The 2011 State Legislators' Check List for Health Reform Implementation

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FY 2011 TASKS

American Health Benefits Exchanges

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**FY2011 Actions**	**ISSUE**

PLANNING FOR STATE EXCHANGE IMPLEMENTATION IN FY2014

The Affordable Care Act (ACA) establishes a plan to facilitate the purchase and sale of qualified health coverage in the individual market, and to provide options for small business through American Health Benefit Exchanges. The ACA directs states to establish and implement the operation of an exchange no later than January 1, 2014. State-established government or nonprofit entities will certifying plans and identify individuals eligible for Medicaid, CHIP, and premium and cost-sharing credits. States have several options to structure their exchanges and many of these decisions will be either made by state legislators or dependent upon actions they take in session from 2011 through to 2014.

INITIAL GUIDANCE TO STATES ON EXCHANGES

The Department of Health and Human Services released guidance November 18th to assist states in the development of their exchanges. The secretary plans to release regulations for public comment in 2011, but has provided this guidance to assist states and territories with their overall planning, including the legislative plans for 2011. This guidance is the first in a series of documents that will be released by HHS over the next three years. The categories of information in this document cover the following:

- Principles and Priorities
- Outline of Statutory Requirements
- Clarifications and Policy Guidance, and
- Federal Support for the Establishment of State based exchanges.

The exchanges have been defined as a mechanism for organizing the health insurance marketplace to help consumers and small business shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality.

LINK TO INITIAL GUIDANCE DOCUMENT— http://www.ncsl.org/documents/health/1118ExchGuid.pdf

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AMERICAN HEALTH BENEFITS EXCHANGES				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**FY2011 Actions**	**PLANNING FOR STATE EXCHANGE IMPLEMENTATION IN FY2014** *(continued)* **LEGISLATIVE CONSIDERATIONS [Based on recommendations from the NAIC model act]** ▪ State options for consideration relating to exchange structure: 1. Designation of the oversight authority within: ▪ a new or existing state agency, or ▪ an independent public agency, or quasi-governmental agency, 2. Whether to establish a regional or interstate exchange, and 3. Whether to operate a unified exchange by merging the SHOP Exchange[1] and the exchange for the individual market. ▪ Determine governance mechanisms if the exchange is not located within a state agency including: 1. a governing board, it's size, composition and terms, 2. determine the process of appointments to the board, their powers and duties, 3. designation of committees or other entities involved in day-to-day responsibilities, and 4. licensure requirements. ▪ If the state exchange will require certain health benefits that exceed the essential benefits package established by the Department of Health and Human Services. *(States must develop a mechanism to defray the cost of additional benefits in relation to premium and cost-sharing assistance for enrollees.)* ▪ Duties of the exchange. ▪ Designate state authority responsible for health benefit plan certification. ▪ Conform all state law to Federal ERISA fiduciary duties. ▪ Grant necessary rule making authority to appropriate state entities responsible for implementing state law related to exchanges. ▪ Determine budget for exchange, Medicaid, and CHIP information technology systems needs capable of meeting interoperability requirement, (refer to resource documents, **Guidance for Exchange and Medicaid IT Systems, Version 1.00).**

[1] "SHOP Exchange" is defined as meaning the Small Business Health Options Program.

FY 2011 TASKS				
AMERICAN HEALTH BENEFITS EXCHANGES				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**FY2011 Actions**	**GUIDANCE FOR STATUTORY REQUIREMENT** (BASED ON HHS GUIDANCE RELEASED NOVEMBER 17, 2010) According to the ACA there are two basic types of federal requirements for exchanges which include 1) minimum functions exchanges must undertake directly or, in some cases, by contract; and 2) oversight responsibilities the exchanges must exercise in certifying and monitoring the performance of Qualified Health Plans (QHPs). Plans participating in the exchanges must also comply with state insurance laws ad federal requirements in the Public Health Service Act. **I. EXCHANGE FUNCTIONS** ▪ **Core functions that an exchange must meet:** 1. Certification, recertification and decertification of plans, 2. Operation of a toll-free hotline, 3. Maintenance of a website for providing information on plans to current and prospective enrollees, 4. Assignment of a price and quality rating to plans, 5. Presentation of plan benefit options in a standardized format, 6. Provision of information on Medicaid and CHIP eligibility and determination of eligibility for individuals in these programs, 7. Provision of an electronic calculator to determine the actual cost of coverage taking into account eligibility for premium tax credits and cost sharing reductions, 8. Certification of individuals exempt from the individual responsibility requirement, 9. Provision of information on certain individuals and to employers, 10. Establishment of a Navigator program that provides grants to entities assisting consumers. ▪ **Additional Exchange functions include:** 1. Presentation of enrollee satisfaction survey results, 2. Provision for open enrollment periods, 3. Consultation with stakeholders, including tribes, and **4.** Publication of data on the exchange's administrative costs.

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AMERICAN HEALTH BENEFITS EXCHANGES				
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☐	☐	☐	**FY2011 Actions**	**GUIDANCE FOR STATUTORY REQUIREMENT** (BASED ON HHS GUIDANCE RELEASED NOVEMBER 17, 2010) (CONTINUED) **I. OVERSIGHT RESPONSIBILITIES** ▪ HHS is required to develop regulatory standards in five areas that insurers must meet in order to be certified as QHP by an Exchange: 1. Marketing 2. Network adequacy 3. Accreditation for performance measures 4. Quality improvement and reporting 5. Uniform enrollment procedures ▪ Additional areas where exchanges must ensure plan compliance with regulatory standards established by HHS include: 1. Information on the availability of in-network and out-of-network providers, including provider directories and availability of essential community providers, 2. Consideration of plan patterns and practices with respect to past premium increases and a submission of the plan justifications for current premium increases, 3. Public disclosure of plan data identified, including claims handling policies, financial disclosures, enrollment and disenrollment data, claims denials, rating practices, cost sharing for out of network coverage, and other information identified by HHS, 4. Timely information for consumers requesting their amount of cost sharing for specific services from specified providers, 5. Information for participants in group health plans, 6. Information on plan quality improvement activities.

