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ANALYSIS OF THE HEALTH CARE REFORM LAW: PPACA AND THE RECONCILIATION ACT

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). On March 30, 2010, the Health Care and Education Reconciliation Act was enacted, the reconciliation law that made changes to the PPACA. After 18 months of legislative activity, preceded by decades of fits and starts, a major step forward was taken in reforming the country's health care system. Health care reform offers coverage for the majority of uninsured individuals in the United States and eventually will add up to 16 million individuals to the Medicaid program.

The National Health Law Program (NHeLP) analysis includes the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148) as well as the amendments made to PPACA by the Health Care and Education Reconciliation Act (Recon. Act, P.L. 111-152). For those of you who are looking for an integrated version of the PPACA, including the Manager's Amendment and the Reconciliation Act, an unofficial version is available at http://s3.amazonaws.com/thf_media/2010/pdf/ppaca-consolidated.pdf.

NHeLP has undertaken a comprehensive analysis of these laws. Given NHeLP's focus on Medicaid and CHIP, civil rights, reproductive health and justice, and empowering low-income beneficiaries and their advocates, we have concentrated our analysis on areas of the law most related to those areas and populations.

The Table of Contents identifies the sections that have been analyzed. In addition to this broad analysis, NHeLP will release more in-depth analyses on specific topics. We anticipate that these focused stand-alone analyses will cover topics such as Medicaid, children's health, health care disparities, reproductive health and health care for immigrants.

The analysis primarily focuses on Titles I and II of the law. We have divided the document into three parts:

- Part I includes an analysis of PPACA Title I, covering the private insurance reforms and state-based exchanges;
- Part II includes an analysis of PPACA Title II, covering changes to the Medicaid program; and
- Part III analyzes selected provisions from Titles III, IV, VI, XIII and IX.

Notes

When reading this analysis, "Secretary" generally refers to the Secretary of the Department of Health and Human Services, unless specifically noted otherwise.

A few other notes and abbreviations are relevant to this analysis:

Abbreviations of Laws:

- SSA refers to the Social Security Act
- PHSA refers to the Public Health Service Act, 42 U.S.C. § 300gg et seq.
- DRA refers to the Deficit Reduction Act
- CHIPRA refers to the Children's Health Insurance Program Reauthorization Act
- IRC refers to the Internal Revenue Code of 1986

Abbreviation of Terms:

- FMAP refers to the Federal Medical Assistance Percentage
- FPL refers to the Federal Poverty Level
- LIS refers to the Low Income Subsidy for Medicare Part D

Abbreviation of Federal Agencies or other Organizations:

- DHS – Department of Homeland Security
- SSA – Social Security Administration
- Treasury – Department of the Treasury
- NAIC – National Association of Insurance Commissioners

We have generally included effective dates for each section. However, it is important to recognize that many provisions will not be implemented without appropriations. Thus, the appropriations process is critical to ensuring that many of the Act's important provisions can be implemented.

If you have any questions about the analysis or need further information, please call NHeLP at (202) 289-7661, or e-mail Mara Youdelman at Youdelman@healthlaw.org.

And finally, much thanks to the NHeLP staff – in particular Mara Youdelman – who worked tirelessly to complete this analysis:

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We hope you find this analysis useful.

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TITLE II—ROLE OF PUBLIC PROGRAMS

Subtitle A—Improved Access to Medicaid

Subtitle B—Enhanced Support for the Children's Health Insurance Program

Subtitle C—Medicaid and CHIP Enrollment Simplification

Subtitle D—Improvements to Medicaid Services

Subtitle E—New Options for States to Provide Long-Term Services and Supports

Subtitle F—Medicaid Prescription Drug Coverage

Medicaid Coverage for the Lowest Income Populations, PPACA§§ 2001, 10201 and Recon. § 1201

When it was enacted in 1965, Medicaid eligibility was categorical in nature, meaning that applicants needed to fit within a recognized category, i.e. age, blindness, disability, or a family with children, and meet income thresholds tied to other public assistance programs (i.e. SSI, AFDC). Over the last 20 years, the categorical nature of the program has been moderated somewhat by provisions making some populations (e.g. children) eligible if their family incomes are below thresholds tied to the federal poverty level. When deciding eligibility, states determine "countable" income and resources and disregard (or ignore) certain income and resources. *See* 42 U.S.C. § 1396a(a)(10)(A).

Medicaid recipients have traditionally obtained services from Medicaid-participating health care providers or through Medicaid-participating managed care entities. In recent years, however, Congress has amended the Medicaid Act, 42 U.S.C. § 1396u-7, to give states the option to provide medical assistance to certain populations through benchmark or benchmark-equivalent coverage. Benchmark coverage is equal to one of the following:

- the standard Blue Cross/Blue Shield preferred provider option for federal employees in the state;
- a health plan that is offered and generally available to state employees in the state;
- coverage offered by the largest commercial, non-Medicaid HMO in the state; or
- Secretary-approved coverage.

Benchmark-equivalent coverage offers basic services (e.g. hospital, physician, preventive services) with an actuarial value equivalent to one of the benchmark benefit plans listed above and, for additional services, an actuarial value equal to at least 75 percent of the actuarial value of that additional service in the benchmark plan. Some population groups are exempted from mandatory enrollment in benchmark coverage, including individuals who qualify for medical assistance under the state plan because they are disabled, regardless of whether they are eligible for SSI, dually eligible individuals (entitled to Medicare and Medicaid), disabled children living at home under the "Katie Beckett" option, and institutionalized individuals. *Id*. at § 1396u-7(a)(2)(B). For an in-depth discussion of the benchmark coverage, *see* NHeLP, An Advocate's Guide to the Medicaid Program (updated ed. forthcoming summer 2010); NHeLP, *The Deficit Reduction Act of 2005*, HEALTH ADVOCATE 25-28 (Spring 2006).[1]

The PPACA adds new mandatory and optional coverage groups to the Medicaid program. This section describes these groups, the coverage that is available to them, federal payment and maintenance of effort requirements, and reporting requirements.

Mandatory Eligibility Expansion

[1] *See* http://www.healthlaw.org/index.php?option=com_content&view=article&id=134%3Ahealth-advocate-archive&catid=40&Itemid=191.

Beginning January 1, 2014, states must extend Medicaid to certain individuals whose incomes do not exceed 133 percent of the FPL applicable for the family size involved. To qualify, individuals must not be:

- over age 65;
- pregnant;
- entitled to or enrolled in Medicare Part A;
- enrolled in Medicare Part B; or
- described in any of the previously existing mandatory categorically needy groups set forth in § 1396a(a)(10)(A)(i).

§ 2001(a)(1) (adding 42 USC § 1396a(a)(10(A)(i)(VIII) (hereafter referred to as Subsection VIII). A conforming amendment increases the FPL eligibility threshold for children aged 6-19 from the current 100 percent to 133 percent of the FPL. § 2001(a)(5) (amending 42 U.S.C. § 1396a(l)(2)(C)). When determining income, the PPACA's newly enacted "modified adjusted gross income" ("MAGI") rules will be used for most people. Resource tests will not apply and a standard income disregard will be used. *See* § 2002, discussed below.

This coverage is significant because, for the first time, Medicaid will be extended to individuals below the income threshold without requiring a categorical link. Those most affected by Subsection VIII are very low-income childless, nondisabled adults and parents in some states that have very low income limits for parents.[2] "All rules applicable under the Medicaid program in general apply to this new eligibility group, including rules relating to cost-sharing and immigration status." CMS, *Dear State Health Official, Dear State Medicaid Director* (Apr. 9, 2010) (SMDL #10-005, PPACA #1), http://www.cms.gov/smdl/downloads/smd10005.pdf (hereafter *CMS April 9 Letter*).

Options for Early Coverage

Effective April 1, 2010, states can elect to provide early coverage to individuals described in Subsection VIII. § 2001(a)(4), as amended by § 10201 (adding 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(XX), 1396a(k)(2)). A state plan amendment will be needed, and CMS is expected to develop a pre-print template for states to use. A state can phase-in this eligibility based on income so long as it does not cover individuals with higher incomes before covering individuals with lower incomes. Also, if the individual to be enrolled is a parent or caretaker relative of a child under age 19 (or such higher age as a state may set), the individual cannot be enrolled into coverage unless the individual's child is enrolled. § 2001(a)(4); *CMS April 9 Letter*.

States can also use presumptive eligibility for this population group. If a state has elected the presumptive eligibility option for pregnant women[3] or children,[4] it can elect to provide

[2] For more details on which states have Medicaid or state-funded programs that cover adults, *see Where are States today? Medicaid and State Funded Coverage Eligibility Levels for Low-Income Adults*, Kaiser Commission on Medicaid and the Uninsured (Dec. 2009).

[3] *See* 42 U.S.C. § 1396r-1.

presumptive eligibility for individuals who are eligible under Subsection VIII. States also have the option to extend presumptive eligibility to individuals who are eligible for Medicaid under § 1931 (42 U.S.C. § 1396u-1), the provision that covers families who would have been eligible under the now-repealed AFDC rules. § 2001(a)(4) (adding 42 U.S.C. § 1396r-1(k)).

Beginning January 1, 2014, states may also elect to cover individuals who are under age 65 and are not described in previous optional categorically needy coverage groups and whose incomes *exceed* 133 percent of the FPL. The state will have the flexibility to set the income eligibility level under the state plan or a waiver of the plan. The state can phase in this coverage based on categorical group or income so long as the state does not cover individuals with higher incomes before covering individuals with lower incomes. Also, if the individual to be enrolled is a parent or caretaker relative of a child under age 19 (or such higher age as a state may set), the individual cannot be enrolled into coverage unless the individual's child is enrolled. § 2001(e) (adding 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(XX), 1396a(hh)).

Benchmark Coverage

Medicaid coverage for most Subsection VIII individuals will consist of the benchmark coverage or benchmark-equivalent coverage described in 42 U.S.C. § 1396u-7, unless the individual is listed in § 1396u-7 as exempt from mandatory enrollment. § 2001(a)(2) (adding 42 U.S.C. § 1396a(k)(1)). CMS has verified that individuals exempted from mandatory benchmark coverage by § 1396u-7(a)(2)(B) who become eligible under Subsection VIII must receive medical assistance under the state's currently approved state Medicaid plan. And, children made eligible under Subsection VIII must receive all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. *See CMS April 9 Letter*.

If a state opts to provide early coverage to Subsection VIII individuals, it will probably be required to use benchmark or benchmark-equivalent coverage, unless the individuals are among those excluded from mandatory enrollment. The PPACA provision establishing the option does not actually discuss this point. § 2001(a)(4). However, a subsequent "conforming amendment" provides that the medical assistance available to an individual "described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1) [the benchmark coverage]." § 2001(a)(5) (amending 42 U.S.C. § 1396a(a)(10), text following subparagraph (G)). Since the early coverage is being extended to individuals described in Subsection VIII, this conforming amendment would appear to control.

As noted above, the definition of benchmark coverage includes four options, including an option for Secretary-approved coverage.[5] Thus, one possibility exists for CMS to allow states to provide Subsection VIII individuals with full-Medicaid benefits by providing Secretary-approved benchmark coverage. Thus, it is possible states that elect the early coverage option prior to 2014 may be permitted to provide full Medicaid coverage for Section VIII individuals. Further clarification from CMS will be needed.

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[4] *See* 42 U.S.C. § 1396r-1a.

[5] *See* 42 U.S.C. § 1396u-7(b)(1)(d).

The new law makes some important amendments to the existing provisions governing benchmark coverage. These changes apply to both existing and future benchmark coverage options and are effective upon enactment of the PPACA. § 2001(c) (amending 42 U.S.C. § 1396u-7(a)(2)(B)). First, the list of required basic services for benchmark-equivalent coverage, which currently includes hospital, physician, laboratory and preventive services, is expanded to include coverage of prescription drugs and mental health services. Second, coverage of mental health benefits is updated to reflect parity requirements enacted in the Mental Health Parity Act. Benchmark or benchmark-equivalent coverage offered by an entity that is not a Medicaid managed care organization must comply with the requirements of § 2705(a) of the Public Health Service Act (PHSA). Thus, if the entity provides both medical/surgical benefits and mental health or substance use disorder benefits, it must ensure that the mental health or substance disorder benefits are subject to the same financial requirements and treatment limitations as the medical/surgical benefits. § 2001(c)(6) (adding 42 U.S.C. § 1396u-7(a)(2)(6)). Coverage provided to mandatory and optional categorically needy children under the state plan (those covered under 42 U.S.C. § 1396a(a)(10)(A)) will be deemed to be in compliance with the mental health services parity requirements if that coverage is the EPSDT services described in §§ 1396d(a)(4)(B) and 1396d(r) and provided is accordance with § 1396a(a)(43). *Id.*

Finally, effective January 1, 2014, all benchmark and benchmark-equivalent coverage must provide at least the "essential health benefits" [6] that will be available through exchanges. § 2001(c) (adding 42 U.S.C. § 1396u-7(a)(5)). Implementation of this coverage will thus need to be monitored closely to assure that covered benefits include services that are essential to people with disabilities and low-income populations.

Advocates may want to suggest that these coverage provisions establish a floor for state coverage. The PPACA requires the provision of "at least minimum essential services," § 2001(a)(2), and for benchmark benefits to consist of "at least minimum essential coverage." § 2001(c). Similarly, as of January 1, 2014, the benchmark coverage must provide "at least essential health benefits." *Id.* Moreover, the benchmark option allows states the flexibility to provide for coverage beyond the basic required services, particularly with the Secretary-approved coverage option. *See* 42 U.S.C. § 1396u-7. Additional clarification from CMS would be helpful.

Provisions for Federal Matching Payments

According to the new law, federal matching funds will not be made for the individuals described in Subsection VIII other than through benchmark or benchmark-equivalent coverage. § 2001(a)(2) (adding 42 U.S.C. § 1396b(i)(26)). This provision will need to be clarified by CMS because, as noted above, individuals exempted from mandatory benchmark coverage by § 1396u-7(a)(2)(B) who become eligible under Subsection VIII will receive medical assistance under the state's currently approved state plan.

The PPACA temporarily increases the federal medical assistance percentage (FMAP) for certain newly eligible Subsection VIII populations. A "newly eligible individual" is an

[6] For a discussion of "essential health benefits", *see* § 1302, *supra.*

individual described in Subsection VIII who is not under 19 years of age (or such higher age as the state may have elected) and who, as of December 1, 2009:

- was not eligible under the state plan or a waiver of the plan for full benefits;
- was not eligible for benchmark or benchmark-equivalent coverage or a plan that has a value of *at least* the value of the benchmark or benchmark equivalent plan; or
- was eligible but not enrolled (or was on a waiting list) for such benefits or coverage through a waiver that had a capped or limited enrollment that had been reached.

For most states and the District of Columbia, the FMAP amounts expended for medical assistance for newly eligible individuals will be equal to:

- 100 percent for calendar quarters in 2014-2016;
- 95 percent for calendar quarters in 2017;
- 94 percent for calendar quarters in 2018;
- 93 percent for calendar quarters in 2019; and
- 90 percent for calendar quarters in 2020 and each year thereafter.

Recon. Act, § 1201 (adding 42 U.S.C. § 1396b(y)(1)).

