment methods</i> and require all health plans to report demographic, diagnostic, and prescription drug data. Further guidance addressing risk adjustment rules and formulas will be provided in subsequent regulations. As specified by the law, federal rules will apply risk adjustment consistently to all plans in the individual and small group markets, both inside and outside of exchanges. Federal rules on reinsurance payments will apply to all plans in the individual market, and rules on risk corridors will apply to all qualified health plans in the individual and small group market, as specified in the law.</li> </ul>
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### AMERICAN HEALTH BENEFITS EXCHANGES

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>FY2011 Actions</b> CLARIFICATION AND POLICY GUIDANCE (BASED ON HHS GUIDANCE RELEASED NOVEMBER 17, 2010) (CONTINUED)</p> <ul style="list-style-type: none"> <li>▪ <b>Performance Measures.</b> Standardized public data reporting will be used to evaluate exchange performance and assure transparency.</li> <li>▪ <b>State Choices.</b> Federal rules will clarify that the following policy areas, among others, are State decisions, although HHS may offer recommendations and technical assistance to States as they make these decisions:                             <ol style="list-style-type: none"> <li>1. Whether to form the exchange as a governmental agency or a non-profit entity,</li> <li>2. Whether to form regional exchanges or establish interstate coordination for certain functions,</li> <li>3. Whether to elect the option under the ACA to use 50 employees as the cutoff for small group market plans until 2016, which would limit access to exchange coverage to employer groups of 50 or less,</li> <li>4. Whether to require additional benefits in the exchange beyond the essential health benefits,</li> <li>5. Whether to establish a competitive bidding process for plans,</li> <li>6. Whether to extend some or all exchange-specific regulations to the outside insurance market (beyond what is required in the ACA).</li> </ol> </li> <li>▪ <b>State Authority.</b> The federal government will work with the Governor of the State as the chief executive officer unless authority to operate the exchange has been delegated to a specific authority through state law.</li> </ul>
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**AMERICAN HEALTH BENEFITS EXCHANGES**

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>FY2011 Actions</b> <b>PLANNING FOR STATE EXCHANGE IMPLEMENTATION IN FY2014</b> <i>(continued)</i></p> <p><b>FUNDING OPPORTUNITY</b></p> <p><b>§ 1311 AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS</b> <i>(STATE PLANNING GRANTS)</i></p> <ul style="list-style-type: none"> <li>▪ Authorizes the Secretary of Health and Human Services to award grants to states to support planning efforts in the establishment of the American Health Benefit Exchange.</li> <li>▪ Grants must be awarded within one year of enactment of the Affordable Care Act, March 2011.</li> <li>▪ The amount of the grants to each state will be determined by the secretary.</li> <li>▪ Planning grant recipients may renew the grant if the recipient—             <ol style="list-style-type: none"> <li>1. is making progress toward establishing an Exchange; and implementing the insurance reforms that comply with the provisions within the health reform law; and</li> <li>2. is meeting any benchmarks as established by the Secretary.</li> </ol> </li> </ul> <p><b>No grants may be awarded after January 1, 2015.</b></p>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>FY2011 Actions</b> <b>FUNDING OPPORTUNITY</b></p> <p><b>EARLY INNOVATORS GRANT</b></p> <ul style="list-style-type: none"> <li>▪ Announcement released by OCIO<sup>2</sup> October 29, 2010.</li> <li>▪ Provides competitive incentives for states to design and implement the Information Technology (IT) infrastructure needed to operate Health Insurance Exchanges - new competitive insurance market places that will help Americans and small businesses purchase affordable private health insurance starting in 2014.</li> <li>▪ This competitive “Early Innovators” grant announcement will reward States that demonstrate leadership in developing cutting-edge and cost-effective consumer-based technologies and models for insurance eligibility and enrollment for Exchanges. These “Early Innovator” States will develop Exchange IT models, building universally essential components that can be adopted and tailored by other States. The innovations produced from this Cooperative Agreement will be used to help keep costs down for taxpayers, States, and the Federal Government. The systems developed through these Cooperative Agreements will complement the health plan information on HealthCare.gov.</li> </ul> <p>Two-year grants will be awarded by February 15, 2011 to up to five States or coalitions of States that have ambitious yet achievable proposals that can yield IT models and best practices that will benefit all States. These States will lead the way in developing consumer-friendly, cost-effective IT systems that can be used and adopted by other States and help all States and the Federal government save money as they work to develop these new competitive market places.</p>
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<sup>2</sup> OCIO-Office of Consumer Information and Insurance Oversight.

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>FY2011 Actions</b></p> <p><b>Rules</b></p> <p><b>FEDERAL FUNDING FOR MEDICAID ELIGIBILITY DETERMINATIONS AND ENROLLMENT ACTIVITIES PROPOSED RULES</b></p> <ul style="list-style-type: none"> <li>▪ CMS proposed rules were released November 3, 2010.</li> <li>▪ Comment period 60 days.</li> <li>▪ Provides an enhanced FFP of 90 percent for state expenditures for design, development, installation or enhancement of systems until calendar year 2015.</li> <li>▪ Provides an enhanced FFP of 75 percent for maintenance and operation of systems before 2015 if the system already meets standards and after 2015 for systems that have just become compliant.</li> </ul> <p>Newly developed standards will build upon the work of the Medicaid Information Technology Architecture (MITA) (see resource documents, <b>MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE (MITA)</b>—framework documents)</p>
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### FY 2011 TASKS

#### AMERICAN HEALTH BENEFITS EXCHANGES

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY2011 Actions	<b>RESOURCE DOCUMENTS</b> <ul style="list-style-type: none"> <li>▪ <b>HHS INITIAL GUIDANCE TO STATES ON EXCHANGES NOVEMBER 18, 2010—</b> <a href="http://www.ncsl.org/documents/health/1118ExchGuid.pdf">http://www.ncsl.org/documents/health/1118ExchGuid.pdf</a></li> <li>▪ <b>NATIONAL ASSOCIATION OF INSURANCE COMMISSIONER “American Health Benefit Exchange Model Act”</b> adopted 11/22/10, <a href="http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf">http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf</a></li> <li>▪ <b>STATE PLANNING GRANTS—“EARLY INNOVATOR”</b> grants competitive funding to design and implement the information technology (IT) infrastructure needed to operate Health Insurance Exchanges.               <ol style="list-style-type: none"> <li>1. announcement released October 29, 2010- <a href="http://www.ncsl.org/documents/health/InstElgrts.pdf">http://www.ncsl.org/documents/health/InstElgrts.pdf</a> .</li> <li>2. grant application package- <a href="http://www.ncsl.org/documents/health/EarlyInovGrts.pdf">http://www.ncsl.org/documents/health/EarlyInovGrts.pdf</a> .</li> </ol> </li> <li>▪ <b>GUIDANCE FOR EXCHANGE AND MEDICAID IT SYSTEMS, VERSION 1.0—</b> <a href="http://www.cms.gov/apps/docs/Joint-IT-Guidance-11-3-10-FINAL.pdf">http://www.cms.gov/apps/docs/Joint-IT-Guidance-11-3-10-FINAL.pdf</a> .</li> <li>▪ <b>HHS Memorandum: Federal Support and Standards for Medicaid and Exchange Information Technology Systems</b> <a href="http://www.healthcare.gov/center/letters/improved_it_sys.pdf">http://www.healthcare.gov/center/letters/improved_it_sys.pdf</a> .</li> <li>▪ <b>FEDERAL FUNDING FOR MEDICAID ELIGIBILITY DETERMINATIONS AND ENROLLMENT ACTIVITIES PROPOSED RULES—</b> <a href="http://www.ofr.gov/OFRUpload/OFRData/2010-27971_PI.pdf">http://www.ofr.gov/OFRUpload/OFRData/2010-27971_PI.pdf</a> .</li> <li>▪ <b>MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE (MITA)—</b>framework documents are available to the public at <a href="http://www.cms.gov/MedicaidInfoTechArch/">http://www.cms.gov/MedicaidInfoTechArch/</a> .</li> </ul>