FY 2011 TASKS				
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☐	☐	☐	FY2011 Actions	CLARIFICATION AND POLICY GUIDANCE (BASED ON HHS GUIDANCE RELEASED NOVEMBER 17, 2010) (CONTINUED)

States should consider the following issues in establishing an Exchange.

- **Organizational Form**. States have the option to establish their exchange as a governmental agency or nonprofit entity. Within the governmental agency category, the exchange could be housed within an existing state office, or it could be an independent public authority. Regardless of its organizational form, the exchange must be publicly accountable, transparent, and have technically competent leadership, with the capacity and authority to meet federal standards, including the discretion to determine whether health plans offered through the exchange are "in the interests of qualified individuals and qualified employers". Exchanges also must have security procedures and privacy standards necessary to receive tax data and other information needed for enrollment.
- **Operating Model**. States have options to operate their exchange from an "*active purchaser*" model, in which the exchange operates as large employers often do in using market leverage and the tools of managed competition to negotiate product offerings with insurers, to an "*open marketplace*" model, in which the exchange operates as a clearinghouse that is open to all qualified insurers and relies on market forces to generate product offerings. States should provide comparison shopping tools that promote choice based on price and quality and enable consumers to narrow plan options based on their preferences.
- **Small Business (SHOP) Exchanges**. Federal rules will provide a framework for SHOP Exchanges, including options for how employers can provide contributions toward employee coverage that meet standards for small business tax credits. States are permitted to define "small employers" as employers with one to 50 employees for plan years beginning before January 1, 2016. States with differing legal standards for counting employer size should review their definitions for consistency with federal law.
- **Risk Adjustment**. Federal rules in 2011 will outline *risk adjustment methods* and require all health plans to report demographic, diagnostic, and prescription drug data. Further guidance addressing risk adjustment rules and formulas will be provided in subsequent regulations. As specified by the law, federal rules will apply risk adjustment consistently to all plans in the individual and small group markets, both inside and outside of exchanges. Federal rules on reinsurance payments will apply to all plans in the individual market, and rules on risk corridors will apply to all qualified health plans in the individual and small group market, as specified in the law.

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AMERICAN HEALTH BENEFITS EXCHANGES				
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☐	☐	☐	**FY2011 Actions**	CLARIFICATION AND POLICY GUIDANCE (BASED ON HHS GUIDANCE RELEASED NOVEMBER 17, 2010) (CONTINUED) ▪ **Performance Measures**. Standardized public data reporting will be used to evaluate exchange performance and assure transparency. ▪ **State Choices**. Federal rules will clarify that the following policy areas, among others, are State decisions, although HHS may offer recommendations and technical assistance to States as they make these decisions: 1. Whether to form the exchange as a governmental agency or a non-profit entity, 2. Whether to form regional exchanges or establish interstate coordination for certain functions, 3. Whether to elect the option under the ACA to use 50 employees as the cutoff for small group market plans until 2016, which would limit access to exchange coverage to employer groups of 50 or less, 4. Whether to require additional benefits in the exchange beyond the essential health benefits, 5. Whether to establish a competitive bidding process for plans, 6. Whether to extend some or all exchange-specific regulations to the outside insurance market (beyond what is required in the ACA). ▪ **State Authority**. The federal government will work with the Governor of the State as the chief executive officer unless authority to operate the exchange has been delegated to a specific authority through state law.

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AMERICAN HEALTH BENEFITS EXCHANGES				
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☐	☐	☐	**FY2011 Actions**	**PLANNING FOR STATE EXCHANGE IMPLEMENTATION IN FY2014** *(continued)* **FUNDING OPPORTUNITY** **§ 1311 AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS *(STATE PLANNING GRANTS)*** ▪ Authorizes the Secretary of Health and Human Services to award grants to states to support planning efforts in the establishment of the American Health Benefit Exchange. ▪ Grants must be awarded within one year of enactment of the Affordable Care Act, March 2011. ▪ The amount of the grants to each state will be determined by the secretary. ▪ Planning grant recipients may renew the grant if the recipient— 1. is making progress toward establishing an Exchange; and implementing the insurance reforms that comply with the provisions within the health reform law; and 2. is meeting any benchmarks as established by the Secretary. **No grants may be awarded after January 1, 2015.**
☐	☐	☐	**FY2011 Actions**	**FUNDING OPPORTUNITY** **EARLY INNOVATORS GRANT** ▪ Announcement released by OCIIO[2] October 29, 2010. ▪ Provides competitive incentives for states to design and implement the Information Technology (IT) infrastructure needed to operate Health Insurance Exchanges - new competitive insurance market places that will help Americans and small businesses purchase affordable private health insurance starting in 2014. ▪ This competitive "Early Innovators" grant announcement will reward States that demonstrate leadership in developing cutting-edge and cost-effective consumer-based technologies and models for insurance eligibility and enrollment for Exchanges. These "Early Innovator" States will develop Exchange IT models, building universally essential components that can be adopted and tailored by other States. The innovations produced from this Cooperative Agreement will be used to help keep costs down for taxpayers, States, and the Federal Government. The systems developed through these Cooperative Agreements will complement the health plan information on HealthCare.gov. Two-year grants will be awarded by February 15, 2011 to up to five States or coalitions of States that have ambitious yet achievable proposals that can yield IT models and best practices that will benefit all States. These States will lead the way in developing consumer-friendly, cost-effective IT systems that can be used and adopted by other States and help all States and the Federal government save money as they work to develop these new competitive market places.

[2] OCIIO-Office of Consumer Information and Insurance Oversight.