However, not all states will receive this level of federal matching funds. Some states, called "expansion states," already provide Medicaid or state-funded health coverage to Subsection VIII populations. The new law provides these states with some "equitable support" until 2019, when all states will receive the same enhanced FMAP for the childless adults described in Subsection VIII.

A state is an "expansion state" if, on the date of PPACA enactment, it offered "health benefits coverage" (which can be either Medicaid or a state-funded program), statewide, to parents *and* non-pregnant, childless adults whose incomes were at least 100 percent of the FPL[7] and the following was true:

- the benefit coverage included inpatient hospital services;
- it was not dependent on access to employer-sponsored coverage or contribution; and
- it was not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a Health Opportunity Account demonstration program authorized under 42 U.S.C. § 1396u-8.

A state that offered health benefits coverage only to parents *or* nonpregnant childless adults is not an expansion state. The expansion states include Arizona, Delaware, District of Columbia, Hawaii, Maine, Massachusetts, Minnesota, New York, Pennsylvania, Vermont, Washington and Wisconsin. However, for some of the states on this list the "expansion state" analysis will not apply. States that will provide Medicaid coverage and meet the definition of covering "newly

[7] For more information of adult Medicaid and state-funded programs and their eligibility levels, *see* footnote 2, Kaiser Commission on Medicaid and the Uninsured Fact Sheet.

eligible" Section VIII individuals will be eligible for the higher enhanced FMAP, not the FMAP applied to an "expansion state." For example, the District of Columbia is applying for the early state option to cover current enrollees in its state-funded non-Medicaid program as Section VIIII individuals. D.C's new Section VIII individuals will meet the definition of "newly eligible" because they were not Medicaid enrollees in the state plan or waiver prior to December 1, 2009. They were in a state-only funded health coverage program. Thus, even though D.C. is on the "expansion state" list, the expansion state FMAP rules will not apply.

Expansion states will receive additional federal matching funds for individuals described in Subsection VIII who are non-pregnant, childless adults[8] whom the state requires to enroll in benchmark coverage. Recon. Act, § 1201 (adding 42 U.S.C. § 1396d(z)(2)). For calendar quarters in 2014 and thereafter, the statute sets forth a formula that we think will operate as follows.

Step 1: Determine the gap between the regular FMAP that ordinarily would be due to the state and the percentage that non-expansion states receive for that year.

Step 2: Determine the transition percentage for the year in question. The transition percentages are as follows:

- 50 percent in 2014;
- 60 percent in 2015;
- 70 percent in 2016;
- 80 percent in 2017; and
- 90 percent in 2018.

Step 3: Determine the difference between these two percentages.

Step 4: Add the percentage obtained in Step 3 to the regular FMAP to arrive at the increased FMAP.

> Illustration for hypothetical expansion state Lincoln: Step 1: In 2014, Lincoln's FMAP would ordinarily be 60 percent. In 2014, nonexpansion states will receive 100 percent FMAP for the newly eligible groups. The gap is 40 percent. Step 2: The transition percentage for expansion states in 2014 is 50 percent. Step 3: Lincoln's FMAP will be increased to cover 50 percent of its 40 percent gap, or by 20 percent. Step 4: In 2014, Lincoln's FMAP is 80 percent (60 percent regular FMAP+ 20 percent gap).

[8] While the statute here specifies that the transition FMAP will be for new Section VIII enrollees who are childless adults, many parents may also be newly eligible under Section VIII, if their state has not covered parents up to 133% FPL in their Medicaid program. It is likely that expansion states will be able to obtain transition FMAP for new Section VIII Medicaid beneficiaries who are parents as well. Clarification from CMS or a legislative change may be needed.

During calendar year 2015, some expansion states will have 2.2 percent added to their increased FMAP. The Secretary will determine which states will receive the increased FMAP. Recon. Act, § 1201 (adding 42 U.S.C. § 1396d(z)(1)).

States that require political subdivisions to contribute toward meeting the state share of Medicaid expenditures will not receive any increase in the FMAP, under either the PPACA or under the existing enhanced FMAP provisions of the American Recovery and Reinvestment Act if they require any political subdivision to contribute a greater share toward expenditures for medical assistance or disproportionate share hospital payments than were required on December 31, 2009. This provision does not apply to voluntary contributions. PPACA, § 10201(c)(6).

Maintenance of Effort (MOE) Requirements

The PPACA includes a maintenance of effort provision to avoid having states drop coverage until the January 2014 effective date of Subsection VIII (and until 2019 for children). As a condition of receiving *any* federal funding, the states cannot implement "eligibility standards, methodologies, or procedures" under the state plan or a waiver that are more restrictive than the eligibility standards, methodologies, or procedures in effect on the date of PPACA enactment (March 23, 2010). For adult populations, the MOE lasts until the date on which the HHS Secretary determines that a "fully operational" exchange has been established in the state. For children under age 19 (or such higher age as a state may have elected), the MOE is extended through September 30, 2019. § 2001(b) (adding 42 U.S.C. §§ 1396a(a)(74), 1396a(gg)). Notably, a state will not be penalized if it is determining eligibility in accordance with the modified adjusted gross income requirements of the newly enacted 42 U.S.C. § 1396a(e)(14) (§ 2002, discussed below).

The MOE does not prohibit states from implementing less restrictive eligibility rules or from moving populations from coverage through a waiver to coverage through the state plan, so long as the eligibility requirements do not become more restrictive. § 2001(b)(4) (adding 42 U.S.C. §§ 1396a(a)(74), 1396a(gg)).

There is an exception to the MOE requirements for states in budget crisis. An affected state will need to certify to the HHS Secretary that it has a budget deficit for the current fiscal year or that the state is projected to have a budget deficit in the succeeding year. The certification will lift the MOE requirement for nonpregnant, nondisabled adults whose incomes exceed 133 percent of FPL line. The exception is available beginning January 1, 2011 and ends on December 31, 2013. § 2001(b) (adding 42 U.S.C. §§ 1396a(a)(74), 1396a(gg)).

Annual Reporting

Beginning January 2015, states must report annually to the HHS Secretary on the total number of enrolled and newly enrolled individuals, disaggregated by populations to show children, parents, non-pregnant childless adults, individuals with disabilities, elderly individuals, and such other categories as the Secretary may require. The reports must describe outreach and enrollment processes used by the state, along with other data requested by the Secretary to monitor enrollment and retention of eligible individuals. Beginning April 2015, the Secretary

will annually submit a report on the state activities, with recommendations, to the appropriate committees of Congress. § 2001(d) (adding 42 U.S.C. § 1396a(a)(75)).

Income Eligibility for Nonelderly Determined Using Modified Adjusted Gross Income, PPACA § 2002, Recon. § 1004

Medicaid eligibility is determined by looking at an individual's income and resources at the point in time when the application for medical assistance is filed or redetermined. Currently, states must establish reasonable standards – thresholds, procedures and methodologies – for determining whether an individual's income and resources qualify them for Medicaid. Under these rules, some types of income and resources are counted when determining eligibility, while others are disregarded or ignored. These disregards vary from state to state. Once established, eligibility is periodically redetermined.[9]

Except for the populations and services described below, the PPACA changes the method for determining income in Medicaid state plan and waiver programs and eliminates resource tests for these same populations. § 2002(a) (as amended by Recon. Act § 1004, adding 42 U.S.C. § 1396a(e)(14)). Moreover, the new provision, 42 U.S.C. § 1396a(e)(14), will be excluded from the Medicaid "reasonable standards" requirements of § 1396a(a)(17). § 2002(b).

New MAGI Rules

Effective January 1, 2014, states will use different income rules for determining Medicaid eligibility for most applicants (including, but not limited to, the Subsection VIII populations). Specifically, states must establish income eligibility by using "modified adjusted gross income" of an individual and, in the case of an individual in a family, the "household income" of the family. *Id.* (adding 42 U.S.C. § 1396a(e)(14)(A)). These terms are defined in the newly added Internal Revenue Code § 36B(d)(2),[10] and will also be applied to determine premium tax credits in the exchanges. *Id.* (adding 42 U.S.C. § 1396a(e)(14)(G)). The states must work with the HHS Secretary to establish their income eligibility thresholds using MAGI/household income that are not less than the income eligibility thresholds in effect on March 23, 2010, the date of enactment of the PPACA. *Id.* (adding 42 U.S.C. § 1396a(e)(14)(A)).

States' current income disregards policies will be replaced by a standard five percent income disregard. When determining eligibility based on MAGI, the state will determine the dollar equivalent of the difference between the upper income limit on eligibility (a percentage of the FPL) for the individual and the upper income limit increased by five percentage points and use as the applicable income of such individual an amount equal to the MAGI applicable to such individual reduced by that dollar equivalent amount. Recon. Act, § 1004(e) (further amending 42 U.S.C. § 1396a(e)(14)).

> Illustration for hypothetical expansion state Lincoln: Assume that in 2014, Lincoln's upper income limit is 133 percent of the FPL, equal to $15,000 for a Medicaid applicant.

[9] *See* 42 U.S.C. §§ 1396a(a)(10), 1396a(a)(17).
[10] For a discussion of IRC § 36B, *see* § 1401, *supra.*

The dollar equivalent of a five percent increase in the upper income limit would be $750 ($15,000 x .05). When determining income eligibility, the MAGI would thus be reduced by $750.

The Secretary can waive provisions of Medicaid and CHIP "as necessary to ensure that states establish income and eligibility determination systems that protect beneficiaries." *Id.* (adding 42 U.S.C. § 1396a(e)(14)(A)). By contrast, the Secretary cannot waive compliance with the new MAGI income requirements, except to the extent necessary to permit a state to coordinate eligibility requirements for dual eligible individuals and individuals who require an institutional level of care. § 2002(a) (adding 42 U.S.C. § 1396a(e)(14)(F)).

Populations and Services Exempt from MAGI

The use of the MAGI/household income rules will not be applied to certain populations and services. The following populations and services will continue to be subject to the current income rules, absent a waiver:

- individuals eligible on a basis that does not require determination of income by the state agency, including on the basis of receiving or being treated as receiving SSI and as a result of being or being deemed to be a child in foster care under the responsibility of the state;
- individuals who have attained age 65;
- individuals who qualify for Medicaid on the basis of being blind or disabled, or treated as such, without regard to whether the individual is eligible for SSI, including individuals eligible through the Katie Becket option;
- medically needy individuals; and
- individuals for whom Medicaid is paying Medicare cost-sharing amounts, including Qualified Medicare Beneficiaries.

Id. (adding 42 U.S.C. § 1396a(e)(14)(D)(i)). States using express lane eligibility[11] may rely on the express lane agencies' findings relating to eligibility. *Id*. (adding 42 U.S.C. § 1396a(e)(14)(D)(ii)). The provision does not apply to determinations of eligibility for subsidies under the Medicare Part D prescription drug benefit program. *Id*. (adding 42 U.S.C. § 1396a(e)(14)(D)(iii)). The provision also does not apply to Medicaid long-term care, including nursing facility services, home or community based waiver services, home health services, personal care services, and home and community based services for functionally disabled or elderly persons. *Id.* (adding 42 U.S.C. § 1396a(e)(14)(D)(iv)).

As noted in § 2001, the PPACA includes a maintenance of effort provision requiring states to maintain their eligibility levels for adults in Medicaid until the health insurance exchanges are fully operational (set for January 1, 2014), and for children until September 30, 2019. To comply with this provision during the transition period, the state, working with the HHS Secretary, will establish an equivalent income test that ensures that individuals eligible for

[11] *See* 42 U.S.C. § 1396a(e)(13).

Medicaid on March 23, 2010 would not lose coverage. States must submit information to the Secretary including the proposed income eligibility thresholds, the proposed methodologies, and procedures to be used to determine income eligibility using the new standard, and, if applicable, a state plan amendment to establish an optional eligibility category under new subsection 1396a(a)(10)(A)(ii)(XX). To the extent practicable, the state should use the same methodologies and procedures for making determinations as the state used on March 23, 2010. The Secretary must ensure that the proposed income eligibility thresholds, methodologies, and procedures will not result in making children ineligible who would have been eligible for Medicaid on March 23, 2010. *Id.* (adding 42 U.S.C. § 1396a(e)(14)(E)).

Finally, the PPACA includes a grandfathering provision. Individuals enrolled in Medicaid, as of January 1, 2014, who would be ineligible as a result of the application of the new income rules will remain eligible, with the same premiums and cost-sharing, through the later of March 31, 2014, or the date of the next regularly scheduled date for redetermination of eligibility. *Id.* (adding 42 U.S.C. § 1396a(e)(14)(D)(v)).

Implications on Medicaid Families using the New MAGI Rules

The move towards MAGI will likely have both positive and negative effects on beneficiaries. Some will certainly benefit, particularly from the elimination of the resource test. Others, however, may find themselves ineligible under the new rules. However, states are required to shift their income calculations to use MAGI, regardless of the MOE requirements. The problem is that some of the provisions of the PPACA are internally inconsistent. Thus, further clarification from CMS is needed about how this will be implemented.

The shift to the MAGI rules for beneficiaries in the Medicaid program will have a significant impact in three areas. First, MAGI, a concept based in the tax code, does not include disregards used by a majority of state Medicaid programs, such as earned income and child care disregards. Those disregards have been critical to bringing families with low earned income, often in jobs with no or unaffordable health insurance, and child care expenses into the Medicaid program. The new five percent income disregard noted above will be helpful to individuals and families, but is not likely to fully offset the elimination of the earned income and child care disregards for most Medicaid recipients.[12] However, MAGI allows for deduction of other income or expenses not currently deducted by most state Medicaid programs. Deductions available under MAGI include alimony and educational expenses such as student loans.[13]

Second, use of MAGI requires a different analysis of what will be *countable* gross income. Under the IRS/tax model, certain income will not be countable as gross income. This will include SSI and Social Security Survivors benefits in certain circumstances and child

[12] For more information on the Medicaid eligibility levels and current earned income disregards by state, *see* Tables 3 and 3A, *A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009*, Kaiser Commission on Medicaid and the Uninsured and the Center on Budget and Policy Priorities (December 2009).

[13] For a more full description of the deductions offered under MAGI, *see* § 1401(a).

support.[14] These new countable gross income rules will likely benefit Medicaid recipients, allowing certain income to be excluded, which currently is counted by some Medicaid programs.

Third, family size under MAGI is defined as who is filing taxes together.[15] This will be a change for some current Medicaid households. Under the MAGI rules, if a step-parent is in the family and they file taxes together, the step-parent will be included in the family unit and the income will be counted. This contrasts with the current Medicaid rules which allow a step-parent to be excluded from a family unit as well as excluding the individual's income. Similarly, a grandparent or kinship caregiver who may be excluded from the family unit and have her income excluded under a state's current Medicaid rules may be included in the family unit and have the income counted, assuming the individual is filing taxes and counting the grandchild or kinship child as a dependent for tax purposes.

The implication of this provision is significant. Further, this provision has generated some confusion because, as discussed above, the new law repeatedly instructs states to develop eligibility standards that will not cause individuals who would be eligible on March 23, 2010, to lose eligibility. States also may not establish rules that will result in current Medicaid child beneficiaries losing coverage. Thus, further clarification from CMS is needed about how this provision will be implemented.