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**FY 2011 TASKS**

**Fraud, Waste and Abuse**

NOT STARTED	IN PROGRESS	COMPLETED	EFFECTIVE DATE	
			Jan. 1, 2011	<p>Legislators should consider the potential financial impact of noncompliance with fraud, waste, and abuse provisions in the Affordable Care Act.</p> <p><u>ISSUE</u></p> <p><b>§6402. FUNDING TO FIGHT FRAUD, WASTE, AND ABUSE.</b></p> <ul style="list-style-type: none"> <li>Amends provisions in the Social Security Act pertaining to the Health Care Fraud and Abuse Control Account by adding additional funding of \$95 million for FY 2011, \$55 million for FY 2012, \$30 million for FY 2013 and 2014, and \$20 million for FY 2015 and 2016.</li> <li>The additional funding will be allocated for use by the Departments of Health and Human Services and Justice for their fraud and abuse control programs, and for the Medicare Integrity Program.</li> <li>The additional funding will also support Medicaid Integrity Program activities.</li> </ul> <p><u>LEGISLATIVE CONSIDERATIONS</u></p> <ul style="list-style-type: none"> <li>The Department of Health and Human Services Office of the Inspector General has released their plans for FY 2011 which will include a review of State Medicaid agencies' program integrity activities. They will examine state policies and procedures required by the federal regulations at 42 CFR pt. 455 to identify best practices and verify which procedures are operating as intended. Medicaid program integrity includes identifying payment risks, implementing actions to minimize the risks, and identifying and collecting overpayments.</li> </ul>
			FY 2011	<p><u>ISSUE</u></p> <p><b>§10201. WAIVER TRANSPARENCY.</b> - Applies to applications for or renewal of experimental projects, pilots or demonstration projects under Section 1115 of the Social Security Act.</p> <p><u>RESOURCE DOCUMENTS</u></p> <ul style="list-style-type: none"> <li><b>CMS Proposed Rules</b> released September 17, 2010, <a href="http://edocket.access.gpo.gov/2010/pdf/2010-23357.pdf">http://edocket.access.gpo.gov/2010/pdf/2010-23357.pdf</a></li> </ul>
			Jan. 1, 2011	<p><u>ISSUE</u></p> <p><b>§6402. ENHANCED MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.</b></p> <ul style="list-style-type: none"> <li><b>Overpayments</b> - Requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report was due, whichever is later. The ACA also provides that failure to return an overpayment within the timeframe is considered an "obligation" under the False Claims Act ("FCA") and could lead to liability for additional penalties if a FCA violation is found to exist.</li> <li><b>National Provider Identifier</b> - Requires the Secretary to issue a regulation mandating that all Medicare, Medicaid, and CHIP providers include their NPI on enrollment applications.</li> <li><b>Medicaid Management Information System</b> - Authorizes the Secretary to withhold the Federal matching payment to States for medical assistance expenditures when the State does not report enrollee encounter data in a timely manner to the State's Medicaid Management Information System (MMIS).</li> </ul>

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FRAUD, WASTE AND ABUSE				
NOT STARTED	IN PROGRESS	COMPLETED	EFFECTIVE DATE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 1, 2011	<p><u>ISSUE</u>  <b>§6411. EXPANSION OF THE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM</b> - Requires States to establish contracts with one or more Recovery Audit Contractors (RACs). These state RAC contracts would be established to identify underpayments and overpayments and to recoup overpayments made for services provided under state Medicaid plans as well as state plan waivers.</p> <p><u>RESOURCE DOCUMENTS</u></p> <ul style="list-style-type: none"> <li>▪ <b>The CMS</b> state Medicaid Directors letter October 1, 2010- <a href="http://www.cms.gov/smdl/downloads/SMD10021.pdf">http://www.cms.gov/smdl/downloads/SMD10021.pdf</a>.</li> <li>▪ <b>CMS Proposed Rules</b> released November 10, 2010, <a href="http://edocket.access.gpo.gov/2010/pdf/2010-28390.pdf">http://edocket.access.gpo.gov/2010/pdf/2010-28390.pdf</a>.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 1, 2011	<p><u>ISSUE</u>  <b>§6501. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID - IF TERMINATED UNDER MEDICARE OR OTHER STATE PLAN</b> - Requires States to terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another state's Medicaid program.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 1, 2011	<p><u>ISSUE</u>  <b>§ 6502. MEDICAID EXCLUSION FROM PARTICIPATION RELATING TO CERTAIN OWNERSHIP, CONTROL, AND MANAGEMENT AFFILIATIONS.</b> Requires Medicaid agencies to exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that: (1) has failed to repay overpayments during the period as determined by the Secretary; (2) is suspended, excluded, or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 1, 2010	<p><u>ISSUE</u>  <b>§ 6504. REQUIREMENT TO REPORT EXPANDED SET OF DATA ELEMENTS UNDER MMIS TO DETECT FRAUD</b> - Requires states and Medicaid managed care entities to submit data elements from MMIS as determined necessary by the Secretary for program integrity, program oversight, and administration.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	As determined by the Secretary.	<p><u>ISSUE</u>  <b>§ 6505. PROHIBITION ON PAYMENTS TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES</b> - Prohibits states from making any payments for items or services provided under a Medicaid state plan or waiver to any financial institution or entity located outside of the United States.</p>

The 2011 State Legislators' Check List for Health Reform Implementation

**FY 2011 TASKS**

**FRAUD, WASTE AND ABUSE**

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 1, 2011	<p><u>ISSUE</u></p> <p><b>§ 6506. OVERPAYMENTS</b> - Extends the period for states to repay uncollected overpayments to one year; states are still required to repay collections in the period collected. When overpayments due to fraud are pending a final determination of the amount of the overpayment due to an ongoing judicial or administrative process, state repayments of the Federal portion would not be due until 30 days after the date of the final judgment.</p> <p><u>RESOURCE DOCUMENTS</u></p> <p>The Centers for Medicare and Medicaid Services memorandum July 13, 2010, <i>Extended Period for Collection of Provider Overpayments</i>, <a href="http://www.cms.gov/smdl/downloads/SMD10014.pdf">http://www.cms.gov/smdl/downloads/SMD10014.pdf</a></p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<p><u>ADDITIONAL RESOURCES</u></p> <ul style="list-style-type: none"> <li>▪ <b>Presentation from the National Association for Medicaid Program Integrity Conference:</b> Angela Brice-Smith, Director, Medicaid Integrity Group, Center for Program Integrity, Centers for Medicare and Medicaid Services, <a href="http://www.nampi.org/members/2010presentations/MIGUpdate.pdf">http://www.nampi.org/members/2010presentations/MIGUpdate.pdf</a>.</li> </ul>