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AMERICAN HEALTH BENEFITS EXCHANGES

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**FY2011 Actions**	**Rules** **FEDERAL FUNDING FOR MEDICAID ELIGIBILITY DETERMINATIONS AND ENROLLMENT ACTIVITIES PROPOSED RULES** ▪ CMS proposed rules were released November 3, 2010. ▪ Comment period 60 days. ▪ Provides an enhanced FFP of 90 percent for state expenditures for design, development, installation or enhancement of systems until calendar year 2015. ▪ Provides an enhanced FFP of 75 percent for maintenance and operation of systems before 2015 if the system already meets standards and after 2015 for systems that have just become compliant. Newly developed standards will build upon the work of the Medicaid Information Technology Architecture (MITA) (see resource documents, **MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE (MITA)**—framework documents)

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AMERICAN HEALTH BENEFITS EXCHANGES

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☐	☐	☐	**FY2011 Actions**	**RESOURCE DOCUMENTS** ▪ **HHS INITIAL GUIDANCE TO STATES ON EXCHANGES NOVEMBER 18, 2010—** http://www.ncsl.org/documents/health/1118ExchGuid.pdf ▪ **NATIONAL ASSOCIATION OF INSURANCE COMMISSIONER** "*American Health Benefit Exchange Model Act*" adopted 11/22/10, http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf ▪ **STATE PLANNING GRANTS—"EARLY INNOVATOR"** grants competitive funding to design and implement the information technology (IT) infrastructure needed to operate Health Insurance Exchanges. **1.** announcement released October 29, 2010- http://www.ncsl.org/documents/health/InstEIgrts.pdf **.** 2. grant application package- http://www.ncsl.org/documents/health/EarlyInovGrts.pdf . ▪ **GUIDANCE FOR EXCHANGE AND MEDICAID IT SYSTEMS, VERSION 1.0—** http://www.cms.gov/apps/docs/Joint-IT-Guidance-11-3-10-FINAL.pdf **.** ▪ HHS Memorandum: **Federal Support and Standards for Medicaid and Exchange Information Technology Systems** http://www.healthcare.gov/center/letters/improved_it_sys.pdf . ▪ **FEDERAL FUNDING FOR MEDICAID ELIGIBILITY DETERMINATIONS AND ENROLLMENT ACTIVITIES PROPOSED RULES—** http://www.ofr.gov/OFRUpload/OFRData/2010-27971_PI.pdf . ▪ **MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE (MITA)**—framework documents are available to the public at http://www.cms.gov/MedicaidInfoTechArch/ .

FY 2011 TASKS				
Fraud, Waste and Abuse				
NOT STARTED	IN PROGRESS	COMPLETED	EFFECTIVE DATE	
				Legislators should consider the potential financial impact of noncompliance with fraud, waste, and abuse provisions in the Affordable Care Act.
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** **§6402. FUNDING TO FIGHT FRAUD, WASTE, AND ABUSE.** ▪ Amends provisions in the Social Security Act pertaining to the Health Care Fraud and Abuse Control Account by adding additional funding of $95 million for FY 2011, $55 million for FY 2012, $30 million for FY 2013 and 2014, and $20 million for FY 2015 and 2016. ▪ The additional funding will be allocated for use by the Departments of Health and Human Services and Justice for their fraud and abuse control programs, and for the Medicare Integrity Program. ▪ The additional funding will also support Medicaid Integrity Program activities. **LEGISLATIVE CONSIDERATIONS** ▪ The Department of Health and Human Services Office of the Inspector General has released their plans for FY 2011 which will include a review of State Medicaid agencies' program integrity activities. They will examine state policies and procedures required by the federal regulations at 42 CFR pt. 455 to identify best practices and verify which procedures are operating as intended. Medicaid program integrity includes identifying payment risks, implementing actions to minimize the risks, and identifying and collecting overpayments.
☐	☐	☐	**FY 2011**	**ISSUE** **§10201. WAIVER TRANSPARENCY. -** Applies to applications for or renewal of experimental projects, pilots or demonstration projects under Section 1115 of the Social Security Act. **RESOURCE DOCUMENTS** ▪ **CMS Proposed Rules** released September 17, 2010, http://edocket.access.gpo.gov/2010/pdf/2010-23357.pdf
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** **§6402. ENHANCED MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.** ▪ **Overpayments -** Requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report was due, whichever is later. The ACA also provides that failure to return an overpayment within the timeframe is considered an "obligation" under the False Claims Act ("FCA") and could lead to liability for additional penalties if a FCA violation is found to exist. ▪ **National Provider Identifier -** Requires the Secretary to issue a regulation mandating that all Medicare, Medicaid, and CHIP providers include their NPI on enrollment applications. ▪ **Medicaid Management Information System** - Authorizes the Secretary to withhold the Federal matching payment to States for medical assistance expenditures when the State does not report enrollee encounter data in a timely manner to the State's Medicaid Management Information System (MMIS).

FY 2011 TASKS

FRAUD, WASTE AND ABUSE

NOT STARTED	IN PROGRESS	COMPLETED	EFFECTIVE DATE	
☐	☐	☐	**To be published in the final rule in FY2011**	ISSUE **§6411. EXPANSION OF THE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM -** Requires States to establish contracts with one or more Recovery Audit Contractors (RACs). These state RAC contracts would be established to identify underpayments and overpayments and to recoup overpayments made for services provided under state Medicaid plans as well as state plan waivers. RESOURCE DOCUMENTS ▪ **CMCS Informational Bulletin** (CPI-B 11-03) February 1, 2011, http://www.cms.gov/MedicaidIntegrityProgram/Downloads/6411racdelay.pdf . ▪ **The CMS** state Medicaid Directors letter October 1, 2010- http://www.cms.gov/smdl/downloads/SMD10021.pdf. ▪ **CMS Proposed Rules** released November 10, 2010, http://edocket.access.gpo.gov/2010/pdf/2010-28390.pdf.
☐	☐	☐	**Jan. 1, 2011**	ISSUE **§6501. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID - IF TERMINATED UNDER MEDICARE OR OTHER STATE PLAN -** Requires States to terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another state's Medicaid program.
☐	☐	☐	**Jan. 1, 2011**	ISSUE **§ 6502. MEDICAID EXCLUSION FROM PARTICIPATION RELATING TO CERTAIN OWNERSHIP, CONTROL, AND MANAGEMENT AFFILIATIONS.** Requires Medicaid agencies to exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that: (1) has failed to repay overpayments during the period as determined by the Secretary; (2) is suspended, excluded, or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.
☐	☐	☐	**Jan. 1, 2010**	ISSUE **§ 6504. REQUIREMENT TO REPORT EXPANDED SET OF DATA ELEMENTS UNDER MMIS TO DETECT FRAUD -** Requires states and Medicaid managed care entities to submit data elements from MMIS as determined necessary by the Secretary for program integrity, program oversight, and administration.
☐	☐	☐	**As determined by the Secretary.**	ISSUE **§ 6505. PROHIBITION ON PAYMENTS TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES -** Prohibits states from making any payments for items or services provided under a Medicaid state plan or waiver to any financial institution or entity located outside of the United States.