Extension of Premium Assistance for Employer-Sponsored Insurance, PPACA §§ 2003, 10203

This section extends the state option to provide premium assistance to all Medicaid recipients and their families, amending 42 U.S.C. § 1396e-1. Previously, the option to provide premium assistance to employer-sponsored insurance was available only for children on Medicaid. The PPACA provides that Medicaid recipients and parents of Medicaid recipients (where the recipient is under 19) may be eligible for premium assistance for employer-sponsored coverage. The state is not required to provide premium assistance to its Medicaid program recipients but may elect this option to do so. Further, should a state elect this option, individual applicants are free to decide if they want to apply for premium assistance.

The premium assistance subsidy for Medicaid recipients must also be cost-effective, as defined by the CHIP program. To determine if the premium assistance is cost-effective, the cost of the premium assistance subsidy is compared to the cost of providing coverage to an individual and/or family under CHIP, including administrative expenses or the aggregate cost of providing coverage under CHIP, including administrative expenses.[16]

Effective date: January 1, 2014.

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[14] For more details on countable gross income, *see* IRS Publication 54, Tax Guide for U.S. Citizens and Resident Aliens Abroad (2009); IRS Publication 17, Your Federal Income Tax for Individuals (Nov. 2009).

[15] See § 1401(a), establishing new § 36B of the IRC.

[16] "Cost-effective" is defined in CHIP at 42 U.S.C. § 1397ee(c)(3)(A).

Medicaid Coverage for Former Foster Care Children, PPACA §§ 2004, 10201

After January 1, 2014, states must provide Medicaid coverage to individuals under the age of 26 who were in foster care and:

- who are not described or enrolled in any of the previous subclauses in the Medicaid Act (I through VII);[17] or
- who are described in any of the previous subclauses (I through VII), but have income that *exceeds* the allowable income for eligibility pursuant to the state plan for those categories; and

Further, these individuals must have been under the responsibility of the state on the date of attaining 18 years of age (or higher age as the state may have elected). To enroll in or maintain Medicaid eligibility, these individuals must have been enrolled in Medicaid through the state plan or a waiver while in foster care. §§ 2004(a), 10201(a) (amending 42 U.S.C. § 1396a(a)(10)(A)(i), by establishing a new section IX).

This provision will provide a critical benefit to former foster care children, who until 2014 can only receive Medicaid coverage to the age of 21. Because former foster care children between the ages of 21 and 26 are likely to be pursuing higher education or starting a new career, neither of which guarantees health care coverage, the access to Medicaid benefits will be significant to obtaining needed health care services and maintaining a healthy lifestyle. The provision offers them a benefit that is similar to the one provided up to age twenty-six to dependent children of parents with private health insurance.

States have the option to offer presumptive eligibility to this population. § 2004(b) (amending 42 U.S.C. § 1396r-1(e)).

Effective date: January 1, 2014.

Payments to Territories, PPACA §§ 2005, 10201, Recon. Act § 1204

The territories receive both a capped level of funding and a FMAP. FMAP is the federal payment to a state for Medicaid services covered by the state, issued to each of the 50 states, plus the District of Columbia. The amount of the state's FMAP is adjusted annually and depends on the per capita income of the state. States with lower per capita incomes receive a higher FMAP, which range from 50 to 83 percent.[18] The 50 states and the District of Columbia do not have a cap on federal Medicaid funding that it can receive through FMAP.

[17] Amending 42 U.S.C. § 1396a(a)(10)(A)(i), by establishing a new section IX. Note the newly established Section VIII is the newly eligible Medicaid recipients up to 133% of household income established in § 2001(a).

[18] States have been receiving an enhanced FMAP since October 1, 2008 under the American Recovery and Reinvestment Act (ARRA). Those enhanced FMAP rates are set to expire on December 31, 2010.

This section establishes a payment cap of $6.3 billion of federal Medicaid funds to the territories[19] between July 1, 2011, and September 30, 2019, amending 42 U.S.C. § 1308(g). In addition, the FMAP for the territories is increased from 50 to 55 percent, amending 42 U.S.C. § 1396d(b). The FMAP increase takes effect July 1, 2011.

While the FMAP increase will provide additional financial resources to the territories to increase access to Medicaid, it does not achieve parity between the territories and the states. Territories will be awarded FMAP until the cap of $6.3 billion is reached. After the federal funding cap is reached, the territories could continue coverage by using local funding or establishing an enrollment cap and waiting list.

In addition, a territory may be treated as a state for purposes of electing to implement an exchange, or if the territory does not elect to implement an exchange, the payment cap may be increased. One billion dollars is allocated to pay for tax credits and cost-sharing reductions should a territory elect to establish an exchange between 2014 and 2019. Recon. Act § 1204, adds PPACA § 1323. This provision became effective on the date of enactment, March 30, 2010.

Special FMAP Adjustment for States Recovering from a Major Disaster, PPACA § 2006

This section allows an increase in FMAP for states that are disaster-recovery states. States qualify for increased FMAP funds if the President has declared a major disaster in the preceding seven fiscal years, and, as a result of that disaster, every county or parish received disaster relief from the federal government or other "individual and public assistance."[20] This section amends 42 U.S.C. § 1396d, by adding a new subsection (aa). The FMAP disaster-recovery adjustment does not apply to:

- disproportional share hospital payments (DSH);
- CHIP enhanced FMAP or other CHIP payments; or
- payments under the Temporary Assistance for Needy Families (TANF) program, except for foster care and adoption assistance under Title IV, Part E of the Social Security Act.

Effective date: January 1, 2011.

Medicaid Improvement Fund Rescission, PPACA § 2007

However, legislation is currently pending in Congress to continue the enhanced FMAP rates through June 30, 2011.

[19] The territories include: Puerto Rice, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

[20] The statutory language is unclear. Eligibility is determined by a Presidential declaration of a major disaster and determined that "as a result of such disaster that every county or parish in the state warrant individual and public assistance or public assistance from the Federal government. . .". PPACA § 2006, adding new subsection (aa)(2) to 42 U.S.C. § 1396d.

This section rescinds any unobligated monies in the Medicaid Improvement Fund (Fund) for fiscal years 2014 through 2018. The Fund was established to improve the management of the Medicaid program, including oversight of contracts, contractors and evaluations of demonstration project.[21] Eliminating this fund would save $10 million in fiscal year 2014 and $150 million each year for fiscal years 2015 to 2018.

Effective date: March 23, 2010.

Additional Federal Financial Participation for CHIP, PPACA § 2101

This section provides states with enhanced FMAP and increased federal financial participation of 23 percent for the period beginning October 1, 2015, through September 30, 2019. Note that the total FMAP plus enhanced match cannot exceed 100 percent. §§ 2101(a) (amending 42 U.S.C. § 1397ee(b)), 10203(c).

More importantly, this section establishes for the first time a maintenance-of-effort (MOE) requirement in the CHIP program in addition to extending the date of the Medicaid MOE beyond December 31, 2010, as provided by ARRA.[22] The provision relating to CHIP requires that states, as a condition of receiving payment until September 30, 2019, maintain eligibility standards, methodologies, or procedures under the state child health plan (including any waivers), for children that were in place as of enactment of PPACA, and prevents them from instituting more restrictive eligibility standards, methodologies or procedures under such plan than those in effect at the time of enactment. States that violate the CHIP or Medicaid MOE will forego all of their federal Medicaid funding, not just the enhanced funding. However, states are not prohibited from applying less restrictive eligibility standards, methodologies, or procedures for children under the state child health plan than were in effect on the date of the PPACA enactment, nor from imposing restrictions that limit expenditures under the state health plan for which federal financial participation is available. §§ 2101(b) (amending 42 U.S.C. § 1397ee(d)), 10203(c).

This provision places enormous financial pressure on states to maintain their eligibility standards for CHIP given the significant amount of federal Medicaid funding they receive, which would be jeopardized if they make modifications (the one exception is a state offering Medicaid coverage to adults with incomes above 133 percent FPL may scale back adult eligibility if the state is experiencing a budget deficit).[23] Among the possibilities that states would ordinarily consider is scaling back income eligibility, dropping legal immigrants from Medicaid or CHIP coverage, and instituting new paperwork requirements. These are likely to be precluded with the MOE provision. Because the MOE is limited to eligibility standards, states may consider cuts to benefits offered in their Medicaid and CHIP programs as an alternative means to limiting funding during the recession. Note that this MOE is substantially different that the ARRA MOE because it impacts *all* federal Medicaid funding, not simply the additional Medicaid fiscal relief that ARRA provided.

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[21] 42 U.S.C. 1396w-1.
[22] The American Recovery and Reinvestment Act of 2009, P.L. 111-5.
[23] *See* § 2001, *supra.*

This section also provides that if CHIP allotments are insufficient to cover all eligible, targeted low-income children under the state child health program, states must establish procedures to screen and enroll eligible children into Medicaid through the state plan or a waiver. If children are found ineligible for Medicaid, the state must ensure that these children are provided enrollment in a qualified health plan through a state exchange. For purposes of eligibility for premium assistance for a qualified health plan, the children described above are deemed ineligible for CHIP. PPACA § 2101(b) (amending 42 U.S.C. § 1397ee(d)), § 10201(g)). This provision is effective in 2015.

The HHS Secretary is instructed to review benefits offered for children and cost-sharing imposed with respect to qualified health plans in the exchange, and certify that they are at least comparable to benefits offered and cost-sharing protections provided by the state's CHIP program. § 10203(c) (amending 42 U.S.C. § 1397ee(a)(3)(F)(iii)).

The section also explains that for children enrolled in Medicaid and CHIP after October 1, 2013, there will no longer be performance bonuses paid to states. In the Children's Health Insurance Program Reauthorization Act (CHIPRA),[24] states were offered performance bonuses to encourage greater enrollment of Medicaid-eligible children. Those that implemented at least five of eight simplification procedures and increased enrollment beyond a target level received additional federal payment between 15-62 percent of the projected per capita state Medicaid expenditures for the fiscal year. §§ 2101(b)) (amending 42 U.S.C. § 1397ee(d)), (c) (amending 42 U.S.C. § 1397ee(a)(3)(F)(iii)).

Another important part of this section establishes the use of modified adjusted gross income and household income, as defined by IRC § 36B(d)(2),[25] for purposes of determining CHIP eligibility and the imposition of premiums and cost-sharing, beginning January 1, 2014. This conforms CHIP to Medicaid to the financial assistance for premiums and cost-sharing in the Exchange. § 2101(d) (amending 42 U.S.C. § 1397bb(b)(1)(B)). This provision becomes effective January 1, 2014.

Finally, the provision adds the application of streamlined enrollment system, originally described in the Balanced Budget Act of 1997, to the coordination of the state exchanges and the state Medicaid Agency. The section also states that children found ineligible for Medicaid as a result of the elimination of income disregards will be treated as targeted low-income children and provided access to their state's CHIP program. This will offer an important safety-net for children who may become ineligible for Medicaid during the application of the new MAGI rules discussed above at § 2002. §§ 2101(e) (amending 42 U.S.C. § 1397gg(e)(1)), (f). This provision becomes effective January 1, 2014.

Technical Corrections, PPACA § 2102

[24] P.L. 111-3.
[25] For a discussion of IRC § 36B, *see* § 1401, *supra.*

This section offers technical modifications to CHIPRA and ARRA. One noteworthy change involves increasing the fiscal year 2010 CHIP allotment for Medicaid expansion programs for coverage of children with incomes below 200 percent FPL from birth through age five. The increase reflects the enhanced FMAP rate, offered to CHIP programs, rather than the FMAP Medicaid rate, which states typically receive when they cover this population under Medicaid. § 2102(a).

Additionally, this section strikes the term "legal residents" from one section of CHIPRA and replaces it with "lawfully residing in the United States." The technical correction was to synchronize the terminology with a different provision of CHIPRA. § 2102(a). The result reduces the likelihood that individuals would have been denied eligibility due to the use of different terminology in related sections.

This section is effective as if it were included in the original CHIPRA and ARRA legislation.

Enrollment Simplification and Coordination with State Health Insurance Exchanges, PPACA § 2201

This provision requires that in order to receive any federal financial assistance for Medicaid after January 1, 2014, states must establish procedures that do the following:

- enable individuals through a website to apply for Medicaid under the state plan or a waiver, to be enrolled, to renew enrollment, and to consent through an electronic signature;
- enroll individuals identified through an exchange as eligible for Medicaid/CHIP without further determination by the state;
- ensure that children determined to be ineligible for Medicaid/CHIP be screened for eligibility for enrollment in qualified health plans offered through an exchange as well as premium assistance; these children should be enrolled in such a plan without having to submit an additional application and should receive information about reduced cost-sharing options;
- ensure that state agencies for Medicaid, CHIP and an exchange utilize secure electronic interfaces for determination of eligibility;
- coordinate the provision of services for Medicaid/CHIP enrollees for those who are also in a qualified health plan in an exchange;[26] and

[26] It is likely in only very limited circumstances that an individual would be enrolled in Medicaid/CHIP and also in a qualified health plan in an exchange. It is likely that this applies only when Medicaid/CHIP is providing premium assistance to a Medicaid/CHIP beneficiary to enroll in a qualified health plan. Further clarification from HHS or CMS on the application of this provision will be necessary. When this does occur, the coordination includes Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Ensuring access to EPSDT services is critical for all children, but especially to low-income children in Medicaid and CHIP, many of whom need comprehensive services not traditionally offered by private health plans.

- conduct outreach to and enroll in Medicaid/CHIP vulnerable and underserved populations, including unaccompanied homeless youth, children with special health care needs, pregnant women, racial and ethnic minorities, rural populations and individuals with HIV/AIDS. § 2201(b) (amending 42 U.S.C. § 1397aa).

This provision is critical for several reasons. With § 1413, this provision seeks to conduct outreach to vulnerable populations, simplify, and coordinate enrollment in Medicaid, CHIP and qualified health plans in a state exchange using electronic means.

Additionally, this provision allows the state Medicaid/CHIP agency to enter into an agreement with the exchange to determine whether a state resident is eligible for premium assistance for purchase of a qualified health plan. The agreement must meet the conditions determined by the Secretary of the Treasury to reduce administrative costs, likelihood of eligibility errors and disruptions in coverage.

The state Medicaid/CHIP agencies are required to participate in and comply with the requirements of the streamlined enrollment system under PPACA §1413. States are required to have the enrollment website established and in operation no later than January 1, 2014, and linked to any exchange website and also the state CHIP agency (if different from the state Medicaid agency). The website should include information that allows individuals who are eligible for both Medicaid and premium assistance for purchasing a qualified health plan to compare benefits, premiums and cost-sharing under the various options.

The website offers applicants and beneficiaries a valuable resource for comparing various options, and also an opportunity to apply electronically, possibly in the comfort of their own homes, without mailing the application or visiting a welfare office, as was required in Medicaid several years ago. Alongside that important feature is the ability to obtain application assistance from a live person; while nothing in the statute provides for that, it is critical in the implementation phase that advocates express the need for such assistance.

Effective date: January 1, 2014.

Permitting Hospitals to Make Presumptive Eligibility Determinations for All Medicaid Eligible Populations PPACA § 2202

This section authorizes states to allow Medicaid-participating hospitals to serve as qualified entities and make presumptive eligibility determinations in the same manner and subject to the same requirements as described in 42 U.S.C. §§ 1396r-1, 1396r-1a and 1396r-1b. The ability of Medicaid-participating hospitals to determine presumptive eligibility for all Medicaid-eligible individuals greatly expands the outstationing function already performed by many hospitals and gives countless low-income individuals access to Medicaid-covered services at the point of service, their local hospital.