The 2011 State Legislators' Check List for Health Reform Implementation

**FY 2011 TASKS**

Health Care Facilities & Workforce

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	July 1, 2011	<p><u>ISSUE</u></p> <p><b>§ 5503. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.</b></p> <ul style="list-style-type: none"> <li>▪ Beginning July 1, 2011, the secretary is directed to redistribute unfilled residency positions allotted for payment under the graduate medical education program, if they have been unfilled for three cost reports, and convert them for training of primary care physicians.</li> <li>▪ Grants an exception to hospitals in rural areas with fewer than 250 acute care inpatient beds and hospitals that are part of a qualifying entity which had a voluntary residency reduction plan approved.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY 2011	<p><u>ISSUE</u></p> <p><b>§ 340H. PROGRAM OF PAYMENTS TO TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.</b></p> <ul style="list-style-type: none"> <li>▪ Creates a new section of the Public Health Service Act requiring HHS to make payments for direct and indirect costs to qualified teaching health centers (THCs) for the expansion of existing or the establishment of new approved graduate medical education (GME) training programs.</li> <li>▪ Payments will be in addition to GME payments and will not count against the limit in number of full-time equivalent residents paid for by Medicare or Children's Hospital GME Programs.</li> <li>▪ Payments are to be reduced by 25 percent if the THC fails to report certain information.</li> <li>▪ Appropriates for this purpose may not exceed \$230 million, for the period of FY2011 through FY2015.</li> </ul>

The 2011 State Legislators' Check List for Health Reform Implementation

FY 2011 TASKS				
HEALTH CARE FACILITIES & WORKFORCE				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY2011	<u>ISSUE (FUNDING)</u> <b>§ 10503. COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS FUND.</b> <ul style="list-style-type: none"> <li>▪ Creates the Community Health Center Fund.</li> <li>▪ Appropriates \$1 billion for FY 2011, for community health center operations and patient services, and</li> <li>▪ Also appropriates \$1.5 billion for health center construction and renovation to be available for FY2011 through FY2015 and remain available until expended.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dec. 31, 2011	<u>ISSUE</u> <b>§ 6102. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES AND NURSING FACILITIES.</b> <ul style="list-style-type: none"> <li>▪ Directs HHS to establish and implement a quality assurance and performance improvement program for Medicare and Medicaid skilled nursing facilities (SNFs) and nursing facilities (NFs), including multi unit chains of facilities.</li> <li>▪ Calls for the establishment of standards relating to quality assurance and performance improvement.</li> <li>▪ Facilities must develop and submit a plan to meet these standards to HHS by the end of FY 2015.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY 2011	<u>ISSUE</u> <b>§ 1109. PAYMENT FOR QUALIFYING HOSPITALS.</b> <ul style="list-style-type: none"> <li>▪ Increases Medicare payments to acute care hospitals in low-cost counties by \$400 million for fiscal years 2011 and 2012.</li> <li>▪ Qualifying hospitals must be located in counties ranked in the lowest quartile of adjusted Medicare Part A and B benefit spending.</li> <li>▪ Payments will be in proportion to its Medicare inpatient hospital payments relative to Medicare inpatient hospital payments for all qualifying hospitals.</li> </ul>

The 2011 State Legislators' Check List for Health Reform Implementation

**FY 2011 TASKS**

**HEALTH CARE FACILITIES & WORKFORCE**

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deadline Sept. 30, 2011	<p><u>ISSUE</u> [GRANT OPPORTUNITY]</p> <p><b>§ 10502. INFRASTRUCTURE TO EXPAND ACCESS TO CARE. [hospital construction grants]</b></p> <ul style="list-style-type: none"> <li>▪ Authorizes \$100 million beginning in FY 2010 through to September 30, 2011 for debt service, construction or renovation of:               <ol style="list-style-type: none"> <li>1. a health care facility that provides research</li> <li>2. an inpatient tertiary care facility, or</li> <li>3. an outpatient clinical services facility.</li> </ol> </li> <li>▪ The applicable facility must be affiliated with an academic health center at a public research university that contains the state's sole public academic medical and dental school.</li> <li>▪ To be eligible the governor of a state must submit an application to HHS that certifies that the new facility is critical for the provision of greater access to care, the facility is essential to the viability of the schools, the additional support would be no more than 40 percent of the total cost, and the state has established a dedicated funding mechanism necessary to complete the project.</li> </ul>

The 2011 State Legislators' Check List for Health Reform Implementation

**FY 2011 TASKS**

**INSURANCE REFORM**

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY2011	<p><u>ISSUE</u></p> <p><b>§1001 DEVELOPMENT AND UTILIZATION OF UNIFORM EXPLANATION OF COVERAGE DOCUMENTS AND STANDARDIZED DEFINITIONS.</b></p> <ul style="list-style-type: none"> <li>Directs HHS to develop standards within 12 months of enactment for summaries and benefits information to be used by health insurers to inform beneficiaries of their insurance coverage.</li> <li>Noncompliance by health insurers will result in a fine of \$1000 per incident. Applies to all health insurers.</li> </ul> <p><u>LEGISLATIVE CONSIDERATIONS</u></p> <ul style="list-style-type: none"> <li>May preempt state law if the state requirements provide less information than is required in the Affordable Care Act.</li> <li>Analyze and conform as necessary state laws relating to required plan information distributed to health insurance beneficiaries.</li> </ul>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 1, 2011	<p><u>ISSUE</u></p> <p><b>§1001 BRINGING DOWN THE COST OF HEALTH CARE COVERAGE (MEDICAL LOSS RATIO [MLR]).</b></p> <ul style="list-style-type: none"> <li>Requires health insurance issuers (group, individual, and grandfathered health plans) to report to HHS annually their ratio of incurred loss (claims) plus the loss adjustment expense (change in contract reserves) to earned premiums. The report must include total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that the coverage expends:               <ol style="list-style-type: none"> <li>On payment for medical services,</li> <li>For health care quality improvement,</li> <li>On all non-claims costs, excluding federal and state taxes and licensing or regulatory fees.</li> </ol> </li> <li>Issuers will not have to account for collections or receipts for risk adjustment, risk, corridors, and payments of reinsurance until 2014.</li> <li>Insurers will be required to provide an annual rebate to enrollees if the ratio of the amount of premium revenue expended on costs versus total premium revenue for the plan year is less than 85 percent in the large group market, or 80 percent in the small group market.</li> </ul> <p><u>LEGISLATIVE CONSIDERATIONS</u></p> <ul style="list-style-type: none"> <li>Review state medical loss reporting requirements and harmonize state definitions, application, and scope with those established under federal law.</li> <li>Conform state law to mirror federal requirements concerning calculation and timing of rebate payments</li> </ul> <p><u>RESOURCE DOCUMENTS</u></p> <ul style="list-style-type: none"> <li><b>OCIIO Interim Final Rule</b> posted 11/22/10, <a href="http://www.ofr.gov/OFRUpload/OFRData/2010-29596_PI.pdf">http://www.ofr.gov/OFRUpload/OFRData/2010-29596_PI.pdf</a>.</li> <li><b>The National Association of Insurance Commissioners Regulation</b> adopted 10/21/10, <a href="http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf">http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf</a></li> </ul>
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The 2011 State Legislators' Check List for Health Reform Implementation

**FY 2011 TASKS**

LONG-TERM CARE

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	ISSUE
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Jan. 1, 2011

ISSUE

**§ 8002. COMMUNITY LIVING ASSISTANCE SERVICE AND SUPPORTS.**

- Establishes a new, voluntary, self-funded public long-term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations. Requires the Secretary to develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides cash benefit that is not less than an average of \$50 per day. No taxpayer funds will be used to pay benefits under this provision.
- Creates a new national insurance program to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities.
- Financed through voluntary payroll deductions (with opt-out enrollment similar to Medicare Part B), this program will remove barriers to independence and choice (e.g., housing modifications, assistive technologies, personal assistance services, transportation) by providing a cash benefit to individuals unable to perform two or more functional activities of daily living.