FY 2011 TASKS				
FRAUD, WASTE AND ABUSE				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** **§ 6506. OVERPAYMENTS -** Extends the period for states to repay uncollected overpayments to one year; states are still required to repay collections in the period collected. When overpayments due to fraud are pending a final determination of the amount of the overpayment due to an ongoing judicial or administrative process, state repayments of the Federal portion would not be due until 30 days after the date of the final judgment. **RESOURCE DOCUMENTS** **The Centers for Medicare and Medicaid Services** memorandum July 13, 2010, *Extended Period for Collection of Provider Overpayments,* http://www.cms.gov/smdl/downloads/SMD10014.pdf
☐	☐	☐		**ADDITIONAL RESOURCES** ▪ **Presentation from the National Association for Medicaid Program Integrity Conference:** Angela Brice-Smith, Director, Medicaid Integrity Group, Center for Program Integrity, Centers for Medicare and Medicaid Services, http://www.nampi.org/members/2010presentations/MIGUpdate.pdf.

FY 2011 TASKS

Health Care Facilities & Workforce

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**July 1, 2011**	**ISSUE** **§ 5503. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.** ▪ Beginning July 1, 2011, the secretary is directed to redistribute unfilled residency positions allotted for payment under the graduate medical education program, if they have been unfilled for three cost reports, and convert them for training of primary care physicians. ▪ Grants an exception to hospitals in rural areas with fewer than 250 acute care inpatient beds and hospitals that are part of a qualifying entity which had a voluntary residency reduction plan approved.
☐	☐	☐	**FY 2011**	**ISSUE** **§ 340H. PROGRAM OF PAYMENTS TO TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.** ▪ Creates a new section of the Public Health Service Act requiring HHS to make payments for direct and indirect costs to qualified teaching health centers (THCs) for the expansion of existing or the establishment of new approved graduate medical education (GME) training programs. ▪ Payments will be in addition to GME payments and will not count against the limit in number of full-time equivalent residents paid for by Medicare or Children's Hospital GME Programs. ▪ Payments are to be reduced by 25 percent if the THC fails to report certain information. ▪ Appropriates for this purpose may not exceed $230 million, for the period of FY2011 through FY2015.

FY 2011 TASKS

HEALTH CARE FACILITIES & WORKFORCE

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**FY2011**	**ISSUE** *(FUNDING)* **§ 10503. COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS FUND.** ▪ Creates the Community Health Center Fund. ▪ Appropriates $1 billion for FY 2011, for community health center operations and patient services, and ▪ Also appropriates $1.5 billion for health center construction and renovation to be available for FY2011 through FY2015 and remain available until expended. ▪ Applications were accepted beginning August 9, 2010 through January 7, 2011. ▪ Projected award date August 2011.
☐	☐	☐	**Dec. 31, 2011**	**ISSUE** **§ 6102. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES AND NURSING FACILITIES.** ▪ Directs HHS to establish and implement a quality assurance and performance improvement program for Medicare and Medicaid skilled nursing facilities (SNFs) and nursing facilities (NFs), including multi unit chains of facilities. ▪ Calls for the establishment of standards relating to quality assurance and performance improvement. ▪ Facilities must develop and submit a plan to meet these standards to HHS by the end of FY 2015.
☐	☐	☐	**FY 2011**	**ISSUE** **§ 1109. PAYMENT FOR QUALIFYING HOSPITALS.** ▪ Increases Medicare payments to acute care hospitals in low-cost counties by $400 million for fiscal years 2011 and 2012. ▪ Qualifying hospitals must be located in counties ranked in the lowest quartile of adjusted Medicare Part A and B benefit spending. ▪ Payments will be in proportion to its Medicare inpatient hospital payments relative to Medicare inpatient hospital payments for all qualifying hospitals.

FY 2011 TASKS				
HEALTH CARE FACILITIES & WORKFORCE				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**Deadline Sept. 30, 2011**	ISSUE [*GRANT OPPORTUNITY*] **§ 10502. INFRASTRUCTURE TO EXPAND ACCESS TO CARE. [hospital construction grants]** ▪ Authorizes $100 million beginning in FY 2010 through to September 30, 2011 for debt service, construction or renovation of: 1. a health care facility that provides research 2. an inpatient tertiary care facility, or 3. an outpatient clinical services facility. ▪ The applicable facility must be affiliated with an academic health center at a public research university that contains the state's sole public academic medical and dental school. ▪ To be eligible the governor of a state must submit an application to HHS that certifies that the new facility is critical for the provision of greater access to care, the facility is essential to the viability of the schools, the additional support would be no more than 40 percent of the total cost, and the state has established a dedicated funding mechanism necessary to complete the project.