Medicaid payments attributable to erroneous presumptive eligibility determinations will not be included to determine which expenses qualify for federal financial participation. § 2202(a) (amending 42 U.S.C. § 1396a(a)(47)).

Effective date: January 1, 2014.

Coverage for Freestanding Birth Center Services, PPACA § 2301

The PPACA amends 42 U.S.C. § 1396d(a) by adding a new subsection that explicitly makes services provided in freestanding birth centers are part of the care and services and covered as "medical assistance" in the Medicaid program.

Freestanding birth centers are facilities separate from hospitals that are licensed by the state to provide prenatal, labor and delivery, and post-partum care. The PPACA recognizes health professionals such as nurse midwives, birth attendants and other professionals who are licensed by the state. So long as they are recognized and licensed under state law and are operating within their authorized scope of practice, they are not required to be supervised by a physician. PPACA § 2301(a)(2) (adding 42 U.S.C. § 1396d(l)(3)(B), (C)). The covered services must be provided at a freestanding birth center and are not covered when provided at a home birth.

Nurse-midwife and certified nurse-midwife services are explicitly covered services in the Medicaid program, 42 U.S.C. § 1396d(a)(17). The question of whether freestanding birth center services were covered arose when CMS denied a Texas State Plan Amendment. Since 1987, Texas' State Plan Amendment(s) have covered freestanding birth center services as clinics under 42 U.S.C. § 1396d(a)(9). However, in 2008, CMS reversed itself and denied Texas's State Plan Amendment, which recognized birth center facility services as medical assistance. The Texas Human Services Agency appealed, but the Administrative Hearing Officer upheld the CMS decision, finding that CMS acted within its discretion. Reconsideration of Disapproval of Texas State Plan Amendment 07-0111/Non-Compliance Determination (Apr. 15, 2009). In response, The Medicaid Birth Center Reimbursement Act, H.R. 2358 (2008), was introduced to explicitly cover freestanding birth centers. That legislation was incorporated into the PPACA.

This provision became effective immediately. In states where legislation is required to implement this section, states will not be considered out of compliance until the first quarter following the close of the state's next legislative session. PPACA § 2301(c)(2).

Effective date: March 23, 2010.

Concurrent Care for Children, PPACA § 2302

Terminally ill patients enrolled in Medicaid can elect to receive hospice care in a hospice facility or at home. The election to receive hospice care also includes agreement to limits on the medical treatment to which the person is entitled. 42 U.S.C. § 1396d(o)(1)(A). States may also set a time limit for the provision of hospice care.

The PPACA specifies that the election of hospice care for a terminally ill child does not waive the child's right to any treatment for the child's terminal condition. PPACA § 2302(a) (amending 42 U.S.C. § 1396d(o)(C)).

This provision also applies to children enrolled in the Children's Health Insurance Program. PPACA § 2302(b) (amending 42 U.S.C. § 1397jj(a)(23)).

State Eligibility Option for Family Planning Services; Payments to Primary Care Physicians, **PPACA § 2303, Recon. § 1202**

Under 42 U.S.C. § 1396d(a)(4)(C), state medical assistance must cover "family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the state plan and who desire such services and supplies."

Twenty-seven states have extended family planning services through § 1115 demonstration projects ("waivers") to individuals who are not otherwise eligible for Medicaid. Twenty-one states extend eligibility solely on the basis of income. Guttmacher Institute, State Policies in Brief, *State Medicaid Family Planning Eligibility Expansions as of April 1, 2010* (2010). These demonstration projects vary widely in the scope of services and the populations who are eligible for services. The PPACA creates a new state option to extend family planning services and supplies to individuals based solely on income through a state plan amendment rather than a waiver. States can establish income eligibility up to the higher of the maximum income eligibility for pregnant women in the state Medicaid program or in the state Children's Health Insurance Program. In determining eligibility, the state may only consider the income of the individual. PPACA § 2303(a)(2) (amending 42 U.S.C. § 1396a(ii)(3)). The statute refers to "individuals," and therefore would allow states to provide services and supplies to both men and women. In addition, there is no age restriction for eligibility, and states can include adolescents in their family planning expansions. States further have the option of extending coverage to individuals who would have been eligible under a § 1115 demonstration project based on the criteria in place as of January 1, 2007. This provision will allow states to maintain income eligibility that was in place under its § 1115 demonstration project, which exceeded the income levels for pregnant women.

The benefits under this state option are limited to "family planning services and supplies." 42 U.S.C. § 1396a(4)(C). While "family planning services and supplies" remains undefined in the statute, the PPACA adds new language that allows states, under this new option, to include among the services provided "diagnosis and treatment services provided during a family planning service visit in a family planning setting." PPACA § 2303(a)(3).

This provision does not change a state's ability to submit a request to CMS to implement a §1115 demonstration project that provides services or establishes eligibility that exceeds the limits of the new state option.

Presumptive Eligibility for Family Planning Services and Supplies

The PPACA adds a new state option to provide presumptive eligibility for family planning services and supplies for individuals who qualify for the new family planning expansion. PPACA § 2303(b)(1). The presumptive eligibility period begins when a qualified entity determines that an individual would qualify for services based on preliminary information, and ends when either the individual is determined to be either eligible or not eligible based on an application for medical assistance, or, if the individual does not submit an application, the last day of the month following the month in which the entity determined the individual to be presumptively eligible. The mechanism for presumptive eligibility for family planning services and supplies is substantially the same as presumptive eligibility for pregnant women,[27] children,[28] and certain breast and cervical cancer patients.[29]

Requiring Coverage for Family Planning Services and Supplies in Benchmark Plans

In 2005, the Medicaid program was amended by the Deficit Reduction Act of 2005 (DRA),[30] to allow states to enroll certain Medicaid beneficiaries into "benchmark" or "benchmark equivalent" plans. These plans can have a defined set of benefits that is less than what the state is offering in its Medicaid program so long as the coverage is at least equal to the coverage in certain plans offered in the state (the "benchmarks"). See the discussion of benchmark plans in § 2001, *supra*. Certain benchmark plans, in contrast to traditional Medicaid, were not required to include coverage for family planning. 42 U.S.C. § 1396u-7(b)(2). In addition, benchmark plans are allowed to impose premiums and cost-sharing. When CMS finalized rules regarding benchmark and benchmark-equivalent coverage, it required that family planning services and supplies to be covered in "benchmark equivalent" coverage and suggested that Secretary-approved benchmark coverage would have to include coverage of family planning to be considered appropriate for individuals for child-bearing age.[31] And on June 16, 2006, CMS issued guidance on implementing the DRA and clarifying that no cost-sharing may be imposed for family planning services and supplies. CMS State Medicaid Director Letter SMDL #06-015.

Further, the PPACA requires that benchmark plans cover family planning services and supplies. PPACA §§ 2303(c). The CMS rule also references this provision and indicated that the agency will be promulgating a second final rule to take into account this change.

Effective date: March 23, 2010.

Payments to Primary Care Physicians

The Reconciliation law amends § 2303 to also increase payments for certain services to Medicaid primary care providers (with a primary specialty designation in family medicine, general internal medicine or pediatric medicine). The rates will be equal to the payment rates of Medicare primary care providers for FY 2013 and 2014.

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[27] *See* 42 U.S.C. § 1396r-1.
[28] *See* 42 U.S.C. § 1396r-1a.
[29] *See* 42 U.S.C. § 1396r-1b.
[30] *See* 42 U.S.C. § 1396u-7.
[31] 75 Fed. Reg. 23068 (April 30, 2010).

The services covered for fee-for-service are:

- evaluation and management services that are procedure codes (for services covered under Title XVIII) for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December 31, 2009, and as subsequently modified); and
- services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system.

The increased payments also apply to providers in Medicaid managed care. The law increases a state's FMAP to cover 100 percent of these costs.

Because of cost considerations, this provision is limited to two years, FY 2013 and 2014. Increasing provider rates, particularly among primary care providers, is seen as a pivotal step to addressing access issues for Medicaid beneficiaries. Often providers state that they do not accept Medicaid because the reimbursement rates are so low. Access to a provider will become an even more important issue as the PPACA expands Medicaid eligibility for an estimated 16 million more individuals. Bringing primary care provider rates at least to the level of Medicare reimbursement is a first step in addressing this access issue. Depending on an evaluation of its implementation, Congress may decide to extend the provision beyond FY 2014.

Clarification of Definition of Medical Assistance, PPACA § 2304

The PPACA amends the Medicaid Act to clarify that "[t]he term "medical assistance" means payment of part or all of the cost of the following care and services *or the care and services themselves, or both,. . .*" § 2304 (amending 42 U.S.C. § 1396d(a) (emphasis added).

The clarification responds to recent federal court decisions that focused exclusively on the Medicaid Act's reference to medical assistance as payment and held that states had no responsibility under the Act other than to pay bills if they were submitted.[32] This reading of the

[32] *See Equal Access for El Paso v. Hawkins*, 562 F.3d 724 (5th Cir. 2009); *Okla. Chap. of the Am. Acad. of Pediatrics v. Fogerty*, 472 F.3d 1208 (10th Cir. 2006); *Westside Mothers v. Olszewski*, 454 F.3d 532 (6th Cir. 2006).

federal law conflicted with legislative history.[33] The court decisions also rendered numerous Medicaid statutory and regulatory provisions meaningless.[34] The legislative history explains:

> Some recent court opinions have … questioned the longstanding practice of using the term "medical assistance" to refer to both the payment for services and the provision of the services themselves. These opinions have read the term to refer only to payment; this reading makes some aspects of the rest of Title XIX difficult…. To correct any misunderstandings as to the meaning of the term, and to avoid additional litigation, the bill would revise section 1905(a) [1396d(a)] to read in relevant part: "The term 'medical assistance' means payment of part or all of the cost of the following care and services or the care and services themselves, or both." This technical correction is made to conform the definition to the longstanding administrative use and understanding of the term. It is effective on enactment.[35]

The clarifying revision in no way changes the responsibilities states assume when they accept federal Medicaid funds, as those responsibilities had until lately been universally understood. The clarification also does not require states to directly provide medical services by establishing state-owned or operated facilities or employing providers. It does, however, re-affirm the states' obligations as commonly understood prior to the recent circuit court decisions.

Community First Choice Option, PPACA § 2401, Recon. Act § 1205

This provision creates a state option to provide home and community based attendant care and support services for individuals up to the greater of 150 percent FPL or the state income limit for eligibility for nursing facility or equivalent services under the state plan.[36] States may adopt the Community First Choice Option starting October 2011. Individuals are eligible if they are nursing facility clinically eligible[37] (NFCE) and meet the income limit. Eligible individuals

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[33] *E.g.*, H.R. Rep. No. 247, 101st Cong., 1st Sess. 398-399 (1989), *reprinted in* 1989 U.S.C.C.A.N. 2124-25 (stating that "*each state must provide*, at a minimum, … EPSDT *services*"); S. Rep. 89-404, S. Rep No. 404, 89th Cong., 1st Sess. 1965, *reprinted in* 1965 U.S.C.C.A.N. 1943, 1950-51 (stating "best interest of recipient" provision, 42 U.S.C. § 1396a(a)(19), was meant to assure "the State will not administer the provisions for services in a way which adversely affects the availability or the quality of the care to be provided").

[34] *E.g.*, 42 C.F.R. § 440.210(a) ("A State plan must specify that, at a minimum, categorically needy recipients *are furnished* the following services…."); *Id.* at § 440.220 (same, with respect to medically needy beneficiaries) (emphasis added).

[35] H.R. Rep. No. 111-299, 1st Sess., at 649-50, 2009 WL 3321420 (Leg. Hist.) (Oct. 14, 2009); 156 Cong. Rec. H1854, 1856, 2010 WL 1006359 (Mar. 21, 2010) (statement of Rep. Waxman); *Id.* at H1891, 1967, 2010 WL 1027566 (Mar. 21, 2010).

[36] States are permitted to allow eligibility for nursing facility or equivalent HCBS waiver services up to 300 percent of the SSI level (currently equal to about 225 percent FPL). States which do this already would be permitted to set their Community First Choice Option income limit at the default 150 percent FPL limit or the higher 300 percent of SSI level.

[37] NFCE refers to an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the state plan. Due to ambiguous statutory drafting at PPACA § 2401(k)(1), the statute can be read to apply the NFCE requirement only to the population above 150

can receive a broad range of services to assist with ADLs,[38] IADLs,[39] or health-related tasks.[40] Services must be provided according to a care plan, with significant consumer participation, and in a home or community setting. The provision lists available services, including some explicitly included and excluded services. A state's FMAP is increased six percentage points for these services.

The provision lists specific process requirements for a state to implement this option. For example, the option must be implemented in collaboration with a Development and Implementation Council in the state, which must include elderly individuals and people with disabilities. Other requirements create further protections for consumers, ensure adequate state spending and quality, and require reporting. The Secretary is required to conduct an evaluation of services under this provision, collect data from state reports, and make interim and final public reports to Congress.

This provision is significant because there are limited alternatives to institutional care for consumers who need personal care services. Some states do not have home and community based services (HCBS) waiver programs that provide services that could be offered under this option. Other states may have HCBS waiver programs but may lack available slots since the waiver process includes a budget neutrality requirement that constrains a state's ability to extend these services to the full population in need of services.[41] As a state plan service under this provision, in contrast, the state will receive federal matching funds for all the individuals to which it chooses to extend coverage. States will have the option to provide this to the NFCE population, and in states that implement the option, this population will have a definite alternative to institutionalization. Most importantly, states have a strong incentive to participate, given the six-point increase in federal matching funds.

This provision gives states a new significant option to provide services to NFCE individuals in their home and community environment. Note this funding may also be used to help transition an institutionalized individual to community based settings where the individual would then be eligible for services under the State Plan, and could pay for a wide range of related expenditures such as:

- rent and utility deposits;

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percent FPL, and not to the population up to 150 percent FPL. It is likely Congress intended to apply the NFCE requirement to all individuals.

[38] Activities of Daily Living, defined at PPACA § 2401(k)(6)(A), include "tasks such as eating, toileting, grooming, dressing, bathing, and transferring."

[39] Instrumental Activities of Daily Living, defined at PPACA § 2401(k)(6)(F), include meal preparation, essential shopping and chores, telephone use, and other such tasks.

[40] Defined at PPACA § 2401(k)(6)(D) as "specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant."

[41] Other sources of personal care services are also problematic. Mandatory Medicaid home health coverage does not offer the range of services that the Community First Choice Option could provide. Just over half of the states elect to cover Personal Care Services through their state plan, but these services too are less robust than the services Community First Choice could offer.

- first month's rent and utilities;
- bedding;
- basic kitchen supplies; and
- other necessities required for an individual to make the transition.

In addition, this provision includes language that matches the ADA integration mandate and applies this as a requirement for State Plans offering services under this provision. Adding new § (k) to 42 U.S.C 1396n, by § 2401, *see* new § (k)(3)(B) for the integration mandate provision.

Effective Date: October 1, 2011.