*DEFINITIONS*

- "Active enrollee" means an individual who has enrolled and paid premiums to maintain enrollment. "Activities of daily living" include eating, toileting, transferring, bathing, dressing, and incontinence or the cognitive equivalent.
- An "eligible beneficiary" has paid premiums for at least 60 months and for at least 12 consecutive months. (§ 3203)

*CLASS INDEPENDENT BENEFIT PLAN*

- Directs the Secretary of Health & Human Services to develop two alternative benefit plans within specified limits.
- The monthly maximum premiums will be set by the Secretary to ensure 75 years of solvency.
- There is a five year vesting period for benefit eligibility.
- The benefit triggers when an individual is unable to perform not less than two activities of daily living for at least 90 days.
- The cash benefit will be not less than \$50 per day.
- Not later than October 1, 2012, the Secretary will designate a CLASS benefit plan, taking into consideration the recommendations of the CLASS Independence Advisory Council.

The 2011 State Legislators' Check List for Health Reform Implementation

**FY 2011 TASKS**

LONG-TERM CARE

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
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Jan. 1, 2011

ISSUE

**§ 8002. COMMUNITY LIVING ASSISTANCE SERVICE AND SUPPORTS. (continued)**

*ENROLLMENT AND DISENROLLMENT*

- The Secretary will establish procedures to allow for voluntary automatic enrollment by employers, as well as alternative enrollment processes for self-employed, employees of non-participating employers, spouses and others. Individuals may choose to waive enrollment in CLASS in a form and manner to be established by the Secretary. **Employees must opt-out of the program or they will be enrolled automatically.**
- Premiums will be deducted from wages or self-employment income according to procedures established by the Secretary.

*BENEFITS*

- Eligible beneficiaries will receive appropriate cash benefits to which they are entitled, advocacy services, and advice and assistance counseling.
- Cash benefits will be paid into a Life Independence Account to purchase non-medical services and supports needed to maintain a beneficiary's independence at home or in another residential setting, including home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and added nursing support.

*CLASS INDEPENDENCE FUND*

- The CLASS Independence Fund will be located in the Department of the Treasury and the Secretary of the Treasury will act as the Managing Trustee.
- A CLASS Independence Fund Board of Trustees will include the Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, the Secretary of Health & Human Services, and two members of the public.

*CLASS INDEPENDENCE ADVISORY COUNCIL*

- The CLASS Independence Advisory Council, created under this Title, will include not more than 15 members, named by the President, a majority of whom will include representatives of individuals who participate or are likely to participate in the CLASS program.
- The Council will advise the Secretary on matters of general policy relating to CLASS

RESOURCE DOCUMENTS

**CRS report:** Community Living Assistance Services and Supports (CLASS) Provisions in the Patient Protection and Affordable Care Act (PPACA), <http://www.ncsl.org/documents/health/CLASS.pdf> .

The 2011 State Legislators' Check List for Health Reform Implementation

**FY 2011 TASKS**

**MEDICAID**

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 1, 2011	<p><u>ISSUE [BUDGET ITEM]</u></p> <p><b>§2006. SPECIAL ADJUSTMENT TO FMAP DETERMINATION FOR CERTAIN STATES RECOVERING FROM A MAJOR DISASTER.</b></p> <ul style="list-style-type: none"> <li>Reduces projected decreases in federal Medicaid matching funds as a result of the regular updating process, for states that have experienced major disaster.</li> <li>To qualify as a “disaster recovery FMAP adjustment state”, a state must have over the past seven fiscal years received a Presidential declaration of a major disaster under the provisions of sec. 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act <b>and</b> every county or Parrish in the state statewide was eligible for both individual and public assistance.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 1, 2011	<p><u>ISSUE [BUDGET ITEM]</u></p> <p><b>§2001. STATE FINANCIAL HARDSHIP EXEMPTION.</b></p> <ul style="list-style-type: none"> <li>Between January 1, 2011 and December 31, 2013, a state is exempt from the maintenance-of-effort for optional non-pregnant, non-disabled adult populations above 133 percent of the federal poverty level if the state certifies to the Secretary that the state is experiencing a budget deficit for the year in which the certification is made or projects to have a budget deficit for a succeeding state fiscal year.</li> </ul> <p><u>LEGISLATIVE CONSIDERATIONS</u></p> <ul style="list-style-type: none"> <li>A state may make the necessary certification that they are experiencing a budget deficit on or after December 31, 2010.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	July 1, 2011	<p><u>ISSUE [BUDGET ITEM]</u></p> <p><b>§2005. PAYMENTS TO TERRITORIES.</b></p> <ul style="list-style-type: none"> <li>Beginning in July 1, 2011 through September 30, 2019, all territories’ FMAP rate and spending caps will be increased.</li> <li>Requires territories in 2014 to provide coverage to childless adults who met income eligibility standards consistent with those already established for parents by the territories.</li> <li>Provides that the cost of providing coverage to newly eligible individuals will not count towards the spending cap.</li> </ul> <p><i>TERRITORIES AND THE HEALTH INSURANCE EXCHANGES</i></p> <p>Each territory will have a one-time option to “opt-in” to state (or territory)-based insurance exchanges in 2014.</p>

## The 2011 State Legislators' Check List for Health Reform Implementation

### FY 2011 TASKS

#### MEDICAID

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
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March 2011

#### ISSUE

#### **§6401. PROVIDER SCREENING AND OTHER ENROLLMENT REQUIREMENTS UNDER MEDICARE, MEDICAID, AND CHIP.**

- Directs HHS in consultation with the Office of the Inspector General to establish procedures for screening of providers and suppliers who enroll in the Medicare, Medicaid, and CHIP programs.
- At a minimum the procedures would include a process for screening, enhanced oversight measures, disclosure requirements, moratoriums on enrollment, and requirements for developing compliance programs.
- To cover the costs of the screening, certain providers would be subject to fees. Fees would start at \$500 for institutional providers and would increase by the rate of inflation thereafter.
- The HHS may exempt the fees if they impose a hardship.
- Enforcement of compliance of the requirements will begin March 2011 for all new providers in the programs.
- Compliance for all current providers will go into effect two years after enactment of the ACA in 2013.

#### LEGISLATIVE CONSIDERATIONS

In addition to the requirements listed above, the Office of the inspector general plans to review in their FY 2011 work plan how states ensure that Medicaid managed care plans follow a structured process for credentialing and recredentialing of providers. Regulations at 42 CFR 438.214 require states to ensure that managed care plans serving the Medicaid population implement written policies for selection and retention of providers. Each managed care plan must document its process for credentialing and recredentialing providers that have signed contracts or participation agreements. Plans must not employ or contract with provides excluded from participation in federal health care programs. They will also be examining how CMS ensures that states comply with requirements for provider credentialing by Medicaid managed care plans.

