NASUAD
National Association of States United for Aging and Disabilities

AN ANALYSIS OF TITLE II – ROLE OF PUBLIC PROGRAMS

Summaries of Key Provisions in the "Patient Protection and Affordable Care Act" (HR 3590) as amended by the "Health Care and Education Reconciliation Act of 20120 (HR 4872) as of June 9, 2010

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<tr><th>Initiative</th><th>Summary</th><th>Important Dates</th><th>FMAP</th><th>State Role/MOE</th><th>Exceptions/ Requirements</th></tr>
<tr><td colspan="6">COVERAGE EXPANSION</td></tr>
<tr><td>Medicaid Coverage Expansion</td><td>Medicaid will be expanded to provide coverage, consisting of at least the essential health benefits, to all individuals under 65 with incomes at or below 133% FPL (HR 3590, Sec. 2001, as amended by HR 4872, Sec. 1201).</td><td>January 1, 2014: Medicaid coverage will be expanded

Date of Enactment – January 1, 2014: the Maintenance of Effort (MOE) provisions apply

January 1, 2011 – December 31, 2013: A state may be exempt from the MOE provisions for certain adults</td><td>The cost of covering newly eligible individuals will be federally financed as shown in the chart below, with the FMAP decreasing until reaching 90% in 2020 and beyond:

<table><tr><th>FMAP %</th><th>YEAR</th></tr><tr><td>100</td><td>2014</td></tr><tr><td>100</td><td>2015</td></tr><tr><td>100</td><td>2016</td></tr><tr><td>95</td><td>2017</td></tr><tr><td>94</td><td>2018</td></tr><tr><td>93</td><td>2019</td></tr><tr><td>90</td><td>2020 +</td></tr></table></td><td>In order to receive federal payments during the period of time that begins on the date of enactment, and lasts until the Exchanges are fully operational, states may not have in place Medicaid eligibility standards that are more restrictive than those in effect on the date of Enactment.</td><td>Beginning on December 31, 2010, a state certifying that it currently has or will have a budget deficit in the succeeding fiscal year, may be exempt from the MOE requirement with respect to non-pregnant, non-disabled adults with incomes above 133% FPL. This exemption will be available from January 1, 2011</td></tr>
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					– December 31, 2013.
State option to expand Medicaid coverage earlier	States may enact a state plan amendment to provide Medicaid coverage, consisting of at least the essential health benefits, to all individuals under 65 with incomes at or below 133% FPL (HR 3590, Sec. 2001).	April 1, 2010 – January 1, 2014: States may expand Medicaid coverage through a state plan amendment		States may phase in the extension of eligibility to these individuals based on income.	States may not extend eligibility to higher income individuals before it is extended to lower income individuals.
State option to expand Medicaid to higher income individuals	States will have the option to provide Medicaid coverage, consisting of at least the essential health benefits, to individuals under 65 with incomes exceeding 133% FPL (HR 3590, Sec. 2001).	January 1, 2014: States will have this option		States may phase in the extension of eligibility to these individuals based on categorical group or income.	States may not extend eligibility to higher income individuals before it is extended to lower income individuals
Medicaid expansion for former foster care children	Children under the age of 26 who have "aged out" of foster care will remain eligible for Medicaid (HR 3590, Sec. 2004).	January 1, 2019: This expansion is effective		If an individual simultaneously qualifies for Medicaid coverage under this eligibility group and under the 133 percent expansion group, the state must enroll the individual into this group.	The child must have been in foster care for more than six months, and the child must have been enrolled in Medicaid on the day he or she "aged out."
CHIP	The current reauthorization period	From the date of	From October 1, 2013 –	From the date of	The enhanced FMAP