Removal of Barriers to Providing Home and Community Based Services, PPACA § 2402

This section requires the HHS Secretary to promulgate regulations ensuring that all states develop service systems that are responsive to the needs and choices of beneficiaries receiving state and Medicaid-funded, community-based, long-term care services. These systems must also:

- enable beneficiaries to receive services in a way that maximizes their independence, including through the use of client-employed providers;
- provide the support and coordination needed to design a self-directed, community-supported life;
- improve coordination, consistency, and regulation of federally and state-funded services, including development of effective eligibility determination and assessments, complaint, management and monitoring systems; and
- assure an adequate number of qualified direct-care workers to provide self-directed personal assistance services. § 2402(a).

Effective date: March 23, 2010.

State Plan Option to Provide Home and Community Based Services

The Deficit Reduction Act of 2005 added a new section to the Medicaid Act that authorizes states to provide home and community based services through a state plan option – that is, without a waiver – to certain individuals whose household incomes do not exceed 150 percent of FPL. 42 U.S.C. § 1396n(i). Previously, such home and community based services could be offered only pursuant to a waiver.[42] In order to offer this option, states had to establish criteria for determining an individual's need for supportive services covered under this state plan option.

The PPACA amends § 1396n(i) to enable states to expand eligibility by means of a state plan amendment rather than waiver to individuals whose income does not exceed 300 percent of

[42] *See* 42 U.S.C. § 1396n(c), (d), (e) (authorizing home and community based waivers to serve individuals who would otherwise need the level of services provided in an institution).

the Supplemental Security Income (SSI) benefit rate, as long as they meet criteria established for determining the need for supportive services. § 2402(b). States may offer home and community based services that differ in amount, duration, or scope from those offered to others receiving services under this state plan option, as long as the services are within the scope of services described in 42 U.S.C. §1915(c)(4)(B). These services include case management, homemaker/home health aide and personal care, adult day health, habilitation, respite care, and such other services requested by the State as the Secretary may approve, as well as day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness. 42 U.S.C. § 1396n(c)(4)(B).

States may choose to offer home and community based services through this state plan option to specific, targeted populations, and offer different amount, duration, and scope of services to different groups. States are, however, no longer allowed to waive the requirement that services be available statewide or to place caps on enrollment. § 2402(e), (f). This section also removes the limitation on the scope of services that may be covered. Previously, states could only cover the services listed in the statute. Now, states may, with permission from CMS, offer other services not specifically listed. § 2402(c).

States may authorize these programs for a period of five years. States may also phase in eligible individuals and covered services, so long as all are enrolled and all services are provided by the end of that five-year period. States may renew for an additional a five-year term if the Secretary determines that the state had complied with the requirements of the subsection and met quality and outcome improvement goals. § 2402(b).

States retain their ability to modify entrance criteria for the plan if enrollment exceeds projections, but the new legislation extends the period for which grandfathered individuals are eligible. Any individuals who are eligible for services will remain so until they no longer meet the criteria for eligibility. § 2402(e), amending 42 U.S.C. § 1396n(i)(1)(D)(ii)(I). The section becomes effective on the first day of the first fiscal year quarter that begins after the enactment of this Act. § 2402(g).

The PPACA also adds an optional category of eligibility for individuals who would be eligible for home and community based services through § 1396n(i), which will allow states to offer them full scope Medicaid benefits. § 2402(d).

While § 2401 and § 2402 both address home and community based services, § 2402 expands eligibility for existing HCBS options and creates a new optional category of eligibility while § 2401 authorizes optional services that states can provide.

Effective date: The first full day of the first FY quarter after enactment (April 1, 2010).

Money Follows the Person Rebalancing Demonstration, PPACA § 2403

The DRA of 2005 directed the HHS Secretary to award Money Follows the Person

(MFP) Rebalancing Demonstration grants to states to increase the use of the home and community based services offered under a state's waiver or regular Medicaid program. Participating states could waive comparability, income and statewideness requirements. To be eligible, individuals were required to be living in an inpatient facility and have been living there for 6 months to two years. A determination must also have been made that the individual requires home and community based services to remain safely in the community. The program provided grants of up to five years. Deficit Reduction Act of 2005, Pub. L. No. 109-171 § 6071, *codified at* § 1396a (note).

The PPACA extends the demonstration for five additional years. § 2403(a). It also reduces the amount of time an individual must reside in an institution to only 90 days. Days of residency that are solely for the purpose of receiving short-term rehabilitative services during Medicare's waiting period will not be counted toward the 90 days. § 2403(b).

Effective date: April 22, 2010.

Protection for Recipients of Home and Community Based Services from Spousal Impoverishment, PPACA § 2404

Medicaid's spousal impoverishment protections are designed to protect a spouse who continues to live at home from being impoverished by the costs of his/her spouse's institutional care. States have had the option of employing the spousal impoverishment protections not only when one spouse is in a medical institution or a nursing facility, but also when the institutionalized spouse would have been eligible for medical institution or nursing facility care, but instead receives home and community based services (HCBS) under a federal waiver.

This provision removes the state option and makes *mandatory* the use of the spousal impoverishment protections in situations in which a person would have been institutionalized or in nursing facility care but for the HCBS under a federal waiver. § 2404 amending 42 U.S.C. § 1395r-5(h)(1)(A). However, this section only amends the existing federal law from January 1, 2014, through December 31, 2018.

The Act temporarily amends the law to require states to employ the spousal impoverishment protections in most of the prior optional situations and expands the requirement to additional situations. States will be required (at least from 2014 through the end of 2018) to apply the spousal impoverishment protections where a spouse would be institutionalized in a nursing facility or an intermediate care facility (including one for the mentally retarded) if not for the state's provision of HCBS under a federal waiver to enable the individual to live at home or in the community. §§ 2404; 42 U.S.C. § 1396n(c), (d). The Act temporarily removes the state option of applying the spousal impoverishment protections to waivers for children with AIDS or drug dependence at birth. §§ 2404; 42 U.S.C. § 1396n(e). The Act requires a state to apply the provisions where the state has adopted the federal option to offer HCBS as an optional service available to individuals regardless of whether those individuals would otherwise require care in a hospital, nursing facility, or intermediate care facility for the mentally retarded. §§ 2404; 42 U.S.C. § 1396n(i). A state must also apply the spousal impoverishment protections to individuals in the medically needy program and to beneficiaries in 209(b) states who receive

Medicaid, but not SSI, as aged, blind, or disabled. §§ 2402; 42 U.S.C. §§ 1396a(a)(10)(C), 1396a(f). The spousal impoverishment protections must apply under the new Community First Choice Option and in situations in which a Medicaid beneficiary is eligible because the costs of medical or remedial care are subtracted from countable income. §§ 2401, 2404.

The temporary extension of institutional spousal impoverishment rules to HCBS waiver programs will have the added benefit of requiring states to only consider the income of applicants for HCBS waiver programs, and not the income of their community spouses, when making eligibility determinations. 42 U.S.C. § 1395r-5(b).

This section should protect the income of more community spouses as well as people who otherwise have spouses in need of HCBS for the period of 2014-2018.

Funding to Expand State Aging and Disability Resource Centers, PPACA § 2405

The Older Americans Act of 1965 calls for the establishment of State Aging and Disability Resource Centers. 42 U.S.C. § 3012. These centers assist seniors and people with disabilities with understanding and choosing among long-term care options, including home and community based services, as well as understanding preventive care and prescription drug coverage under Medicare. 42 U.S.C. § 3012(b)(8). The Older Americans Act also supports public and private, state and community-based organizations that serve as benefits enrollment centers. 42 U.S.C. § 3012(a)(20)(B)(iii).

This section allocates up to an additional $10 million annually for FY 2010-2014 to augment these services. § 2405. This section makes no other changes to the services that may be offered. The additional funding will help these agencies provide additional assistance to seniors and people with disabilities to learn about and understand new HCBS options, the CLASS Act, and added Medicare preventive care services available under the PPACA.

Sense of the Senate Regarding Long-Term Care, PPACA § 2406

This section contains no changes to the law, but only legislative findings regarding efforts to expand opportunities for home and community based care, and to decrease dependence on institutional care. The findings note the Pepper Commission's "Call for Action" in 1990 and the landmark *Olmstead v. L.C.* decision. § 2406(a). The findings reject most states' continued dependence on institutional care over the more cost-effective home and community based care alternatives. The Senate calls on itself to address the imbalance between these two approaches to long-term care during the current legislative session and calls for the availability of HCBS in addition to institutional care. § 2406(b).

The "Sense of the Senate" may be useful in supporting advocacy efforts to encourage more HCBS in lieu of nursing homes through programs such as the one found in § 10202, and providing financial incentives to states to offer home and community based services as an alternative to institutional nursing home care.

Medicaid Prescription Drug Provisions, PPACA §§ 2501-2503, Recon. Act §§ 1101, 1206

Sections 2501 and 2503 change methodologies for the computations of Medicaid reimbursements for covered prescription drugs. Section 2502 includes additional drugs that will be covered by Medicaid.

To understand the changes made by PPACA, a basic understanding of the current payment system is required: to have their drugs considered for coverage by Medicaid, manufacturers must offer the states a rebate on the price of those drugs.[43] To compute the rebate, the drug company's "average manufacturer price" (AMP) and its "best price" must be first be determined.[44] Next, the amount of the rebate is calculated by multiplying the number of doses of a drug dispensed during any given rebate period (usually a calendar quarter), by the difference between the AMP and the best price, or by the minimum rebate percentage (formerly 15.1 percent) of the AMP, whichever is greater. Consequently, if the AMP is higher and/or the best price is lower, thereby increasing the difference between the two, the resulting rebate to the state will be greater. The state's rebate will also increase if the rebate percentage is increased.

In the PPACA, the rebate percentages in a number of different categories of brand name and generic drugs have been increased, which will increase a state's rebate if it chooses that method over the AMP/best price computation. This section also requires the funds received by the state through the increased rebate percentages to be passed on to HHS. HHS obtains these funds by reducing the overall FMAP payment a state would receive from the federal government.

Effective, January 1, 2010, the following minimum rebate percentage of AMP are increased accordingly:

- for single source and multiple source innovator drugs,[45] an increase from 15.1 to 23.1 percent;[46]
- for two particular groups of single source and multiple source innovator drugs, a particular blood clotting treatment[47] and drugs approved by FDA exclusively for pediatric indications, an increase from 15.1 to 17.1 percent;[48]
- for other covered outpatient drugs, which include generics, an increase from 11 to 13 percent;[49] and

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[43] *See* 42 U.S.C. § 1396r-8(a)(1).
[44] *See* 42 U.S.C. § 1396r-8(k)(1) and (c)(1)(C).
[45] Single or multiple source drugs refer to the number of manufacturers of a drug. For example, a single source drug is considered single source when a new brand name drug is released in the marketplace during the years of the patent. There is only one or single source manufacturing the drug. Once the patent expires, multiple manufacturers can produce therapeutically equivalent drugs, thus producing a drug that has multiple sources. Defined at 42 U.S.C. § 1396r-8(k)(7).
[46] Adding new subclause (VI), amending 42 U.S.C. § 1396r-8(c)(1)(B)(i), by PPACA § 2501(a)(1)(A).
[47] Called a clotting factor, defined in the Medicare Part B – reimbursements for drugs and biologicals section, at 42 U.S.C. § 1395u(o)(5). There is a list which is updated regularly by the HHS Secretary.
[48] Adding new subsection (iii) to 42 U.S.C. § 1396r-8(c)(1)(B), by PPACA § 2501(a)(1)(B).
[49] Adding new subsection (iii) to 42 U.S.C. § 1396r-8(c)(3)(B), by PPACA § 2501(b)(3).

- adds a new rebate calculation for a new formulation drug (such as a line extension – i.e. adding an extended release formulation) for either a single source or innovator multiple source drug that is in an oral solid form.[50]

This provision also sets a maximum rebate amount the state may receive from the manufacturer of 100 percent of AMP of the drug.[51]

This section also allows states to obtain prescription drug rebates for covered outpatient drugs received by Medicaid managed care plan enrollees. In the past, drug rebates have only been available to the states for fee-for-service Medicaid beneficiaries. In 2007, 20 of 32 states that have Medicaid managed care either fully or partially carved out prescription drugs from the managed care, likely in an attempt to obtain the rebates formerly restricted to outside of managed care.[52] This section also adds a reporting requirement of a managed care plan to report to the state the units, dosage and package size of drugs received by enrollees eligible for the rebate.[53]

Note: this rebate does not apply if the covered outpatient drugs receive a discount under the 340B program of the Public Health Service Act. The 340B program requires drug manufacturers to contract with HHS and provide a discount on prescription drugs to certain covered entities including Federally Qualified Health Centers, other community health centers, and state AIDS Drug Assistance Programs.[54]

Recapture of Savings Due to Increase in Rebate Percentage by HHS, PPACA § 2501(a)(2)

The state share of the increase in the AMP rebate percentage received by the state from the manufacturer and for the new drugs received by managed care enrollees are to revert back to HHS. This repayment to HHS will occur through a payment reduction or disallowance from the state's regular FMAP quarterly payments. Money will not have to be sent from the state to HHS. This disallowance is not subject to an appeal or reconsideration by the state under 42 U.S.C. § 1316(d).

HHS issued guidance on the implementation of this provision on April 22, 2010. Go to http://www.cms.gov/smdl/downloads/SMD10006.pdf for a copy of the Dear State Medicaid Director (DSMD) letter.

Effective date: March 23, 2010, except for the increase in the rebate percentages, which became effective January 1, 2010.

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[50] Adding new subsection (C) to 42 U.S.C. § 1396r-8(c)(2) by PPACA § 2501(d), amended by Recon. Act, § 1206.
[51] Adding new subsection (D) to 42 U.S.C. § 1396r-8(c)(2) by PPACA § 2501(e).
[52] 2007 State Perspectives: Medicaid Pharmacy Policies and Practices, National Association of State Medicaid Directors and Health Management Associates (Nov. 2007).
[53] Adding subsection (xiii) to 42 U.S.C. § 1396b(m)(2)(A) by PPACA § 2501(c).
[54] The 340B program is administered by the Office of Pharmacy Affairs at the Health Resources Services Administration within HHS. For more information, go to http://www.hrsa.gov/opa.

Elimination of Exclusion of Certain Drugs, PPACA § 2502

Current Medicaid law excludes coverage of three classes of drugs:

- over-the-counter smoking cessation drugs;
- barbiturates; and
- benzodiazepines.

Starting January 1, 2014, the exclusion will be eliminated for these drugs, classes of drugs, or their medical uses.[55]

This change will also result in an expansion of coverage for some barbiturates for Medicare recipients who receive their prescription drug coverage through Medicare Part D, as most Medicare Part D drug coverage rules are tied to Medicaid. Medicare Part D covered smoking cessation drugs since its inception and will begin coverage of benzodiazepines and barbiturates for certain conditions after January 1, 2013, through the Medicare Improvements for Patients and Providers Act (MIPPA**),** signed into law in 2008. Thus in 2014, barbiturates not already included in the MIPPA expansion will be covered under Part D through the expansion of Medicaid rules under § 2502.

This section becomes effective January 1, 2014.

Providing Adequate Pharmacy Reimbursement, PPACA § 2503, Recon. Act § 1101

To understand the import of the changes made by this section, it is necessary to give some background. Federal Upper Limits (FUL) are the Medicaid reimbursement limits established for pharmacies purchasing drugs from manufacturers or wholesalers for multiple source drugs[56] (or drugs that have a generic available). The DRA made a number of important changes to the calculation of Average Manufacturer Price (AMP)[57] and the FUL that would have resulted in cuts in reimbursement rates to pharmacies. A lawsuit, *National Association of Chain Drug Stores v. Levitt*, was brought and an injunction issued by the U.S. District Court for the District of Columbia in 2007 to prevent the regulations issued subsequent to the DRA from being implemented. Thus, the DRA provisions have never been implemented.