#### RESOURCE DOCUMENT

- **CMS Proposed Rule** published September 23, 2010. <http://edocket.access.gpo.gov/2010/pdf/2010-23579.pdf>
- **HHS presentation** during the National Association for Medicaid Program Integrity Conference September 2010, <http://www.namp.org/members/2010presentations/MIGUpdate.pdf>.

The 2011 State Legislators' Check List for Health Reform Implementation

**FY 2011 TASKS**

**MEDICAID**

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FY 2011	<p><b>ISSUE [DEMONSTRATION]</b></p> <p><b>§2707. MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT.</b></p> <ul style="list-style-type: none"> <li>▪ Requires the Secretary of HHS to establish a three-year Medicaid demonstration project in <b>up to eight states</b>.</li> <li>▪ Participating states would be required to reimburse certain institutions for mental disease (IMDs) for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition.</li> </ul> <p><i>APPROPRIATIONS</i></p> <ul style="list-style-type: none"> <li>▪ Appropriates \$75 million for FY 2011. These funds will remain available for obligation through December 31, 2015.</li> </ul> <p><i>EVALUATION</i></p> <ul style="list-style-type: none"> <li>▪ Directs the Secretary to conduct an evaluation to determine the impact of the demonstration project and to make recommendations as to whether the demonstration project should be continued after December 31, 2013 and expanded nationwide.</li> </ul> <p><i>REPORT TO CONGRESS</i></p> <ul style="list-style-type: none"> <li>▪ Directs the Secretary to submit a report to Congress no later than December 31, 2013 and make available to the public a report on the findings of the evaluation.</li> </ul> <p><b>RESOURCE DOCUMENT</b></p> <ul style="list-style-type: none"> <li>▪ <b>Substance Abuse and Mental Health Services Administration (SAMHSA) document-</b> <a href="http://www.samhsa.gov/healthreform/docs/Medicaid_Emergency_Psychiatric_Demo_508.pdf">http://www.samhsa.gov/healthreform/docs/Medicaid_Emergency_Psychiatric_Demo_508.pdf</a></li> </ul>

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**FY 2011 TASKS**

**MEDICAID**

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	October 1, 2010	<p><u>ISSUE</u></p> <p><b>CHANGES TO MEDICAID PAYMENT FOR PRESCRIPTION DRUGS</b></p> <p><b>§2503. MEDICAID PHARMACY REIMBURSEMENT.</b></p> <ul style="list-style-type: none"> <li>Changes the Federal upper payment limit (FUL) to no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recent average manufacturer prices (AMPs) for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through retail community pharmacies.</li> <li>Establishes a new formula for determining AMP based on sales to wholesalers and sales to retail community pharmacies.</li> <li>Effective on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.</li> </ul> <p><u>RESOURCE DOCUMENT</u></p> <ul style="list-style-type: none"> <li><b>CMS FINAL RULE NOVEMBER 15, 2010</b>— Medicaid Program; Withdrawal of Determination of Average Manufacturer Price, Multiple Source Drug Definition, and Upper Limits for Multiple Source Drugs <a href="http://EDOCKET.ACCESS.GPO.GOV/2010/PDF/2010-28649.PDF">HTTP://EDOCKET.ACCESS.GPO.GOV/2010/PDF/2010-28649.PDF</a></li> <li><b>CMS memo</b> September 28, 2010, <i>Revised Policy on Federal Offset of Rebates</i>, <a href="http://www.cms.gov/smdl/downloads/SMD10019.pdf">http://www.cms.gov/smdl/downloads/SMD10019.pdf</a></li> </ul>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 1, 2010	<p><u>ISSUE</u></p> <p><b>§2501. INCREASE MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS.</b></p> <ul style="list-style-type: none"> <li>Increases the minimum manufacturer rebate for brand-name drugs purchased by state Medicaid programs from 15.1% of average manufacturer price to 23.1% of average manufacturer price.</li> </ul> <p><i>Increase Minimum Rebate Percentage for Clotting Factors and Drugs Approved by the FDA for Pediatric Use Only</i></p> <ul style="list-style-type: none"> <li>Increases the minimum manufacturer rebate for brand-name drugs purchased by state Medicaid programs from 15.1% of average manufacturer price to 17.1% of average manufacturer price.</li> </ul> <p><i>Application of Rebates to New Formulations of Existing Drugs</i></p> <ul style="list-style-type: none"> <li>The rebate for line extension drugs will be the greater of the amount computed under the rebate statute or the product of the AMP for the line extension drug multiplied by the highest additional rebate for any strength of the original brand name drug.</li> </ul>
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The 2011 State Legislators' Check List for Health Reform Implementation

**FY 2011 TASKS**

**MEDICAID**

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE
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ISSUE

**§2501. INCREASE MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS. (CONTINUED)**

*Rebates for Drugs Dispensed by Medicaid Managed Care Organizations (MCOs)*

- Requires manufacturers to pay rebates for drugs dispensed by Medicaid MCOs, effective March 23, 2010.

*Limit on Total Rebate Liability*

- Limits total rebate liability on an individual single source or innovator multiple source drug to 100 percent of AMP for that drug product. Other features of the drug rebate program, such as the Medicaid's best price provision, would remain unchanged.

RESOURCE DOCUMENT

**CMS memo** September 28, 2010, *Revised Policy on Federal Offset of Rebates*,

<http://www.cms.gov/smdl/downloads/SMD10019.pdf>



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**FY 2011 TASKS**

MEDICAID			
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 1, 2010
<p><u>ISSUE</u></p> <p><b>§2501. INCREASED REBATE PERCENTAGE FOR GENERIC DRUGS.</b></p> <ul style="list-style-type: none"> <li>Increases the rebate percentage for non innovator, multiple source drugs to 13% of AMP.</li> </ul> <p><u>RESOURCE DOCUMENT</u></p> <ul style="list-style-type: none"> <li><b>CMS memo</b> September 28, 2010, <i>Revised Policy on Federal Offset of Rebates</i>, <a href="http://www.cms.gov/smdl/downloads/SMD10019.pdf">http://www.cms.gov/smdl/downloads/SMD10019.pdf</a></li> </ul>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>ISSUE</u></p> <p><b>§2501. MAXIMUM REBATE AMOUNT.</b></p> <p>Increases the amount of rebates that drug manufacturers are required to pay under the Medicaid drug rebate program, with different formulas for single source and innovator multiple source drugs (brand name drugs), noninnovator multiple source drugs (generic drugs), and drugs that are line extensions of a single source drug or an innovator multiple source drug, effective January 1, 2010. The Affordable Care Act also required that amounts "attributable" to these increased rebates be remitted to the Federal government drug.</p> <p><u>RESOURCE DOCUMENT</u></p> <p><b>CMS memo</b> September 28, 2010, <i>Revised Policy on Federal Offset of Rebates</i>, <a href="http://www.cms.gov/smdl/downloads/SMD10019.pdf">http://www.cms.gov/smdl/downloads/SMD10019.pdf</a></p>			