FY 2011 Tasks				
Insurance Reform				
Not Started	**In Progress**	**Completed**	**Implementation Date**	
☐	☐	☐	**FY2011** Standards developed within 12 months of enactment. Implement use of documents within 24 months of enactment.	**Issue** **§1001 Development and Utilization of Uniform Explanation of Coverage Documents and Standardized Definitions.** ▪ Directs HHS to develop standards within 12 months of enactment for summaries and benefits information to be used by health insurers to inform beneficiaries of their insurance coverage. ▪ Noncompliance by health insurers will result in a fine of $1000 per incident. Applies to all health insurers. **Legislative Considerations** ▪ May preempt state law if the state requirements provide less information than is required in the Affordable Care Act. ▪ Analyze and conform as necessary state laws relating to required plan information distributed to health insurance beneficiaries.
☐	☐	☐	**Jan. 1, 2011**	**Issue** **§1001 Bringing Down the Cost of Health Care Coverage (Medical Loss Ratio [MLR]).** ▪ Requires health insurance issuers (group, individual, and grandfathered health plans) to report to HHS annually their ratio of incurred loss (claims) plus the loss adjustment expense (change in contract reserves) to earned premiums. The report must include total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that the coverage expends: 1. On payment for medical services, 2. For health care quality improvement, 3. On all non-claims costs, excluding federal and state taxes and licensing or regulatory fees. ▪ Issuers will not have to account for collections or receipts for risk adjustment, risk, corridors, and payments of reinsurance until 2014. ▪ Insurers will be required to provide an annual rebate to enrollees if the ratio of the amount of premium revenue expended on costs versus total premium revenue for the plan year is less than 85 percent in the large group market, or 80 percent in the small group market. **Legislative Considerations** ▪ Review state medical loss reporting requirements and harmonize state definitions, application, and scope with those established under federal law. ▪ Conform state law to mirror federal requirements concerning calculation and timing of rebate payments **Resource Documents** ▪ **Interim Final Rule Technical Correction**, 12/30/10, http://edocket.access.gpo.gov/2010/pdf/2010-32526.pdf . ▪ **OCIIO Technical Guidance (OCIIO 2010 – 2A)**: Process to Request an Adjustment to the MLR Standard, 12/17/10, http://www.hhs.gov/cciio/regulations/12-17-2010ociio_2010-2a_guidance.pdf . ▪ **OCIIO Interim Final Rule** posted 11/22/10, http://www.ofr.gov/OFRUpload/OFRData/2010-29596_PI.pdf . ▪ **The National Association of Insurance Commissioners** Regulation adopted 10/21/10, http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf .

FY 2011 TASKS				
LONG-TERM CARE				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	Jan. 1, 2011	ISSUE **§ 8002. COMMUNITY LIVING ASSISTANCE SERVICE AND SUPPORTS.** ▪ Establishes a new, voluntary, self-funded public long-term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations. Requires the Secretary to develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides cash benefit that is not less than an average of $50 per day. No taxpayer funds will be used to pay benefits under this provision. ▪ Creates a new national insurance program to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities. ▪ Financed through voluntary payroll deductions (with opt-out enrollment similar to Medicare Part B), this program will remove barriers to independence and choice (e.g., housing modifications, assistive technologies, personal assistance services, transportation) by providing a cash benefit to individuals unable to perform two or more functional activities of daily living. *DEFINITIONS* ▪ "Active enrollee" means an individual who has enrolled and paid premiums to maintain enrollment. "Activities of daily living" include eating, toileting, transferring, bathing, dressing, and incontinence or the cognitive equivalent. ▪ An "eligible beneficiary" has paid premiums for at least 60 months and for at least 12 consecutive months. (§ 3203) *CLASS INDEPENDENT BENEFIT PLAN* ▪ Directs the Secretary of Health & Human Services to develop two alternative benefit plans within specified limits. ▪ The monthly maximum premiums will be set by the Secretary to ensure 75 years of solvency. ▪ There is a five year vesting period for benefit eligibility. ▪ The benefit triggers when an individual is unable to perform not less than two activities of daily living for at least 90 days. ▪ The cash benefit will be not less than $50 per day. ▪ Not later than October 1, 2012, the Secretary will designate a CLASS benefit plan, taking into consideration the recommendations of the CLASS Independence Advisory Council.

FY 2011 TASKS			
LONG-TERM CARE			
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE
☐	☐	☐	Jan. 1, 2011

ISSUE

§ 8002. COMMUNITY LIVING ASSISTANCE SERVICE AND SUPPORTS. *(continued)*

ENROLLMENT AND DISENROLLMENT

- The Secretary will establish procedures to allow for voluntary automatic enrollment by employers, as well as alternative enrollment processes for self-employed, employees of non-participating employers, spouses and others. Individuals may choose to waive enrollment in CLASS in a form and manner to be established by the Secretary. **Employees must opt-out of the program or they will be enrolled automatically**.
- Premiums will be deducted from wages or self-employment income according to procedures established by the Secretary.

BENEFITS

- Eligible beneficiaries will receive appropriate cash benefits to which they are entitled, advocacy services, and advice and assistance counseling.
- Cash benefits will be paid into a Life Independence Account to purchase non-medical services and supports needed to maintain a beneficiary's independence at home or in another residential setting, including home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and added nursing support.

CLASS INDEPENDENCE FUND

- The CLASS Independence Fund will be located in the Department of the Treasury and the Secretary of the Treasury will act as the Managing Trustee.
- A CLASS Independence Fund Board of Trustees will include the Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, the Secretary of Health & Human Services, and two members of the public.

CLASS INDEPENDENCE ADVISORY COUNCIL

- The CLASS Independence Advisory Council, created under this Title, will include not more than 15 members, named by the President, a majority of whom will include representatives of individuals who participate or are likely to participate in the CLASS program.
- The Council will advise the Secretary on matters of general policy relating to CLASS

RESOURCE DOCUMENTS

CRS report: **C**ommunity Living Assistance Services and Supports (CLASS) Provisions in the Patient Protection and Affordable Care Act (PPACA), http://www.ncsl.org/documents/health/CLASS.pdf .