The following are changes made by § 2503:

- The Federal Upper Limit reimbursement rate is set at 175 percent of AMP when there are multiple source drugs available for purchase by community retail pharmacies nationwide;[58]

[55] Amending 42 U.S.C. § 1397r-8(d), striking and redesignating certain subparagraphs, and adding new subparagraph (7).
[56] See § 2501 for definition of multiple source drugs.
[57] The use of AMP is also discussed above in the Drug Rebate Section analyzing § 2501.
[58] Amending 42 U.S.C. § 1396r-8(e), by striking paragraph (5) and replacing it with a new paragraph (5).

- While the DRA defined multiple source drugs as drugs where there are two therapeutically equivalent drugs (one brand name and one generic), § 2503(a)(3) defines multiple source drugs as drugs where there are at least *three* therapeutically equivalent drugs (two generics and one brand name). Using the definition of three or more returns it to the definition of multiple source drugs prior to the DRA. By delaying use of the FUL for reimbursement when there are three multiple source drugs and clarifying that the drugs must be available for purchase to community retail pharmacies nationwide, the pharmacist retains reimbursement at the higher payment level during a time when prices may not yet have been reduced significantly and the generic may not yet be available wide-spread.[59]
- It changes the definition of AMP to be calculated specifically for drugs purchased by wholesalers who distribute to retail community pharmacies and by retail community pharmacies that purchase directly from the manufacturer. This is significant because § 2503(a)(4) provides a new definition of retail community pharmacy that excludes mail-order pharmacies, hospital pharmacies, nursing home pharmacies, and others that have greater purchasing power and thus lower prices than a community retail pharmacy can negotiate. Mail-order pharmacies were included in the retail pharmacy definition in the final regulations[60] that were not implemented due to the injunction issued in *NACDS v. Levitt*. As mail-order pharmacies are able to obtain lower prices for drugs than a retail pharmacy located in the community, removing mail-order pharmacies from the definition of community retail pharmacy should increase the AMP, and thus the pharmacy reimbursement level.[61]
- The new definition of AMP expands the list of exclusions of items that are not included in the AMP calculation. The exclusions include service fees, reimbursement by manufacturers for damaged or expired goods, and other kinds of discounts offered by manufacturers to pharmacies. These deductions are like tax deductions from gross income prior to calculation of taxes. Expanding the list of exclusions to the AMP calculation allows the AMP to be higher, also providing higher reimbursement rates to pharmacies.[62]

Providing for adequate reimbursement rates for community retail pharmacies may have the effect of stabilizing the community pharmacies and thereby increasing access for Medicaid beneficiaries to pharmacies, particularly independent and rural-based pharmacies.

In addition, § 2503(c) makes adjustments to disclosure and public reporting provisions regarding prescription drug reimbursement. It requires:

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[59] Amending 42 U.S.C. § 1396r-8(k)(7) by PPACA § 2503(a)(1), (3). When the first generic is released there is a six month period where it is allowed to charge prices equivalent or similar to the brand name drug. In addition, distribution may be conducted to exclusive retailers during this time. Therefore, there is a period of time after the first generic is issued when prices may not have reduced significantly and distribution of the generic may not yet be wide-spread.

[60] 72 Fed. Reg. 39142 (July 17, 2007).

[61] Amending 42 U.S.C. § 1396r-8(k), by adding new subsections (10) and (11).

[62] Amending 42 U.S.C. § 1396r-8(k)(1) by § 2503(a)(2).

- the manufacturer to send to HHS the total number of units used to calculate AMP for each covered out-patient drug each month;
- HHS to provide, at least monthly, the weighted average AMP for single source and multiple source drugs to states; and
- HHS to post and update this information on its website.[63]

Effective date: The first day of the new quarter after 180 days after enactment (September 2010), regardless of whether final regulations on these sections have been issued.

Disproportionate Share Hospital Payments, PPACA §§ 2551, 10201, Recon. Act § 1203

Disproportionate Share Hospital (DSH) payments are made to hospitals that serve a disproportionate number of low-income patients, or that are located in an urban area, have 100 or more beds, and can demonstrate that they derive more than 30 percent of their revenues from state and local government payments for indigent care provided to patients not covered by Medicare or Medicaid. DSH payments are intended to help hospitals defray the costs of providing uncompensated care and are calculated by a formula set forth in the Medicaid Act. 42 U.S.C. § 1396r-4(f); *see also* § 1395ww(d)(5)(F)(i), (v).

The PPACA gradually reduces the amount of Medicaid DSH payments in anticipation of a reduction in the number of uninsured people. When more people have insurance, fewer people should be seeking emergency or urgent care from hospitals, and more people should have insurance to pay for such care when it is needed. Thus, hospitals' uncompensated care costs should decrease. Aggregate reductions in annual DSH allotments to states begin in FY 2014 and continue through FY 2020. These reductions are:

- $500 million for FY 2014;
- $600 million for FYs 2015 and 2016;
- $ 1.8 billion for FY 2017;
- $5 billion for FY 2018;
- $5.6 billion for FY 2019;
- $4 billion for FY 2020.

Quarterly Medicaid payments to states will be reduced in an amount equal to one-quarter of the amount of the allotment reduction. § 1203(a).

The Secretary must determine the reduction in allotments for specific states pursuant to a methodology that imposes the largest percentage reductions on states:

- with the lowest percentage of uninsured individuals (during the most recent year for which data is available); or
- that fail to target DSH payments on hospitals with high volumes of Medicaid inpatients and that have high levels of uncompensated care.

[63] Amending 42 U.S.C. § 1396r-8(b)(3).

The methodology must also impose a smaller percentage reduction on low DSH states, currently defined as a state whose DSH expenditures are more than zero but less than three percent of its annual Medicaid expenditures. 42 U.S.C. § 1396r-4(f)(5)(B). Finally, it must also take into account the extent to which the DSH allotment for a state was included in a budget neutrality calculation for coverage expansions made pursuant to an 1115 waiver that was in effect as of July 31, 2009.[64] § 1203. Payment reductions must be deemed an overpayment to be disallowed against the state's regular quarterly draw for all spending and is not subject to reconsideration.

The DSH allotment, as calculated by the current methodology, is extended for the last three quarters of FY 2012 and all of FY 2013. Tennessee, which would otherwise have no DSH allotment for 2012 and 2013, will instead receive $47.2 million for each of the last three quarters of FY 2012 and $53.1 million for FY 2013. The DSH allotment for Hawaii for the last three quarters of FY 2012 will be $7.5 million and, thereafter, Hawaii will be treated as a low DSH state. § 101201(e)(1)(A).

Finally, the HHS Secretary may not place any limits on the amount of payments made to hospitals under Hawaii's QUEST Section 1115 Demonstration Project, except to ensure that:

- hospitals do not receive payments in excess of the amount specified above;
- payments under the Demonstration and pursuant to the DSH allotment do not exceed the FMAP attributable to DSH payment adjustments reflected in the QUEST program's budget neutrality provision.

Effective date: March 23, 2010.

Five-Year Period for Demonstration Projects, PPACA §2601

This provision amends § 1915 of the Social Security Act[65] to allow demonstration programs that target or include dual eligibles to be approved for five-year periods, and subsequently reauthorized for additional five-year periods. Approval or extension is subject to the Secretary's determination that the waiver complies with all requirements, is cost-effective, and consistent with the purpose of § 1915. The default provision in § 1915(h) limits waivers to two-year authorizations and creates a few exceptions for longer waiver duration periods. PPACA §2601 creates a new exception for waivers for dual eligibles. Note that the additional exception also applies to waivers that include non-duals in addition to dual eligibles, and applies as well to waivers under § 1115 of the Social Security Act.

Effective Date: March 23, 2010.

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[64] Section 1115 authorizes waivers of Medicaid requirements to enable states to conduct pilot programs that are consistent with the Medicaid Act, including coverage expansions for individuals who could not otherwise be covered by Medicaid. 42 U.S.C. § 1315.

[65] *See* 42 U.S.C. § 1396n.

Providing Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries, PPACA § 2602

This provision creates a new federal Coordinated Health Care Office (CHCO) within CMS charged with better integrating Medicaid and Medicare programs, and improving coordination between federal and state governments implementing the programs. The law specifically states this coordination is to ensure that dual eligible individuals "get full access to the items and services to which they are entitled" under Medicare and Medicaid. This requirement is then listed again as the first of eight general "goals" for the CHCO. The CHCO was to be established by the HHS Secretary by March 1, 2010.[66]

The CHCO is responsible for helping align benefits for duals, helping coordinate and align acute care and long-term care services for duals; supporting CMS contracting and oversight for integration; consulting and coordinating with MACPAC[67] with respect to duals; and studying access to drug benefits and reporting on expenditures, outcomes, and access for duals. The Secretary is required to submit an annual report to Congress containing recommendations for further legislation that would improve care coordination and benefits for dual eligibles.

The composition of the CHCO is not specified, except that it is located within CMS and will have a Director that is appointed by and reports to the CMS Administrator. There are no specific requirements for consumer participation, either directly or through an advisory capacity. Furthermore, the law does not create new or reference existing disclosure requirements, conflict of interest checks, recusal requirements, rules around gifts, etc., for entities that will provide the CHCO with advisory input in a formal or informal capacity.

Dual eligible consumers certainly face additional barriers to care due to having to use two forms of health care coverage. Under the current system they may have long-standing difficulties such as understanding which providers they can visit for treatment, what benefits are covered, or how the billing for their care should work. The first priority of CHCO should be generally improving the access of dual eligibles to their Medicare and Medicaid benefits, and not strictly focusing on integration of the benefits.

In principle, better integration of Medicare and Medicaid coverage could improve the care and user experience for dual eligibles. However, if integration is done in a way that reduces access to either Medicaid or Medicare program benefits, it would likely be detrimental to consumers. Consumers would benefit if integration is done in a way that provides duals the best protections of both programs, and not the protections of just one program or the worst of both. Integration efforts should consider the following:

- existing Medicare networks are often wholly inadequate for supporting the vast array of Medicaid services available through the Medicaid network, most notably services such as home and community based services and mental health services;

[66] Note that the PPACA was signed into law on March 23, 2010.
[67] The Medicaid and CHIP Payment and Access Commission, or "MACPAC", was established by CHIPRA to advise Congress on a wide range of Medicaid and CHIP topics.

- Medicare service delivery does not include many innovative Medicaid service delivery models, which are essential to optimizing patient care and function, such as "consumer directed models" or "cash and counseling;"
- Medicare and Medicaid have different standards that impact access to care (e.g. "medical necessity"), and consumers would be best served by a unified system that takes the most favorable standards from each program;
- the process for appeals of service denials for consumers should adopt the least restrictive timeframes and relevant standards (for example, "amount in controversy"[68] requirements) from Medicare and Medicare, with no reduction in options;
- decisions around the integration of benefits should ultimately belong to the consumer, and consumer choice should specifically be defined to mean active selection by affirmative choice and not selection by passive omission;
- initiatives around integration must require extensive and carefully constructed notice – with consumer input – for any integration opportunities, selections or transitions;
- requiring initial care assessments, the development of a care plan, and periodic reassessments are necessary first steps to ensure that fractured Medicare and Medicaid services are well integrated;
- the CHCO must work to ensure that care coordination truly happens – in the context of Medicare generally and SNPs – by creating explicit requirements for care coordination and advancing models that directly reimburse care coordination, including clinical and personal care coordination, as well as coordination to reduce barriers to care (e.g. difficulties coordinating coverage types, language access difficulties, and transportation barriers); and
- to the extent that integration leverages off of the private industry (e.g. through Medicare MCOs), CHCO must ensure a heavy investment in a fair enrollment process for consumers that includes access to adequately funded independent enrollment counseling.

Effective Date: March 23, 2010.

Adult Health Quality Measures, PPACA § 2701

Congress took the opportunity to improve reporting on the quality of health care services in Medicaid for adults similar to the way it did in CHIPRA,[69] to strengthen the quality of care and health outcomes for children enrolled in Medicaid and CHIP. No later than January 1, 2011, the HHS Secretary must identify and publish for public comment a recommended core set of adult health quality measures for Medicaid-eligible adults in the same manner as the quality

[68] In the legal system, sometimes a particular court or review panel only has jurisdiction to handle an appeal if the value of the issue in dispute meets a minimum value limit, known as the "Amount in Controversy". For example, a 'third level' appeal in Medicare will only be accepted if the Amount in Controversy is at least $130.

[69] 42 U.S.C. § 1320b-9a, enacted by P.L. 111-3 (2/4/09), *available at* http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ003.111.pdf.

measurement program enacted in CHIPRA.[70] The Secretary must publish an initial core set of adult health quality measures for eligible adults in Medicaid by January 1, 2012. The Child Health Quality Measure provisions in CHIPRA provide more specific guidance for the Secretary since there is more detail in the CHIPRA provision[71] regarding the quality improvement process.

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. The Secretary must also create procedures to encourage states to use the quality measures to voluntarily report information regarding the quality of health care for Medicaid-eligible adults. The Secretary's report to Congress must include information regarding the adult health quality measures by January 1, 2014, and every three years after that, similar to the timeframe required for the child health care measures. SSA § 1139B(b)(3), (4) (added by PPACA § 2701).[72]

The Secretary must also establish a Medicaid Quality Measurement Program (MQMP) no later than 12 months after the release of its recommended core set of adult health quality measures, in the same manner as the Secretary established the pediatric quality measures program under CHIPRA.[73] There will be funding allocated for grants and contracts for the development, testing, and validation of emerging and innovative measures to advance adult health quality measures at the same level as that allocated for pediatric quality measures. No later than 24 months after the MQMP is created, and annually thereafter, the Secretary must publish recommended changes to the core set of adult health quality measures that reflect the results of the testing, validation, and consensus process for the development of the adult quality measures. SSA § 1139B(b)(5).

The PPACA includes an important beneficiary protection, which is analogous to one in CHIPRA, which prevents prescribed items or services from being denied or terminated by the state on grounds that they do not reflect "evidence-based" medicine. The section explicitly prohibits a construction that would restrict coverage or limit available services under Medicaid or CHIP. SSA § 1139B(c).

States also have critical responsibilities under the new law. Each state with a state plan or Medicaid waiver must annually report to the Secretary, either separately or with the report required under CHIPRA, state-specific adult health quality measures applied by the state under its plan, including:

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[70] The initial set of children's health quality measures was published by HHS on December 29, 2009 with a public comment period ending March 1, 2010. *See* 74 Fed. Reg. 68846-49.

[71] *See* 42 U.S.C. § 1320b-9.

[72] As this is a new section of the U.S.C., we do not yet have the corresponding citation to the Social Security Act.

[73] The Pediatric Quality Measures Program is in the process of being developed by CMS, the Agency for Healthcare Research and Quality, and the Federal Quality Work Group, which held its first meeting on February 24, 2010. *See* 75 Fed. Reg. 6673-74 (Feb. 10, 2010).[74] These are sometimes also referred to as medical homes although there may be differences in implementation between this provision and other provisions related to health or medical homes. *See* PPACA § 3502.