The 2011 State Legislators' Check List for Health Reform Implementation

**FY 2011 TASKS**

**MEDICAID**

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oct. 1, 2011	<p><u>ISSUE [BUDGET ITEM]</u></p> <p><b>§2401. COMMUNITY FIRST CHOICE OPTION.</b></p> <p><i>State Plan Option to Provide Home and Community-Based Attendant Services and Supports</i></p> <ul style="list-style-type: none"> <li>Establishes an optional Medicaid benefit which allows states to offer community-based attendant services and supports to Medicaid beneficiaries to assist in accomplishing activities of daily living, instrumental activities of daily living, and health related tasks through hands-on assistance, supervision, or cueing in a person-centered plan that is based on an assessment of functional need.</li> <li>Provides an <b>enhanced federal matching rate</b> of an additional six percentage points for reimbursable expenses in the program.</li> <li>Consider the need for any statutory changes made necessary to accommodate a state plan amendment if your state opts to participate in this program.</li> </ul> <p><u>RESOURCE DOCUMENT</u></p> <p><b>National Association of State Units on Aging (NASUA), LONG-TERM CARE IN BRIEF: Explaining the Medicaid Community First Choice Option,</b>  <a href="http://www.nasuad.org/documentation/aca/NASUAD_materials/l tcb_communityfirstchoiceoption.pdf">http://www.nasuad.org/documentation/aca/NASUAD_materials/l tcb_communityfirstchoiceoption.pdf</a>.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oct. 1, 2011	<p><u>ISSUE [BUDGET ITEM]</u></p> <p><b>§10202. INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES.</b></p> <ul style="list-style-type: none"> <li>Incentivizes states that undertake structural reforms in their Medicaid programs designed to create home and community based services (HCBS) as a viable alternative to nursing home care with a targeted enhanced FMAP.</li> <li>States may participate through a waiver or a state plan amendment.</li> <li>States that choose a SPA would be able to include individuals with incomes up to 300 percent of the maximum Supplemental Security Income payment.</li> <li>Funding for the nursing home diversion program would be available for five years beginning in 2011.</li> </ul>

## The 2011 State Legislators' Check List for Health Reform Implementation

### FY 2011 TASKS

#### MEDICAID

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oct. 1, 2011
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Oct. 1, 2011

ISSUE [BUDGET ITEM]

**\$10202. INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES. (continued)**

*Enhanced Federal Matching Payments*

- FMAP increases will be tied to the percentage of a state's LTC services and supports offered through HCBS, with lower increases going to states needing fewer reforms as follows:
- States with less than 25 percent of their total Medicaid long-term care expenditures for FY 2009 on HCBS will set their target for spending 25 percent for these services, to be achieved by October 1, 2015. **These states will receive a 5 percentage point increase in their FMAP.**
- Other participating states will set their target percentage for HCBS as a percentage of their Medicaid long term services and supports spending at 50 percent, to be achieved by October 1, 2015. **These states will receive a 2 percentage point increase.**
- Maintenance of Effort and Other Requirements
- States must maintain their eligibility standards, methodologies, or procedures for determining eligibility for these services at levels that are no more restrictive than those in place on December 31, 2010.
- Requires that the additional federal funds be used to pay for new or expanded offerings of non-institutional-based long-term services and supports.
- Requires states to implement several structural changes to their Medicaid programs within six-months of application, including:
  - the implementation of a **—no wrong door policy** where beneficiaries may access LTC services and supports through a coordinated network, agency or other statewide system;
  - the development of conflict-free case management services; and
  - development of core assessment instruments to determine eligibility for non-institutionally-based long-term services and supports.
- Requires state to collect data tracking service use, quality, and outcomes by beneficiaries and their families.

*Funding*

- \$3 billion in federal matching funds will be available to incentivize states for the five-year period between October 1, 2011 and September 30, 2016.
- Consider the need for any statutory changes made necessary to accommodate a state plan amendment if your state opts to participate in this program.

RESOURCE DOCUMENT

- **National Association of State Units on Aging (NASUA), LONG-TERM CARE IN BRIEF: Explaining the Medicaid Community First Choice Option,**  
[http://www.nasua.org/documentation/aca/NASUAD\\_materials/l\\_tcb\\_communityfirstchoiceoption.pdf](http://www.nasua.org/documentation/aca/NASUAD_materials/l_tcb_communityfirstchoiceoption.pdf)

## The 2011 State Legislators' Check List for Health Reform Implementation

### FY 2011 TASKS

#### MEDICAID

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	July 1, 2011	<p><u>ISSUE</u></p> <p><b>§2702. PROHIBITS FEDERAL PAYMENTS TO STATES FOR MEDICAID SERVICES RELATED TO HEALTH CARE ACQUIRED CONDITIONS. [HEALTH-CARE ACQUIRED CONDITIONS (HACs)]</b></p> <ul style="list-style-type: none"> <li>Will be defined by the secretary and consistent with the definition of hospital acquired conditions<sup>3</sup> under Medicare, but would not be limited to conditions acquired in hospitals.</li> <li>State Medicaid programs that continue to reimburse health care providers for services associated with a health care acquired condition will no longer receive the federal match for those services.</li> <li>When the Medicare rule affecting claims payment was implemented several states adopted similar reimbursement practices found in the federal rule for hospital claims, some states opted to negotiated agreements with their large hospital systems and the state hospital associations to refrain from billing when these events occurred.</li> </ul> <p><u>LEGISLATIVE CONSIDERATIONS</u></p> <ul style="list-style-type: none"> <li>Legislative intervention may be needed to enable state Medicaid agencies to adopt reimbursement practices that restrict payment for health care acquired conditions.</li> <li>Consider budgetary impact if state Medicaid policies do not conform to CMS requirements for nonpayment.</li> <li>Legislators may want to consider a hold harmless provision If none exists in state law protecting Medicaid beneficiaries for responsibility of payment for services when an error is made on the part of a provider, either administrative or a practice error that applies to the HAC provisions.</li> </ul> <p><u>RESOURCE DOCUMENTS</u></p> <ul style="list-style-type: none"> <li><b>National Guideline Clearinghouse</b> <a href="http://www.guideline.gov/resources/hospital-acquired-conditions.aspx">http://www.guideline.gov/resources/hospital-acquired-conditions.aspx</a></li> </ul>

<sup>3</sup> Deficit Reduction Act Sec. 5001. Hospital Quality Improvement: (c) Quality Adjustment in DRG Payments for Certain Hospital Acquired Infections-(1) Amends Section 1886(d)(4) of the Social Security Act by adding language that states that for discharges occurring after October 1, 2008, the diagnosis related group (DRG) assigned may not result in a higher payment based on a secondary diagnosis associated with conditions identified by the secretary that could have reasonably been avoided through the application of evidence-based guidelines. Hospitals will be required to report the secondary diagnosis present on admission of the patient.

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**FY 2011 TASKS**

**MEDICAID**

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
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Jan. 1, 2011

ISSUE

**§2703. STATE PLAN OPTION PROMOTING HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS.**

- Creates a new Medicaid state plan option under which Medicaid enrollees with at least two chronic conditions or with one chronic condition and at risk of developing another chronic condition, could designate a provider as their health home.
- Requires qualifying providers to meet certain standards, including demonstrating that they have the systems and infrastructure in place to provide comprehensive and timely high-quality care either in-house or by contracting with a team of health professionals.
- The designated provider or a team of health professionals will offer the following services: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; and referral to community and social support services, if relevant and as feasible use health information technology to link such services.
- Teams of providers could be free-standing, virtual, or based at a hospital, community health center, clinic, physician's office, or physician group practice.
- Directs the state to develop a mechanism to pay the health home for services rendered. The state plan amendment will include a plan for tracking avoidable hospital readmissions and plan for producing savings resulting from improved chronic care coordination and management.