	for CHIP is expanded for two years, through September 30, 2015. After October 1, 2013, the enrollment bonus payments for children ends (HR 3590, Sec. 2101).	enactment and until October 1, 1019: the Maintenance of Effort (MOE) provisions apply	September 30, 2019, states will receive a 23 percentage point FMAP increase.	enactment and until October 1, 1019, in order to receive Federal payments during this period, states may not have in effect CHIP eligibility standards that are more restrictive than they those in place on the date of Enactment.	will have a ceiling of 100%.
ENROLLMENT					
Medicaid enrollment	A state will establish procedures enabling individuals to apply for and be enrolled in Medicaid through a website (HR 3590, Sec. 2201).	January 1, 2014: The Maintenance of Effort (MOE) provisions apply		Beginning January 1, 2014, in order to receive any federal financial assistance, a state must comply with these enrollment requirements.	
Medicaid and CHIP enrollment	For those individuals that the Exchange identifies as eligible for enrollment in Medicaid or CHIP, the state will establish procedures for enrolling those individuals accordingly (HR 3590, Sec. 2201).	January 1, 2014: The Maintenance of Effort (MOE) provisions apply		Beginning January 1, 2014, in order to receive any federal financial assistance, a state must comply with these enrollment requirements.	

Exchange Enrollment	A state will establish procedures for ensuring that individuals who are deemed ineligible for Medicaid or CHIP are screened for eligibility in the Exchange and for premium assistance, and enrolled accordingly (HR 3590, Sec. 2201)	January 1, 2014: The Maintenance of Effort (MOE) provisions apply		Beginning January 1, 2014, in order to receive any federal financial assistance, a state must comply with these enrollment requirements.	
Enrollment Coordination	A state must ensure that the State Medicaid Agency, the State CHIP Agency and the Exchanges utilize a secure electronic interface to determine eligibility for Medicaid, CHIP, premium assistance, and the Exchange, and to enroll these individuals accordingly (HR 3590, Sec. 2201).	January 1, 2014: The Maintenance of Effort (MOE) provisions apply		Beginning January 1, 2014, in order to receive any federal financial assistance, a state must comply with these enrollment requirements.	
Service Coordination	A state must establish procedures to coordinate the coverage, including the provision of services, for individuals enrolled in both Medicaid and the Exchange (HR 3590, Sec. 2201).	January 1, 2014: The Maintenance of Effort (MOE) provisions apply		Beginning January 1, 2014, in order to receive any federal financial assistance, a state must comply with these enrollment requirements.	
Outreach and Enrollment	A state must establish procedures for reaching out to vulnerable and underserved populations and for enrolling those who are eligible	January 1, 2014: The Maintenance of Effort (MOE) provisions apply		Beginning January 1, 2014, in order to receive any federal financial assistance, a state must	

	into Medicaid and CHIP (HR 3590, Sec. 2201).			comply with these enrollment requirements.	
Optional Coordination	The State Medicaid Agency and the State CHIP Agency may enter into an agreement with the Exchange under which either state agency may determine the eligibility for a resident in that state to receive premium assistance for participation in the Exchange (HR 3590, Sec. 2201).	January 1, 2014: The Maintenance of Effort (MOE) provisions apply		Beginning January 1, 2014, in order to receive any federal financial assistance, a state must comply with these enrollment requirements.	The agreement must meet conditions and requirements to be determined by the Secretary of the Treasury
Streamlined Enrollment System	The State Medicaid Agency and the State CHIP Agency shall participate in, and comply with, the requirements for a streamlined enrollment system established under Section 1413 of the PPACA (HR 3590, Sec. 2201).	January 1, 2014: The Maintenance of Effort provisions apply		Beginning January 1, 2014, in order to receive any federal financial assistance, a state must comply with these enrollment requirements.	
Enrollment Website	By January 1, 2014, each state must have an operating website that is linked to the Exchange, to the State CHIP Agency, and to the State Medicaid Agency. (HR 3590, Sec.2201).	January 1, 2014: The Maintenance of Effort provisions apply		Beginning January 1, 2014, in order to receive any federal financial assistance, a state must comply with these enrollment requirements.	The site must allow an individual eligible for Medicaid, CHIP, or premium assistance for participating in the Exchange to compare the