- the measures described in the MQMP; and
- state-specific information on the quality of health care furnished to Medicaid-eligible adults, including information collected through external quality reviews of managed care organizations.

While for several years, federal law has required states to obtain quality information on Medicaid managed care, this section will now require states to measure the quality of care in their fee-for-service Medicaid programs as well. Obtaining this information certainly will pose new challenges, but it also presents the opportunity to improve care to adults who are less likely to be in managed care than are children. The Secretary will collect, analyze and publish the information reported by the states annually beginning no later than September 30, 2014. SSA § 1139B(d).

For each of the fiscal years 2010 through 2014, $60 million is appropriated for the purpose of carrying out the adult quality improvement activities in § 2701.

Payment Adjustment for Health Care-Acquired Conditions, PPACA § 2702

This section prohibits federal payment to states for Medicaid services related to health care-acquired conditions. The Secretary is directed to identify, determine, and apply promising state practices that prohibit the payment for health care-acquired conditions, and incorporate into regulations the practices identified, or elements of these practices, that the Secretary deems appropriate for the Medicaid program. However, the regulations must ensure that the payment prohibition must not result in any loss of access to care or services for Medicaid beneficiaries.

The provision defines the term "health care-acquired condition" to be a diagnosed medical condition that could be identified by a secondary diagnosis code in 42.U.S.C. § 1395ww(d)(4)(D)(iv). (§ 2702(b)). The Secretary must apply Medicare regulations related to the prohibition of payments based on the presence of a secondary diagnosis code to state plans or waivers to the extent that they are appropriate for the Medicaid program. However, the Secretary may exclude certain conditions in the Medicare regulations if she or he finds the inclusion of such conditions to be inapplicable to Medicaid beneficiaries. § 2702(c).

Effective date: July 1, 2011.

State Option to Provide Health Homes for Enrollees with Chronic Conditions, PPACA § 2703

Beginning January 1, 2011, the PPACA creates a new state option to provide coordinated care through a health home[74] for eligible individuals with chronic conditions by allowing a state to submit a state plan amendment to pay for medical assistance provided by a designated

[74] These are sometimes also referred to as medical homes although there may be differences in implementation between this provision and other provisions related to health or medical homes. *See* PPACA § 3502.

provider, a team of health professionals or a health team. § 2703(a), adding Social Security Act (SSA) § 1945(a). The Secretary must establish qualification standards for a designated provider for the purposes of being eligible to be a health home. SSA § 1945(b).

This section provides the Secretary wide waiver authority. Not only are statewideness and comparability waived, but the Secretary may also waive any other Medicaid provision that the Secretary deems "necessary to waive" in order to implement this section. SSA § 1945(a).

The provision contains several key definitions:

- An "eligible individual with chronic conditions" means an individual who is eligible for medical assistance under the state plan or under a waiver of such a plan and has at least:
    - two chronic conditions;
    - one chronic condition and is at risk of having a second chronic condition; or
    - one serious and persistent mental health condition.

  However, the Secretary may establish higher levels as to the number or severity of chronic or mental health conditions for the purpose of determining eligibility for receipt of health home services under this section;

- "Chronic condition" will be defined by the Secretary and must include, but is not limited to, the following:
    - a mental health condition;
    - substance use disorder;
    - asthma;
    - diabetes;
    - heart disease; or
    - being overweight with a Body Mass Index over 25;

- "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 with chronic conditions to provide health home services;

- Services can include:
    - comprehensive care management;
    - care coordination and health promotion;
    - comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;
    - patient and family support, including authorized representatives;
    - referral to community and social support services, if relevant; and
    - use of health information technology to link services, as feasible and appropriate.

- "Designated provider" means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider, including pediatricians, gynecologists, and

obstetricians, that is determined by the state and approved by the Secretary to be qualified as a health home;[75]

- "Team of health care professionals" means a team of health professionals as described in the state plan amendment;[76] and

- "Health team" has the meaning described in PPACA § 3502.

For the first two years that the state plan amendment is in effect, the state will receive a 90 percent FMAP rate to pay the designated provider, a team of health care professionals, or a health team for health home services. Part of the intent of the legislation appears to be to encourage state innovation in developing new payment methodologies. Although the state has some latitude in determining its payment methodology for the provision of health home services, it must specify its methodology in its state plan amendment, which:

- can be tiered to reflect the severity or number of each individual's chronic conditions or the specific capabilities of the provider, team of health professionals, or health team; and
- must be established consistent with Medicaid principles for payment found in 42 U.S.C. § 1396a(a)(30)(a). SSA § 1945(c)(2)(A).

A state is not limited to a per-member per-month basis of payment, but may propose to use alternate models of payment subject to the Secretary's approval. SSA § 1945(c)(2)(B).

In its state plan amendment, the state must include a requirement for participating hospitals under the state plan amendment or waiver to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers. SSA § 1945(d). The state must also consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions. SSA § 1945(e). For monitoring purposes, the state must include in its state plan:

- a methodology for tracking avoidable hospital readmissions, and calculating savings that result from improved chronic care coordination and management under this section in the state plan amendment; and

[75] The physician, practice or clinic must document that it: (i) has the systems and infrastructure in place to provide health home services and (ii) satisfies the qualification standards established by the Secretary. It is worth noting that a managed care organization is unlikely to qualify as a health home provider under the definition

[76] The team may: (i) include physicians and other professionals, such as a nurse coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the state; and (ii) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the state and approved by the Secretary.

- a proposal for use of health information technology in providing health home services under this section, and improving service delivery and coordination across the care continuum, including using wireless patient technology to improve care coordination and management and patient adherence to recommendations made by their provider. SSA § 1945(f).

The designated provider must report to the state on all applicable measures for determining the quality of health home services, as specified by the Secretary, as a condition for receiving payment for health home services provided to those eligible with chronic conditions. The provider must also use health information technology to provide the state with the required information when appropriate and feasible. SSA § 1945(g).

The Secretary must submit two types of reports to Congress to show the effectiveness and cost-savings of this state option. First, the Secretary must contract with an independent entity or organization to conduct an evaluation and assessment of states that have elected the option to provide coordinated care through a health home for Medicaid beneficiaries with chronic conditions for the purpose of determining the effect of this option on reducing hospital admissions, emergency room visits, and admissions to skilled nursing facilities. SSA § 2703(b)(1)(A). The Secretary must report the results of that evaluation and assessment to Congress by January 1, 2017. SSA § 2703(b)(1)(B).

Second, by January 1, 2014, the Secretary must also report to Congress on a survey of those states using this option on the nature, extent and use of the option as it relates to:

- hospital admission rates;
- chronic disease management;
- coordination of care for individuals with chronic conditions;
- assessment of program implementation;
- processes and lessons learned regarding provisions of coordinated care a through health home for chronically ill Medicaid beneficiaries, information which the state must report to the Secretary as necessary;
- assessment of quality improvements and clinical outcomes under this option; and
- estimates of cost savings. SSA § 2703(b)(2)(A), (B).

In an effort to prompt innovation, the Secretary may award planning grants to states to develop state plan amendments under this section. The planning grant will be funded at the state's regular FMAP rate, not the enhanced rate under ARRA. SSA § 1945(c)(3)(B). The Secretary may award up to $25 million for the planning, beginning January 1, 2011. SSA § 1945(c)(3)(A), (C).

Demonstration Project to Evaluate Integrated Care around a Hospitalization, PPACA § 2704

This section, along with §§ 2705-2707, create demonstration projects with the potential to lower Medicaid program costs while improving health care for Medicaid beneficiaries.

The Secretary is authorized to establish a demonstration project to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary encompassing episodes of care that include a hospitalization and concurrent physicians services provided during a hospitalization. § 2704(a). The demonstration project can be conducted in up to eight states for acute and post-acute care, and those selected may target particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular geographic regions of the state as long as the Secretary ensures that the project is representative of the demographic and geographic composition of Medicaid beneficiaries nationally, to the greatest extent possible. § 2704(b)(1).

There are other requirements imposed on the demonstration projects:

- the project must focus on conditions where there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished to Medicaid beneficiaries while reducing total expenditures under the state Medicaid program;
- the state must specify one or more episodes of care it intends to address in the project, the services to be included in the bundled payments, and the rationale for the selection of the specified episodes, which the Secretary has the authority to modify prior to or after approving the project and to vary such factors among the different states participating in the projects;
- the Secretary must ensure that payments made under this demonstration project are adjusted for the severity of illness and other characteristics of Medicaid beneficiaries within a category, or having a diagnosis targeted as part of the demonstration project. The state must make sure that the beneficiaries are not liable for any additional cost-sharing than if their care had not been subject to the bundled payment;
- hospitals participating in the project must have or establish robust discharge planning programs to ensure that the beneficiaries requiring post-acute care are appropriately placed in, or have ready access to, post-acute care settings; and
- the Secretary and the state must ensure that the beneficiaries covered by the demonstration project are not provided with less items or services than those whose medical assistance is paid for by the non-demonstration project.
  § 2704(b)(2)-(6).

This section allows the Secretary to waive any Medicaid, Medicare, or Title XI provisions necessary to accomplish the goals of the demonstration project; ensure beneficiary access to acute and post-acute care; and maintain quality of care. § 2704(c). As with many of the demonstration projects in PPACA, there is an evaluation component. States must provide the Secretary with relevant data, as specified by the Secretary, necessary to monitor outcomes, costs, and quality, and evaluate the rationales for the selection of the episodes of care and services specified by the states. § 2704(d)(1). No later than one year after the conclusion of the demonstration project, the Secretary must submit a report to Congress on the results of the demonstration project. § 2704(d)(2).

Implementation Dates: January 1, 2012, through December 31, 2016.

Medicaid Global Payment System Demonstration Project, PPACA § 2705

The Secretary, in coordination with the Center for Medicare and Medicaid Innovation (CMI), [77] must establish the Medicaid Global Payment System Demonstration Project in which up to five participating states can adjust their current payment structures for an eligible safety net hospital system or network from a fee-for-service model to a global capitated payment. § 2705(a), (b). The term "eligible safety net hospital system or network" means a large, safety net hospital system or network that operates in one of the five states that the Secretary selects. § 2705(b). CMI must test and evaluate the projects to examine any changes in health care quality outcomes and spending by the eligible safety net hospitals. § 2705(d)(1). During the testing period, budget neutrality requirements normally applied to § 1115[78] waivers are not applicable, and the Secretary has the discretion to modify or terminate the project during the testing period. § 2705(d)(2), (3).

The demonstration projects will operate from fiscal years 2010 through 2012 and the Secretary must report to Congress about the results of the evaluation and testing as described above, along with recommendations for any appropriate legislation and administrative analysis no later than 12 months after the demonstration project is completed. § 2705(b), (e). Appropriate funding is authorized as necessary to carry out this section. § 2705(f).

Pediatric Accountable Care Organization Demonstration Project, PPACA § 2706

The Secretary shall create the Pediatric Care Organization Demonstration Project which allows for qualified pediatric medical providers to be recognized and receive payments as "accountable care organizations" (ACO) under Medicaid and CHIP to share in cost savings.[79] § 2706(a)(1). For a state to participate in the demonstration project, it must apply to the Secretary and comply with the following requirements:

- performance guidelines – the Secretary, in consultation with pediatric providers and the state, must establish guidelines to ensure that the ACO provides individuals with the quality of care that is no less than what those patients otherwise would have received;
- savings requirement – a participating state must develop an annual minimal level of savings in expenditures for items and services covered under the Medicaid and CHIP program in order to receive an incentive payment;

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[77] The Center for Medicare and Medicaid Innovation (CMI), within the Centers for Medicare and Medicaid Services, was created by the PPACA to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care provided to individuals under § 3021. *See infra.*[78] *See* 42 U.S.C. § 1315.

[78] *See* 42 U.S.C. § 1315.

[79] Pediatric medical providers must meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments under the demonstration project, similar to accountable care organizations established pursuant to § 3022. § 2706(a)(1).[80] The demonstration project must be conducted for a period of three consecutive years. § 2707(d).

- minimum participation period – a provider who wants to be an ACO must enter into an agreement with the state to participate in the project for at least three years; and
- incentive payments – an ACO that meets the performance requirements and achieves savings greater than the annual minimal savings established by the state will receive an incentive payment each year equal to a portion, as deemed appropriate by the Secretary, of the amount of the excess savings. The Secretary may set annual caps on the amount of the incentive payments. § 2706(c), (d).

The demonstration program is authorized to have funding appropriated as necessary to carry out this section.

Implementation date: The demonstration program will begin on January 1, 2012 and end on December 31, 2016.

Medicaid Emergency Psychiatric Demonstration Project , PPACA § 2707

To address the mental health needs of Medicaid beneficiaries, the Secretary is authorized to establish three-year[80] demonstration projects for eligible states[81] to reimburse certain institutions for mental disease[82] that are not publicly owned or operated for Medicaid beneficiaries between the ages of 21-65 who require medical assistance to stabilize an emergency medical condition. § 2707(a).

In its application, the state must establish a mechanism for how it will ensure that participating institutions will determine, before the third day of the inpatient stay, whether or not an individual has been stabilized, i.e. that the emergency medical condition no longer exists, and the individual is no longer dangerous to him- or herself or others. The state may manage the provision of services to stabilize the patient through utilization review, authorization, or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health. § 2707(b), (h)(5).

The Secretary must determine the time and format of the application, as well as any other information, provisions, and assurances. § 2707(c)(2). The Secretary shall select states to participate in the demonstration project on a competitive basis and must seek to achieve an appropriate national balance in the geographic distribution of such projects. § 2707(c)(3).

[80] The demonstration project must be conducted for a period of three consecutive years. § 2707(d).
[81] An "eligible state" is any state that has made an application and has been selected by the Secretary to participate in the demonstration project. § 2707(c)(1). The term "state" has the meaning given that term for purposes of Title XIX of the SSA (42 U.S.C. § 1396 et seq.).
[82] "Institution for mental diseases" has the meaning given to the term in § 1905(i) of the Social Security Act, 42 U.S.C. § 1396d(i), which states the term "means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." [83] *See* Pub. L. No. 111-3, § 506 (codified as 42 U.S.C. § 1396).

To carry out this demonstration project, the Secretary shall waive the Medicaid limitation on payments for care or services to individuals 21-65 who are patients in an institution for mental diseases found in 42 U.S.C. § 1396d(a). § 2707(g)(1). The Secretary may waive other requirements of Titles XI and Medicaid, including comparability and statewideness, "only to the extent necessary to carry out the demonstration project." § 2707(g)(2).

For fiscal year 2011, $75 million in federal funding has been appropriated. § 2707(e)(1)(A). These funds will remain available through December 31, 2015, but the total amount of payments cannot exceed $75 million and must be paid by December 31, 2015. § 2707(e)(2), (3). The funds will be allocated to the eligible states on the basis of criteria as determined by the Secretary and according to its FMAP each quarter. § 2707(e)(4), (5). As a condition of payment, the eligible states must collect and report any information determined by the Secretary as necessary to provide federal oversight, and allow the Secretary to conduct an evaluation of the demonstration project to determine the impact on the functioning of the health and mental health service system on Medicaid beneficiaries. § 2707(e)(5), (f)(1). The evaluation must include the following:

- an assessment of access to inpatient mental health services under the Medicaid program, average lengths of inpatient stays, and emergency room visits;
- an assessment of discharge planning by participating hospitals;
- an assessment of the impact of the demonstration project on the costs of the full range of mental health services, including inpatient, emergency and ambulatory care;
- an analysis of the percentage of Medicaid beneficiaries who are admitted to inpatient facilities as a result of the demonstration project as compared to those admitted to these same facilities through other means; and
- a recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.