*FEDERAL MATCH PAYMENTS*

- Provides an **enhanced match of 90 percent** FMAP for two years for states that take up this option.
- In addition, small planning grants may be available to help states intending to take up this option. Pre-Recovery Act service match rate.

*EVALUATION*

- Requires an independent evaluation be conducted after two years to assess the impact of this option on reducing hospital admissions.

LEGISLATIVE CONSIDERATIONS

- Determine participation in state optional expansions.
- Consider cost-savings impact.

RESOURCE DOCUMENTS

- **CMS Letter to State Medicaid Directors** November 16, 2010  
<http://www.cms.gov/smdl/downloads/SMD10024.pdf>



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**FY 2011 TASKS**

MEDICAID			
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 1, 2011
<p><u>ISSUE [GRANT OPPORTUNITY]</u>  <b>§2703. STATE PLAN OPTION PROMOTING HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS. [continued]</b>  <u>PLANNING GRANTS</u></p> <ul style="list-style-type: none"> <li>▪ Authorizes the secretary to award planning grants to states for development of a new plan option,</li> <li>▪ Requires a state match equal to pre-Recovery Act service match rate, and authorizes a maximum of \$25 million for this purpose.</li> </ul>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 1, 2011
<p><u>ISSUE [GRANT OPPORTUNITY]</u>  <b>§4108. INCENTIVES FOR PREVENTION OF CHRONIC DISEASE IN MEDICAID. [PROGRAM FOR HEALTHY LIFESTYLES]</b></p> <ul style="list-style-type: none"> <li>▪ Creates a <b>grant program for states</b> to provide incentives to Medicaid beneficiaries who participate in a program to develop a healthy lifestyle.</li> <li>▪ These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions.</li> <li>▪ Appropriates \$100 million for the program for a five-year period.</li> </ul> <p><u>RESOURCE DOCUMENTS</u></p> <ul style="list-style-type: none"> <li>▪ <b>SAMHSA Fact Sheet,</b>  <a href="http://www.samhsa.gov/healthreform/docs/Incentives_Prevention_Chronic_Disease_Medicaid_508.pdf">http://www.samhsa.gov/healthreform/docs/Incentives_Prevention_Chronic_Disease_Medicaid_508.pdf</a>.</li> </ul>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	January 1, 2011 publication deadline for core set of standards
<p><u>ISSUE [GRANT OPPORTUNITY]</u>  <b>§2701. ADULT HEALTH QUALITY MEASURES.</b></p> <ul style="list-style-type: none"> <li>▪ Similar to the quality provisions enacted in CHIPRA, directs the HHS Secretary, in consultation with the states, to develop an initial set of health care quality measures specific to adults who are eligible for Medicaid.</li> <li>▪ Establishes the Medicaid Quality Measurement Program which will expand upon existing quality measures, identify gaps in current quality measurement, establish priorities for the development and advancement of quality measures and consult with relevant stakeholders.</li> <li>▪ Requires the Secretary, along with states, to regularly report to Congress the progress made in identifying quality measures and implementing them in each state's Medicaid program.</li> <li>▪ Standardized reporting by the states would begin in 2013.</li> <li>▪ States will have an opportunity to receive grant funding to support the development, collection, and reporting of quality measures.</li> <li>▪ Appropriates \$60 million for each FY 2010 through 2014. Total funds available for grants-\$30 million</li> </ul>			

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through 2014.

**FY 2011 TASKS**

MEDICARE

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan., 1, 2011	<p><u>ISSUE</u></p> <p><b>§3108. PERMITTING PHYSICIAN ASSISTANTS TO ORDER POST-HOSPITAL EXTENDED CARE SERVICES.</b></p> <ul style="list-style-type: none"> <li>▪ Adds physician assistances to the list of providers authorized to order (or certify) post-hospital extended care services for Medicare beneficiaries beginning January 1, 2011.</li> <li>▪ May impact state dual eligible populations.</li> </ul> <p><u>LEGISLATIVE CONSIDERATIONS</u></p> <ul style="list-style-type: none"> <li>▪ Conform as necessary the state Medicaid program criteria for authorization of post acute extended care with federal law.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	July 1, 2011	<p><u>ISSUE</u></p> <p><b>§3113. TREATMENT OF CERTAIN COMPLEX DIAGNOSTIC LABORATORY TESTS.</b></p> <ul style="list-style-type: none"> <li>▪ Directs HHS to conduct a demonstration project under part B under which separate payments may be made for complex diagnostic laboratory tests<sup>4</sup> to determine the impact on access to and quality of care, health outcomes, and expenditures.</li> <li>▪ The demonstration project will be conducted over a two-year period beginning July 1, 2011.</li> <li>▪ Payments may not exceed \$100 million.</li> </ul> <p><u>LEGISLATIVE CONSIDERATIONS</u></p> <ul style="list-style-type: none"> <li>▪ Consider impact on projected state expenditures for dual eligibles.</li> </ul>

<sup>4</sup> "complex diagnostic laboratory tests" are defined as meaning a test: (1) that is an analysis of gene protein expression, (2) topographic genotyping, or a cancer chemotherapy sensitivity assay; (3) that is determined by the Secretary to be a laboratory test for which there is not an alternative test having equivalent performance characteristics; (4) which is billed using a Health Care Procedure Coding System (HCPCS) code other than a not otherwise classified code under such Coding System; (5) which is approved or cleared by the Food and Drug Administration or is covered under title XVIII of the Social Security Act; and (6) is described in section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3))

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MEDICARE				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 1, 2011	<p><u>ISSUE</u></p> <p><b>§3114. IMPROVED ACCESS FOR CERTIFIED NURSE-MIDWIFE SERVICES.</b></p> <ul style="list-style-type: none"> <li>Amends the Social Security Act to increase coverage for certified nurse-midwife services to Medicare beneficiaries from 80 percent to full coverage as of January 1, 2011.</li> </ul> <p><u>LEGISLATIVE CONSIDERATIONS</u></p> <ul style="list-style-type: none"> <li>Consider impact on projected state expenditures for dual eligibles.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 1, 2011	<p><u>ISSUE</u></p> <p><b>§3301. MEDICARE COVERAGE GAP DISCOUNT PROGRAM.</b></p> <ul style="list-style-type: none"> <li>Effective January 1, 2011, the Discount Program will make manufacturer discounts available to applicable Medicare beneficiaries receiving applicable covered Part D<sup>5</sup> drugs while in the coverage gap.</li> <li>Drug manufacturer will be required to provide to Part D beneficiaries a 50 percent discount for brand-name drugs and biologics at point-of-sale.</li> </ul> <p><u>LEGISLATIVE CONSIDERATIONS</u></p> <p>Consider impact on projected state expenditures for dual eligibles and State Pharmaceutical Assistance Programs.</p> <p><u>RESOURCE DOCUMENTS</u></p> <ul style="list-style-type: none"> <li><b>CMS memo</b> to plan sponsors April 30, 2010, Medicare Coverage Gap Discount Program beginning in 2011 <a href="https://www.cms.gov/PrescriptionDrugCovContra/Downloads/2011CoverageGapDiscount_043010v2.pdf">https://www.cms.gov/PrescriptionDrugCovContra/Downloads/2011CoverageGapDiscount_043010v2.pdf</a></li> <li><b>CMS memo</b> August 3, 2010, <a href="http://www.cms.gov/PrescriptionDrugCovGenIn/Downloads/CGDMemo_08.03.10.pdf">http://www.cms.gov/PrescriptionDrugCovGenIn/Downloads/CGDMemo_08.03.10.pdf</a></li> <li><b>Medicare.gov:</b> Five Ways to Lower Your Costs During The Coverage Gap, <a href="http://www.medicare.gov/health-and-drugs/bridging-the-coverage-gap.aspx">http://www.medicare.gov/health-and-drugs/bridging-the-coverage-gap.aspx</a></li> <li><b>CMS document:</b> Bridging the Coverage Gap, <a href="http://www.medicare.gov/health-and-drugs/bridging-the-coverage-gap.aspx">http://www.medicare.gov/health-and-drugs/bridging-the-coverage-gap.aspx</a>.</li> </ul>