					benefits, premiums and cost-sharing requirements among plans.
Permitting Hospitals to determine eligibility	Any hospitals that are participating providers under Medicaid may elect to be a qualified entity for purposes of determining an individual's Medicaid eligibility (HR 3590, Sec. 2202).	January 1, 2014: This provision is effective and applies to services furnished on or after this date		At the option of the state, a qualifying hospital may choose to operate in this capacity.	
LONG-TERM SERVICES AND SUPPORTS					
Community First Choice Option	Gives states the option to amend their state Medicaid plans to provide home and community based services and supports to consumers eligible for medical assistance under the state plan whose incomes do not exceed 150 percent FPL, or, if greater, to consumers who meet their state's nursing facility clinical eligibility standards (HR 3590, Sec. 2401, as amended by HR 4872, Sec. 1205).	October 1, 2011: States will have this option	Participating states will receive a six percent enhanced FMAP with respect to the applicable assistance provided to eligible consumers.	During the first full fiscal year in which the state plan amendment is implemented, states must maintain or exceed the level of state expenditures for medical assistance that it provided to individuals with disabilities or elderly individuals in the preceding fiscal year.	
Removal of Barriers to	States will have more flexibility in using the state plan amendment	The first day of the first fiscal quarter		States will have the option to create	The Secretary will develop rules and

providing HCBS	option to provide home and community based services to Medicaid beneficiaries (HR 3590, Sec. 2402).	after enactment/April 1, 2010: These provisions are effective		additional categories of beneficiaries for providing home and community based services and full Medicaid benefits, and states will be able to target services to specific populations.	regulations to ensure that all states develop home and community based service systems that are responsive to beneficiaries, that assist consumers in developing a self-directed treatment plan, and that improve coordination among public programs.
Money Follows the Person	The program is extended through 2016, and the eligibility requirements are modified by reducing the institutional residency period to not more than 90 consecutive days (HR 3590, Sec. 2403).	30 days following enactment: the program is authorized for each of fiscal years 2011 - 2016			Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehab services will not be taken into account for determining the 90-day requirement.
Protection against Spousal Impoverishment	For five years, the protections against spousal impoverishment that apply to the spouses of	January 1, 2014: Beginning on this date, the			

	Medicaid-enrolled nursing home residents will apply to the spouses of Medicaid-enrolled home and community based service recipients (HR 3590, Sec. 2404).	protections will be applied for five years			
Funding to Expand ADRCs	Additional funding is appropriated to the Secretary, acting through the Assistant Secretary for Aging, to carry out the provisions of the Older Americans Act that create and strengthen ADRCs (HR 3590, Sec. 2405).	Fiscal years 2010 – 2014: $10 million, for each of these fiscal years, appropriated			
MEDICAID PRESCRIPTION DRUG COVERAGE					
Minimum Rebate for Brand Name Drugs	For brand name drugs, the minimum rebate percentage is increased from 15.1% of the average manufacturer price (AMP) to 23.1% of AMP (HR 3590, Sec. 2501).	January 1, 2010: The new rebate periods begin			The amount of savings resulting from the increases in the rebate percentages will be remitted to the Federal government, and the maximum rebate amount for each brand name drug is 100% of AMP.
Minimum	For brand name drugs that are	January 1, 2010:			The amount of

Rebate for Brand Name clotting factors and pediatric drugs	qualifying clotting factors or are for pediatric use only, the minimum rebate percentage is increased from 15.1% to 17.1% (HR 3590, Sec. 2501).	The new rebate periods begin			savings resulting from the increases in the rebate percentages will be remitted to the Federal government, and the maximum rebate amount for each brand name drug is 100% of AMP.
Minimum Rebate for Generic Drugs	For generic drugs, the rebate percentage is increased from 11% of AMP to 13% of AMP (HR 3590, Sec. 2501).	January 1, 2010: The new rebate periods begin			The amount of savings resulting from the increases in the rebate percentages will be remitted to the Federal government.
Extension of Prescription Drug Discounts to Enrollees of Medicaid Managed Care Organizations	Manufacturers that participate in the drug rebate program must pay rebates for drugs dispensed to individuals enrolled with a Medicaid MCO, if the MCO is responsible for coverage of such drugs. (HR 3590, Sec. 2501).	Date of Enactment/March 23, 2010: These provisions are effective		To facilitate the collection of these rebates, states must include utilization data reported by each Medicaid MCO to the states when requesting quarterly rebates from manufacturers, as well as in their quarterly utilization reports to	The amount of savings resulting from the increases in the rebate percentages will be remitted to the Federal government.