§ 2707(f)(1). The Secretary must submit a report on the findings of the evaluation to Congress by December 31, 2013, which will be made available to the public. § 2707(f)(2).

MACPAC Assessment of Policies Affecting All Medicaid Beneficiaries, PPACA § 2801

CHIPRA established the Medicaid and CHIP Payment and Access Commission (MACPAC).[83] MACPAC's membership is appointed by the Comptroller General and includes health care providers, third-party payers, employers, and representatives of state programs and enrollees.

CHIPRA charges MACPAC to assess Medicaid and CHIP policies affecting children's access to covered services and make recommendations regarding such access. MACPAC is also to assess payment policies and develop an early-warning system for identifying provider shortages or other problems that may adversely affect access to care and health status of

[83] *See* Pub. L. No. 111-3, § 506 (codified as 42 U.S.C. § 1396).

Medicaid and CHIP enrollees. As originally enacted, MACPAC will report annually to Congress with its assessments and recommendations. *See* 42 U.S.C. § 1396.

The PPACA adds significantly to the MACPAC's duties. New topics for assessment include policies that affect eligibility, enrollment, and retention; quality of care; interactions between Medicare and Medicaid; and expenditures and efficient provision of services, including processes for updating payments for medical and dental professionals, hospitals, long-term care providers, federally qualified health centers, rural health clinics, and managed care entities. MACPAC is to consult with states, the Federal Coordinated Health Care Office (established under PPACA § 2081) and the Medicare Payment Advisory Commission (MedPAC). The PPACA makes conforming amendments to the MedPAC authorizing statute, 42 U.S.C. § 1395b-6(b).

MACPAC is authorized to obtain necessary data and information directly from departments and agencies of the United States and, as a condition of receiving federal Medicaid or CHIP funding, from the states. MACPAC must also submit reports and recommendations to the HHS Secretary and the states. The MACPAC membership is expanded to include individuals who have direct experience as Medicaid and CHIP enrollees or parents/caregivers of enrollees. § 2801 (amending 42 U.S.C. § 1396).

Effective date: March 23, 2010.

Special Rules Relating to Indians, PPACA § 2901

This section prohibits cost-sharing for Indians with incomes below 300 percent of FPL who are enrolled in qualified health plans offered through the exchange. § 2901(a). It also stipulates that health programs operated by the Indian Health Service, Urban Indian or tribal organizations, or Indian Tribes are the payors of last resort for any services they provide to eligible individuals. § 2901(b).

Section 1396a(e)(13) of the Medicaid Act gives states the option of allowing an Express Lane agency to make determinations whether a child satisfies one or more components of eligibility for Medicaid. States may designate a variety of public agencies as Express Lane agencies, including the state Medicaid agency, agencies that determine eligibility for CHIP, Temporary Assistance for Needy Families, or Head Start, as well as others. 42 U.S.C. § 1396a(e)(13)(F). The PPACA adds the Indian Health Service, Indian Tribes and tribal organizations to this list of entities. § 2901(c).

Effective date: March 23, 2010.

Maternal, Infant, and Early Childhood Home Visiting Programs, PPACA § 2951

This newly created section of Title V of the Social Security Act seeks to strengthen and improve programs for maternal and child health, to improve care coordination in at-risk communities, and identify and provide comprehensive services to improve outcomes for families in at-risk communities. Within six months of PPACA enactment, states must conduct a

statewide needs assessment as a condition of receiving their fiscal year 2011 Title V allotment. The needs assessment must identify communities with concentrations of the following:

- premature birth, low-birth weight infants and infant mortality;
- poverty;
- crime;
- domestic violence;
- high rates of high school drop-outs;
- substance abuse;
- unemployment; or
- child maltreatment.

Additionally, the needs assessment must identify the quality and capacity of existing programs for early childhood home visitation in the state, and the state's capacity for providing substance abuse treatment and counseling services. States must submit to the HHS Secretary the results of the statewide needs assessment and a description of how they plan to address the needs, including through the grants available through this section. § 2951(b) (amending 42 U.S.C. § 701 *et seq.*).

This section authorizes the HHS Secretary to make grants to eligible entities for delivery of services under early childhood home visitation programs to promote improvements in maternal and prenatal health, infant health, child health and development, parenting, school readiness and socioeconomic status of such families, as well as reduction in child abuse, neglect and injuries. Grantees must ensure that participation by families is voluntary. In providing services, eligible entities must prioritize high-risk populations. Programs need to have quantifiable, measurable improvement in benchmark areas. Eligible entities must establish three- and five-year benchmarks for demonstrating program results in terms of improvements in:

- maternal and newborn health;
- prevention of child injuries, abuse, neglect and maltreatment;
- school readiness and achievement;
- reduction in crime or domestic abuse;
- family economic self-sufficiency; and
- coordination and referrals for other community resources and supports. § 2951(c), (d).

Funds appropriated for this program include $1.5 billion over five years to states, territories and Indian tribes.

States must conduct the needs assessment no later than six months after the date of enactment of this legislation. Reports to the Secretary of HHS on the home visitation program must be provided no later than 30 days after the end of the third year of the grant, and final reports are due by December 31, 2015.

Effective date: March 23, 2010.

Services to an Individual with a Postpartum Condition and Their Families, PPACA § 2952

According to the American College of Obstetricians and Gynecologists (ACOG), nearly 10 percent of mothers experience postpartum depression. Section 2952 "encourages" the HHS Secretary to expand research into the causes and treatment of postpartum depression and psychosis, and to provide grants for direct services to people with or at risk for postpartum depression and their families.

Specific activities include:

- expanding research into the causes of postpartum depression;
- developing of screening and diagnostic techniques;
- developing of new treatments; and
- increasing awareness of postpartum depression through public education.

PPACA § 2952(a) (adding 42 U.S.C. § 712(b)). In addition, this provision expresses the "sense of Congress" that the National Institute of Mental Health may conduct a longitudinal study from 2010-2019 on the mental health consequences for women from a range of pregnancy outcomes including carrying a pregnancy to term and parenting the child, carrying the pregnancy to term and placing the child for adoption, miscarriage, and abortion.

Services to Individuals with a Postpartum Condition and Their Families, PHSA § 512

In addition, the PPACA adds a new § 512 to the Maternal and Child Health Services Block Grant, 42 U.S.C. § 712, to allow the Secretary to make grants to public and non profit entities to fund projects that develop, operate, or coordinate the provision of direct services to people with or at risk for postpartum depression. The PPACA authorizes $3 million for fiscal year 2010, and "such sums as necessary" for fiscal years 2011 and 2012. PPACA § 2952(b).

Personal Responsibility Education, PPACA §§ 2953, 10201

Personal Responsibility Education, PHSA § 513

The PPACA adds a new § 513 to the Maternal and Child Health Services Block Grant, 42 U.S.C. § 713, that requires the HHS Secretary to allocate funding to the states for programs that work to reduce teen pregnancy and birth rates by educating adolescents ages 10-19 on abstinence and contraception, prevention of pregnancy and STIs and HIV, and preparation for adulthood. Each state must apply to obtain funding. Funding allocations are to be proportionate based on the state's proportion of residents ages 10-19 relative to the population of the state. The minimum state allocation is $250,000 per year.

To qualify for funding, the programs must be evidence-based, medically accurate, complete, age appropriate, culturally competent, and include skill development such as healthy relationships, healthy marriages, financial literacy, career skills, and healthy living skills. § 2953, § 10201 (adding 42 U.S.C. § 713).

If a state does *not* apply for funding under this section in fiscal years 2010 and 2011, the Secretary is required to solicit proposals from non profit organizations that may include faith-based organizations in that state. PPACA §§ 2953, 10201 (adding 42 U.S.C. § 713 (a)(4)(A)).

States and organizations that apply must expend the same level of non-federal funding as was spent in fiscal year 2009. §§ 2953, 10201 (adding 42 U.S.C. § 713 (a)(5)).

Congress appropriated $75 million for each fiscal year 2010 through 2014. Of those funds, $10 million is reserved for innovative pregnancy prevention programs targeted at at-risk youth. From the remaining amount, five percent is reserved for Indian tribes; and 10 percent is reserved for administrative support, technical assistance, training, evaluation, and consultation and resources for grantees. PPACA §§ 2953, 10201 (adding 42 U.S.C. § 713(c)).

Restoration of Funding for Abstinence Education, PPACA § 2954

Despite significant research and evidence that abstinence-only-until-marriage education is not effective in delaying adolescent sexual activity and postponing teen pregnancy, and may result in higher rates of sexually transmitted infections among adolescents, the PPACA restores funding for abstinence education that President Obama had omitted from his 2010-2011 budget and that Congress had allowed to expire. Some abstinence-only programs have been criticized for providing inaccurate and/or biased information.

The PPACA amends 42 U.S.C. § 710 to allocate $50 million per year for fiscal years 2010 – 2014 for abstinence-only-until-marriage education. The statute allows only funding for programs that have as their "exclusive purpose" the teaching of abstinence, that sexual activity should only occur in monogamous marriage relationships, sexual activity outside of marriage has harmful psychological and physical effects, and that bearing children outside of marriage "likely has harmful consequences for the child, the child's parents and society." 42 U.S.C. § 710(b)(2)(A-H).

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, PPACA § 2955

This provision amends three different sections of the Social Security Act. The first part amends 42 U.S.C. § 675(5)(H), which governs the case review system for foster care children by inserting language about the importance of having a designee to make health care decisions on behalf of a child if the child is unable to make the decisions. It also provides the child with the option of executing a health care power of attorney, health care proxy or other similar document. This clarifies that the child is being given the legal authority to execute a legal document even though he or she is below the age of consent. § 2955(a) (amending 42 U.S.C. § 675(5)(H)).

The section also amends 42 U.S.C. § 677(b)(3), which governs the transition of foster care youth to self-sufficiency by requiring certification by the chief executive officer of a state that the state will ensure that an adolescent in the foster care independence program will be

educated about the importance of having a designee to make health care decisions on her/his behalf if the child is unable to make the decisions. It also provides the child with the option of executing a health care power of attorney, health care proxy or other similar document. As described above, the child is being given the legal authority to executive a legal document even thought he or she is below the age of consent. § 2955(b) (amending 42 U.S.C. § 677(b)(3)).

Finally, this section amends 42 U.S.C. § 622(b)(15)(A), which involves child welfare services by adding that child welfare services must take steps to ensure that foster care children are given information about a health care power of attorney, health care proxy or other similar document, and the option to execute such a document. § 2955(c) (amending 42 U.S.C. § 622(b)(15)(A)).

Effective date: October 1, 2010.

Incentives for States to Offer Home and Community Based Services as a Long-Term Care Alternative to Nursing Homes, PPACA § 10202

This section creates the State Balancing Incentive Payments Program (SBIPP) to offer states the incentive of an increase of two or five percent to a state's FMAP on non-institutionally based long-term care services and supports to a state that incorporates certain changes to encourage and significantly increase the use of home and community based services over institutional care by October 1, 2015.

The SBIPP is open to states for which less than half of current long-term care and support expenditures are for non-institutional services. § 10202(b)(1). In 2007, this described all except six states, while half of the states spent less than 25 percent of their long-term care and support money for seniors and people with disabilities on home and community based services. § 2406(a)(4). A state must apply to the Secretary and receive program approval to participate in this program. § 10202(b)(2), (b)(3). A state may seek to participate in SBIPP either through a state plan amendment or through a federal waiver. § 10202(f)(4). If a state chooses to expand the use of HCBS through a state plan amendment under 42 U.S.C. §1396n(i), then the state may expand income eligibility for these services, currently limited under federal Medicaid law at 150 percent FPL, to as high as three times the federal SSI rate. § 10202(c)(1)(B). The program creates incentives for a state to spend less on nursing facility and intermediate care facilities for the mentally retarded, and instead spend the same money and the incentive money on home and community based services, personal care services, and home health care services. § 10202(f)(1).

A state may qualify for the program in one of two ways. If in fiscal year 2009, the state spent less than 25 percent of its long-term care and support services money on HCBS, the state may receive a five percent increase in its federal matching rate on these services by adopting a target of increasing the amount spent on HCBS to 25 percent. § 10202(c)(2)(A), (d)(1). The other option is to adopt a target of 50 percent of long-term care and support services from HCBS and then receive a two percent increase in the state's FMAP for these services. § 10202(c)(2)(B), (d)(2). In either case, the increased match applies to a state's Medicaid HCBS services provided under this program, and the state may not apply eligibility standards, methodologies, or procedures for determining eligibility for the non-institutionally-based long-

term care and support services that are more restrictive than the eligibility standards, methodologies, or procedures that are in effect as of December 31, 2010. § 10202(c)(3). Furthermore, any additional funding that the state receives under this program must be used to provide new or expanded non-institutionally-based services in the state's Medicaid program. § 10202(c)(4). A maximum of 3 billion in total aggregate payments will be available under this program. § 10202(e)(2).

To be eligible for this program and the additional funding, the state must agree to make certain structural changes within six months of applying for the program. § 10202(c)(5). While an earlier section seems to imply that states have flexibility in choosing which changes to make, this later section clearly requires states to implement six structural changes in order to qualify for the program. *Compare* § 10202(c)(1)(A) to (c)(5) and (c)(6). The six areas are:

- "No Wrong Door – Single Entry Point System": The state must develop a statewide system for individuals to access all long-term services and supports. Note that the language says "all long-term services and supports," not only the non-institutionally based services and supports. The access point may be through an agency, organization, coordinated network or portal. The system would provide availability information, application information, referral services, and financial and functional eligibility determinations or assistance with assessment processes for financial and functional eligibility. § 10202(c)(5)(A).
- Conflict-free case management services to develop a service plan, arrange for services and supports, support the beneficiary (and the caregiver, if appropriate) in directing the provision of services and supports, and monitoring to assure that the beneficiary's needs and outcomes are met. § 10202(c)(5)(B).
- Development of core standardized assessment instruments to determine eligibility for the non-institutionally based services and supports. Note that eligibility assessment instruments must be used uniformly throughout the state. The instruments would also be used to determine the beneficiary's need for training, support services, medical care, transportation and other services. The instruments must also be used to develop an individual service plan to address these needs. § 10202(c)(5)(C).
- Collection of services data on a per-beneficiary basis from all providers of non-institutionally based services and supports. § 10202(c)(6)(A).
- Collection of core quality data that are based on population-specific outcomes measures and accessible to providers. § 10202(c)(6)(B).
- Development of outcomes measures that are population-specific and accessible to providers. The outcomes measures must include beneficiary and family caregiver experience with providers, satisfaction with services, and beneficiary-specific measures that indicate whether desired outcomes are achieved in the individual case. § 10202(c)(6)(C).

States that participate in this program may receive the additional FMAP payments for eligible expenses incurred during the "balancing incentive period," which runs from October 1, 2011, through September 30, 2015. § 10202(e), (f)(2). States must meet the target percentages

of non-institutionally based services and supports by October 1, 2015. § 10202(c)(2). However, the six structural changes must be made within six months of application. § 10202(c)(5).