<sup>5</sup> The Medicare Prescription Drug Benefit was enacted into law on December 8, 2003 the law re-designs Part D which establishes the Voluntary Prescription Drug Benefit Program. The Part D program is available for individuals who are entitled to Medicare Part A or enrolled in Medicare Part B. The Part D program became effective January 1, 2006. The prescription drug coverage is subject to an annual deductible, 25 percent coinsurance up to the initial coverage limit, and the greater of \$2/\$5 or five-percent catastrophic coverage for individuals that exceed the annual maximum true out-of-pocket threshold.

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**FY 2011 TASKS**

**Medicare**

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 1, 2011	<p><u>ISSUE</u></p> <p><b>§4103. MEDICARE COVERAGE OF ANNUAL WELLNESS VISIT PROVIDING A PERSONALIZED PREVENTION PLAN.</b></p> <ul style="list-style-type: none"> <li>Amends the Social Security Act to require that Medicare Part B cover once a year, without cost sharing, 'personalized prevention plan services<sup>6</sup>,' including a comprehensive health risk assessment.</li> </ul> <p><u>LEGISLATIVE CONSIDERATIONS</u></p> <ul style="list-style-type: none"> <li>Consider impact on projected state expenditures for dual eligibles.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 1, 2011	<p><u>ISSUE</u></p> <p><b>§4104. REMOVAL OF BARRIERS TO PREVENTIVE SERVICES IN MEDICARE.</b></p> <ul style="list-style-type: none"> <li>Amends the Social Security Act to define preventive services covered by Medicare to mean a specified list of currently covered services, including colorectal cancer screening services even if diagnostic or treatment services were furnished in connection with screening</li> <li>Waives beneficiary coinsurance requirements for most preventive services, requiring Medicare to cover 100% of the costs.</li> <li>Specifies that services for which no coinsurance would be required are the initial preventive physical examination (IPPE), personalized prevention plan services, any additional prevention service covered under the authority of HHS, and any currently covered preventive service (including medical nutrition therapy, and excluding electrocardiograms) if it is recommended with a grade of A or B by the U.S. Preventive Services Task Force (USPSTF)<sup>7</sup></li> </ul> <p><u>LEGISLATIVE CONSIDERATIONS</u></p> <ul style="list-style-type: none"> <li>Consider impact on projected state expenditures for dual eligibles.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<p><u>ADDITIONAL RESOURCE DOCUMENTS</u></p> <ul style="list-style-type: none"> <li><b>Agency on Aging Document: Affordable Care Act Opportunities for the Aging Network,</b> <a href="http://www.aoa.gov/Aging_Statistics/docs/AoA_Affordable_Care.pdf">http://www.aoa.gov/Aging_Statistics/docs/AoA_Affordable_Care.pdf</a>.</li> </ul>

<sup>6</sup> "Personalized prevention plan services" means the creation of plan for an individual: (1) that includes a health risk assessment of the individual that is completed prior to or part of the same visit with a health professional; and (2) that takes into account the results of the health risk assessment.

<sup>7</sup> See the U.S. Preventive Services Task Force, <http://www.ahrq.gov/clinic/uspstfix.htm> .

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**FY 2011 TASKS**

Quality, Prevention & Wellness

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 1, 2011	<p><u>ISSUE</u></p> <p><b>§3011. NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE.</b></p> <ul style="list-style-type: none"> <li>▪ Directs the secretary to establish a national strategy for quality improvement in healthcare.</li> <li>▪ The secretary must collaborate with state agencies responsible for administering the Medicaid and CHIP programs with respect to developing and disseminating strategies, goals, models, and timetables.</li> <li>▪ The deadline for the initial submission of the strategy is no later than January 1, 2011.</li> </ul> <p><i>HEALTH CARE QUALITY INTERNET WEBSITE</i></p> <ul style="list-style-type: none"> <li>▪ Directs the secretary to create an internet website to make public information regarding the national priorities for healthcare quality improvement, agency specific strategic plans, and other pertinent information the secretary deems appropriate.</li> <li>▪ Implementation must be no later than January 1, 2011.</li> </ul> <p><u>LEGISLATIVE CONSIDERATIONS</u></p> <ul style="list-style-type: none"> <li>▪ Consider the state needs for dissemination of information beyond electronic means.</li> </ul> <p><u>RESOURCE DOCUMENTS</u></p> <ul style="list-style-type: none"> <li>▪ <b>HHS Proposed National Health Care Quality Strategy and Plan:</b>  <a href="http://www.hhs.gov/news/reports/quality/nationalhealthcarequalitystrategy.pdf">http://www.hhs.gov/news/reports/quality/nationalhealthcarequalitystrategy.pdf</a>.</li> </ul>

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STATE EMPLOYEE BENEFIT CHANGES

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jan. 2011	<p><u>ISSUE</u>  <b>TITLE IX—REVENUE PROVISIONS.</b>                      Imposes various restrictions on tax-advantaged accounts which are used to pay for unreimbursed medical expenses: health care Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs), Health Savings Accounts (HSAs), and Medical Savings Accounts (MSAs).</p> <p><u>LEGISLATIVE CONSIDERATIONS</u>  <b>Analyze and conform as necessary state employee benefit structures with the provisions in the new federal law concerning the following changes:</b></p> <ul style="list-style-type: none"> <li>▪ <b>DISTRIBUTION FOR MEDICINE QUALIFIED ONLY IF FOR PRESCRIBED DRUG OR INSULIN</b>                          § 9003—Starting in 2011, the PPACA will prohibit using funds from FSA, HAS, and MSA accounts for over-the-counter (OTC) medications (except insulin) unless they are prescribed by a physician beginning taxable years after December 31, 2010.</li> <li>▪ <b>INCREASES IN ADDITIONAL TAX ON DISTRIBUTIONS FROM HSAs AND ARCHER MSAs NOT USED FOR QUALIFIED MEDICAL EXPENSES</b>                          § 9004—Increases the penalties imposed for account withdrawals for nonmedical purposes for those under age 65 in two accounts. The penalty for nonmedical withdrawals from HSAs will increase to 20% from 10%, and the penalty for nonmedical withdrawals from MSAs will increase to 20% from 15%.</li> </ul> <p><u>RESOURCE DOCUMENTS</u></p> <ul style="list-style-type: none"> <li>▪ <b>IRS Document:</b> Sample article for organizations to use to reach customers and taxpayers  <a href="http://www.irs.gov/pub/irs-utl/oc - sept-mid_aca_cust_091710.pdf">http://www.irs.gov/pub/irs-utl/oc - sept-mid_aca_cust_091710.pdf</a></li> </ul>