FY 2011 TASKS

MEDICAID

NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** [*BUDGET ITEM*] **§2006. SPECIAL ADJUSTMENT TO FMAP DETERMINATION FOR CERTAIN STATES RECOVERING FROM A MAJOR DISASTER.** ▪ Reduces projected decreases in federal Medicaid matching funds as a result of the regular updating process, for states that have experienced major disaster. ▪ To qualify as a "disaster recovery FMAP adjustment state", a state must have over the past seven fiscal years received a Presidential declaration of a major disaster under the provisions of sec. 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act **and** every county or Parrish in the state statewide was eligible for both individual and public assistance.
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** *[BUDGET ITEM]* **§2001. STATE FINANCIAL HARDSHIP EXEMPTION.** ▪ Between January 1, 2011 and December 31, 2013, a state is exempt from the maintenance-of-effort for optional non-pregnant, non-disabled adult populations above 133 percent of the federal poverty level if the state certifies to the Secretary that the state is experiencing a budget deficit for the year in which the certification is made or projects to have a budget deficit for a succeeding state fiscal year. **LEGISLATIVE CONSIDERATIONS** ▪ A state may make the necessary certification that they are experiencing a budget deficit on or after December 31, 2010.
☐	☐	☐	**July 1, 2011**	**ISSUE** *[BUDGET ITEM]* **§2005. PAYMENTS TO TERRITORIES.** ▪ Beginning in July 1, 2011 through September 30, 2019, all territories' FMAP rate and spending caps will be increased. ▪ Requires territories in 2014 to provide coverage to childless adults who met income eligibility standards consistent with those already established for parents by the territories. ▪ Provides that the cost of providing coverage to newly eligible individuals will not count towards the spending cap. *TERRITORIES AND THE HEALTH INSURANCE EXCHANGES* Each territory will have a one-time option to "opt-in" to state (or territory)-based insurance exchanges in 2014.

FY 2011 TASKS				
MEDICAID				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	March 2011	ISSUE **§6401. PROVIDER SCREENING AND OTHER ENROLLMENT REQUIREMENTS UNDER MEDICARE, MEDICAID, AND CHIP.** ▪ Directs HHS in consultation with the Office of the Inspector General to establish procedures for screening of providers and suppliers who enroll in the Medicare, Medicaid, and CHIP programs. ▪ At a minimum the procedures would include a process for screening, enhanced oversight measures, disclosure requirements, moratoriums on enrollment, and requirements for developing compliance programs. ▪ To cover the costs of the screening, certain providers would be subject to fees. Fees would start at $500 for institutional providers and would increase by the rate of inflation thereafter. ▪ The HHS may exempt the fees if they impose a hardship. ▪ Enforcement of compliance of the requirements will begin March 2011 for all new providers in the programs. ▪ Compliance for all current providers will go into effect two years after enactment of the ACA in 2013. LEGISLATIVE CONSIDERATIONS In addition to the requirements listed above, the Office of the inspector general plans to review in their FY 2011 work plan how states ensure that Medicaid managed care plans follow a structured process for credentialing and recredentialing of providers. Regulations at 42 CFR 438.214 require states to ensure that managed care plans serving the Medicaid population implement written policies for selection and retention of providers. Each managed care plan must document its process for credentialing and recredentialing providers that have signed contracts or participation agreements. Plans must not employ or contract with provides excluded from participation in federal health care programs. They will also be examining how CMS ensures that states comply with requirements for provider credentialing by Medicaid managed care plans. RESOURCE DOCUMENT ▪ **CMS Final Rule with Comment Period** February 2, 2011, http://edocket.access.gpo.gov/2011/pdf/2011-1686.pdf . ▪ **CMS Proposed Rule** published September 23, 2010. http://edocket.access.gpo.gov/2010/pdf/2010-23579.pdf ▪ **HHS presentation** during the National Association for Medicaid Program Integrity Conference September 2010, http://www.nampi.org/members/2010presentations/MIGUpdate.pdf.

FY 2011 TASKS				
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NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	FY 2011	ISSUE *[DEMONSTRATION]* **§2707. MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT.** ▪ Requires the Secretary of HHS to establish a three-year Medicaid demonstration project in **up to eight states**. ▪ Participating states would be required to reimburse certain institutions for mental disease (IMDs) for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition. *APPROPRIATIONS* ▪ Appropriates $75 million for FY 2011. These funds will remain available for obligation through December 31, 2015. *EVALUATION* ▪ Directs the Secretary to conduct an evaluation to determine the impact of the demonstration project and to make recommendations as to whether the demonstration project should be continued after December 31, 2013 and expanded nationwide. *REPORT TO CONGRESS* ▪ Directs the Secretary to submit a report to Congress no later than December 31, 2013 and make available to the public a report on the findings of the evaluation. RESOURCE DOCUMENT ▪ **Substance Abuse and Mental Health Services Administration** (SAMHSA) document- http://www.samhsa.gov/healthreform/docs/Medicaid_Emergency_Psychiatric_Demo_508.pdf

FY 2011 TASKS				
MEDICAID				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	October 1, 2010	ISSUE **CHANGES TO MEDICAID PAYMENT FOR PRESCRIPTION DRUGS** **§2503. MEDICAID PHARMACY REIMBURSEMENT.** ▪ Changes the Federal upper payment limit (FUL) to no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recent average manufacturer prices (AMPs) for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through retail community pharmacies. ▪ Establishes a new formula for determining AMP based on sales to wholesalers and sales to retail community pharmacies. ▪ Effective on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date. RESOURCE DOCUMENT ▪ **CMS FINAL RULE NOVEMBER 15, 2010—** Medicaid Program; Withdrawal of Determination of Average Manufacturer Price, Multiple Source Drug Definition, and Upper Limits for Multiple Source Drugs HTTP://EDOCKET.ACCESS.GPO.GOV/2010/PDF/2010-28649.PDF ▪ **CMS memo** September 28, 2010, *Revised Policy on Federal Offset of Rebates, http://www.cms.gov/smdl/downloads/SMD10019.pdf*
☐	☐	☐	Jan. 1, 2010	ISSUE **§2501. INCREASE MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS.** ▪ Increases the minimum manufacturer rebate for brand-name drugs purchased by state Medicaid programs from 15.1% of average manufacturer price to 23.1% of average manufacturer price. *Increase Minimum Rebate Percentage for Clotting Factors and Drugs Approved by the FDA for Pediatric Use Only* ▪ Increases the minimum manufacturer rebate for brand-name drugs purchased by state Medicaid programs from 15.1% of average manufacturer price to 17.1% of average manufacturer price. *Application of Rebates to New Formulations of Existing Drugs* ▪ The rebate for line extension drugs will be the greater of the amount computed under the rebate statute or the product of the AMP for the line extension drug multiplied by the highest additional rebate for any strength of the original brand name drug.