				CMS.	
QUALITY AND SYSTEM IMPROVEMENTS					
5-Year Period for Dual Eligibles Demonstration Projects	This section clarifies that the Medicaid waiver demonstration projects for coordinating care for dual eligibles may be conducted for five years (HR 3590, Sec. 2601).			Upon request of the state, the program may be extended for additional five-year periods.	Extensions will be granted unless the Secretary determines that for the previous waiver period, the waiver conditions were not met, or if it would not be cost-effective and efficient to extend the waiver.
Federal Coordinated Health Care Office	The Secretary will establish a Federal Coordinated Health Care Office to more effectively integrate Medicare and Medicaid benefits, to improve coordination between the federal government and the states for individuals eligible for benefits under both to ensure that individuals get full access to all services to which they are entitled (HR 3590, Sec. 2602).	March 1, 2010: By this date, the office will be established			The Office will provide dual eligibles with streamlined, simplified access to Medicaid and Medicare benefits, and will improve continuity and quality of care.
Adult Health Quality	The Secretary will develop procedures for determining a set	For each of fiscal years 2010 – 2014,		The Secretary will establish procedures	Each state with a plan or waiver under

Measures	of health quality measures for Medicaid eligible adults (HR 3590, Sec. 2701).	$60 million is appropriated. January 1, 2011: by this date, the sec. will identify a recommended set of adult health quality measures		for, and provide grants to, states to collect and voluntarily report health care quality data for Medicaid-eligible adults using a standardized format.	Title XIX shall annually report on the state-specific adult health quality measures applied by the state under the plan, and state-specific information on the quality of health care furnished to Medicaid eligible adults under the plan.
Health Care Acquired Conditions	The Secretary will compile a list of health-care acquired conditions, and states will not receive payments under the Medicaid program for any amounts expended for providing medical assistance for these conditions (HR 3590, Sec. 2702).	July 1, 2011: This provision goes into effect, and these payments will be prohibited			The prohibition on payment may not result in a loss of access to care or services for Medicaid beneficiaries.
Medicaid Health Homes	States will have the option enact a state plan amendment that would allow them to provide coordinated care for Medicaid-eligible individuals with chronic conditions through a health home (HR 3590, Sec. 2703).	January 1, 2011: The secretary may award planning grants to states for the purpose of developing a state plan amendment	States electing to amend their state plans to provide for this option will receive a 90 percent FMAP for the first two years that the amendment is in effect with respect to payments made	If awarded a planning grant, a state shall contribute an amount equal to the state share, without the ARRA-enhanced FMAP, for each year the grant is	

		under this section	by the state to the health home. After this initial period, such payments to the health home for applicable services will be treated as medical assistance.	awarded.	
Medicaid Bundled Payments Demonstration Project	The Secretary will establish a program to evaluate the use of bundled payments for the provision of integrated care for Medicaid beneficiaries with respect to an episode that includes hospitalization, and for concurrent physicians' services provided during hospitalization (HR 3590 Sec. 2704).	January 1, 2012 – December 31, 2016: The demonstration project will occur		The project will be conducted in up to eight states. Selected states may target particular categories of beneficiaries, particular diagnoses or particular geographic regions of a state.	The Secretary will determine what states will participate based on the state's potential to lower Medicaid costs while improving care for beneficiaries. The Secretary will ensure that the project is representative of the demographic and geographic composition of Medicaid beneficiaries nationally.
Medicaid Global Payment System	The Secretary, in coordination with the Center for Medicare and Medicaid Innovation, will establish	Fiscal Years 2010 – 2012: the program will operate, and		Up to five states may be selected by the Secretary to participate	

Demonstration Project	a project under which a participating state will adjust the payments made to safety net hospitals from a fee-for-service payment model to a global captivated payment model (HR 3590, Sec. 2705).	such sums as necessary to carry out the project are authorized		in the project.	