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☐	☐	☐		ISSUE **§2501. INCREASE MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS. (CONTINUED)** *Rebates for Drugs Dispensed by Medicaid Managed Care Organizations (MCOs)* ▪ Requires manufacturers to pay rebates for drugs dispensed by Medicaid MCOs, effective March 23, 2010. *Limit on Total Rebate Liability* ▪ Limits total rebate liability on an individual single source or innovator multiple source drug to 100 percent of AMP for that drug product. Other features of the drug rebate program, such as the Medicaid's best price provision, would remain unchanged. RESOURCE DOCUMENT **CMS memo** September 28, 2010, *Revised Policy on Federal Offset of Rebates,* *http://www.cms.gov/smdl/downloads/SMD10019.pdf*

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☐	☐	☐	Jan. 1, 2010	ISSUE **§2501. INCREASED REBATE PERCENTAGE FOR GENERIC DRUGS.** ▪ Increases the rebate percentage for non innovator, multiple source drugs to 13% of AMP. RESOURCE DOCUMENT ▪ **CMS memo** September 28, 2010, *Revised Policy on Federal Offset of Rebates,* http://www.cms.gov/smdl/downloads/SMD10019.pdf
☐	☐	☐		ISSUE **§2501. MAXIMUM REBATE AMOUNT.** Increases the amount of rebates that drug manufacturers are required to pay under the Medicaid drug rebate program, with different formulas for single source and innovator multiple source drugs (brand name drugs), noninnovator multiple source drugs (generic drugs), and drugs that are line extensions of a single source drug or an innovator multiple source drug, effective January 1, 2010. The Affordable Care Act also required that amounts "attributable" to these increased rebates be remitted to the Federal government drug. RESOURCE DOCUMENT **CMS memo** September 28, 2010, *Revised Policy on Federal Offset of Rebates,* http://www.cms.gov/smdl/downloads/SMD10019.pdf

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NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**Oct. 1, 2011**	**ISSUE** *[BUDGET ITEM]* **§2401. COMMUNITY FIRST CHOICE OPTION.** *State Plan Option to Provide Home and Community-Based Attendant Services and Supports* ▪ Establishes an optional Medicaid benefit which allows states to offer community-based attendant services and supports to Medicaid beneficiaries to assist in accomplishing activities of daily living, instrumental activities of daily living, and health related tasks through hands-on assistance, supervision, or cueing in a person-centered plan that is based on an assessment of functional need. ▪ Provides an **enhanced federal matching rate** of an additional six percentage points for reimbursable expenses in the program. ▪ Consider the need for any statutory changes made necessary to accommodate a state plan amendment if your state opts to participate in this program. **RESOURCE DOCUMENT** **National Association of State Units on Aging** (NASUA), LONG-TERM CARE IN BRIEF: Explaining the Medicaid Community First Choice Option, http://www.nasuad.org/documentation/aca/NASUAD_materials/ltcb_communityfirstchoiceoption.pdf.
☐	☐	☐	**Oct. 1, 2011**	**ISSUE** *[BUDGET ITEM]* **§10202. INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES.** ▪ Incentivizes states that undertake structural reforms in their Medicaid programs designed to create home and community based services (HCBS) as a viable alternative to nursing home care with a targeted enhanced FMAP. ▪ States may participate through a waiver or a state plan amendment. ▪ States that choose a SPA would be able to include individuals with incomes up to 300 percent of the maximum Supplemental Security Income payment. ▪ Funding for the nursing home diversion program would be available for five years beginning in 2011.

FY 2011 TASKS				
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NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	Oct. 1, 2011	ISSUE *[BUDGET ITEM]* **§10202. INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES. *(continued)*** *Enhanced Federal Matching Payments* ▪ FMAP increases will be tied to the percentage of a state's LTC services and supports offered through HCBS, with lower increases going to states needing fewer reforms as follows: ▪ States with less than 25 percent of their total Medicaid long-term care expenditures for FY 2009 on HCBS will set their target for spending 25 percent for these services, to be achieved by October 1, 2015. **These states will receive a 5 percentage point increase in their FMAP.** ▪ Other participating states will set their target percentage for HCBS as a percentage of their Medicaid long term services and supports spending at 50 percent, to be achieved by October 1, 2015. **These states will receive a 2 percentage point increase.** ▪ Maintenance of Effort and Other Requirements ▪ States must maintain their eligibility standards, methodologies, or procedures for determining eligibility for these services at levels that are no more restrictive than those in place on December 31, 2010. ▪ Requires that the additional federal funds be used to pay for new or expanded offerings of non-institutional-based long-term services and supports. ▪ Requires states to implement several structural changes to their Medicaid programs within six-months of application, including: ▪ the implementation of a —**no wrong door policy** where beneficiaries may access LTC services and supports through a coordinated network, agency or other statewide system; ▪ the development of conflict-free case management services; and ▪ development of core assessment instruments to determine eligibility for non-institutionally-based long-term services and supports. ▪ Requires state to collect data tracking service use, quality, and outcomes by beneficiaries and their families. *Funding* ▪ $3 billion in federal matching funds will be available to incentivize states for the five-year period between October 1, 2011 and September 30, 2016. ▪ Consider the need for any statutory changes made necessary to accommodate a state plan amendment if your state opts to participate in this program. RESOURCE DOCUMENT ▪ **National Association of State Units on Aging** (NASUA), LONG-TERM CARE IN BRIEF: Explaining the Medicaid Community First Choice Option, http://www.nasuad.org/documentation/aca/NASUAD_materials/ltcb_communityfirstchoiceoption.pdf

FY 2011 TASKS				
MEDICAID				
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☐	☐	☐	July 1, 2011	**ISSUE** **§2702. PROHIBITS FEDERAL PAYMENTS TO STATES FOR MEDICAID SERVICES RELATED TO HEALTH CARE ACQUIRED CONDITIONS. [HEALTH-CARE ACQUIRED CONDITIONS (HACS)]** ▪ Will be defined by the secretary and consistent with the definition of hospital acquired conditions[3] under Medicare, but would not be limited to conditions acquired in hospitals. ▪ State Medicaid programs that continue to reimburse health care providers for services associated with a health care acquired condition will no longer receive the federal match for those services. ▪ When the Medicare rule affecting claims payment was implemented several states adopted similar reimbursement practices found in the federal rule for hospital claims, some states opted to negotiated agreements with their large hospital systems and the state hospital associations to refrain from billing when these events occurred. **LEGISLATIVE CONSIDERATIONS** ▪ Legislative intervention may be needed to enable state Medicaid agencies to adopt reimbursement practices that restrict payment for health care acquired conditions. ▪ Consider budgetary impact if state Medicaid policies do not conform to CMS requirements for nonpayment. ▪ Legislators may want to consider a hold harmless provision If none exists in state law protecting Medicaid beneficiaries for responsibility of payment for services when an error is made on the part of a provider, either administrative or a practice error that applies to the HAC provisions. **RESOURCE DOCUMENTS** ▪ **National Guideline Clearinghouse** http://www.guideline.gov/resources/hospital-acquired-conditions.aspx

[3] Deficit Reduction Act Sec. 5001. Hospital Quality Improvement: (c) Quality Adjustment in DRG Payments for Certain Hospital Acquired Infections-(1) Amends Section 1886(d)(4) of the Social Security Act by adding language that states that for discharges occurring after October 1, 2008, the diagnosis related group (DRG) assigned may not result in a higher payment based on a secondary diagnosis associated with conditions identified by the secretary that could have reasonably been avoided through the application of evidence-based guidelines. Hospitals will be required to report the secondary diagnosis present on admission of the patient.

FY 2011 TASKS				
MEDICAID				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	Jan. 1, 2011	ISSUE **§2703. STATE PLAN OPTION PROMOTING HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS.** ▪ Creates a new Medicaid state plan option under which Medicaid enrollees with at least two chronic conditions or with one chronic condition and at risk of developing another chronic condition, could designate a provider as their health home. ▪ Requires qualifying providers to meet certain standards, including demonstrating that they have the systems and infrastructure in place to provide comprehensive and timely high-quality care either in-house or by contracting with a team of health professionals. ▪ The designated provider or a team of health professionals will offer the following services: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; and referral to community and social support services, if relevant and as feasible use health information technology to link such services. ▪ Teams of providers could be free-standing, virtual, or based at a hospital, community health center, clinic, physician's office, or physician group practice. ▪ Directs the state to develop a mechanism to pay the health home for services rendered. The state plan amendment will include a plan for tracking avoidable hospital readmissions and plan for producing savings resulting from improved chronic care coordination and management. *FEDERAL MATCH PAYMENTS* ▪ Provides an **enhanced match of 90 percent** FMAP for two years for states that take up this option. ▪ In addition, small planning grants may be available to help states intending to take up this option. Pre-Recovery Act service match rate. *EVALUATION* ▪ Requires an independent evaluation be conducted after two years to assess the impact of this option on reducing hospital admissions. LEGISLATIVE CONSIDERATIONS ▪ Determine participation in state optional expansions. ▪ Consider cost-savings impact. RESOURCE DOCUMENTS ▪ **CMS Letter to State Medicaid Directors** November 16, 2010 http://www.cms.gov/smdl/downloads/SMD10024.pdf

FY 2011 TASKS				
MEDICAID				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** *[GRANT OPPORTUNITY]* **§2703. STATE PLAN OPTION PROMOTING HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS. [continued]** **PLANNING GRANTS** ▪ Authorizes the secretary to award planning grants to states for development of a new plan option, ▪ Requires a state match equal to pre-Recovery Act service match rate, and authorizes a maximum of $25 million for this purpose.
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** *[GRANT OPPORTUNITY]* **§4108. INCENTIVES FOR PREVENTION OF CHRONIC DISEASE IN MEDICAID. [PROGRAM FOR HEALTHY LIFESTYLES]** ▪ Creates a **grant program for states** to provide incentives to Medicaid beneficiaries who participate in a program to develop a healthy lifestyle. ▪ These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions. ▪ Appropriates $100 million for the program for a five-year period. **RESOURCE DOCUMENTS** ▪ **SAMHSA Fact Sheet,** http://www.samhsa.gov/healthreform/docs/Incentives_Prevention_Chronic_Disease_Medicaid_508.pdf .
☐	☐	☐	**January 1, 2011** publication deadline for core set of standards	**ISSUE** *[GRANT OPPORTUNITY]* **§2701. ADULT HEALTH QUALITY MEASURES.** ▪ Similar to the quality provisions enacted in CHIPRA, directs the HHS Secretary, in consultation with the states, to develop an initial set of health care quality measures specific to adults who are eligible for Medicaid. ▪ Establishes the Medicaid Quality Measurement Program which will expand upon existing quality measures, identify gaps in current quality measurement, establish priorities for the development and advancement of quality measures and consult with relevant stakeholders. ▪ Requires the Secretary, along with states, to regularly report to Congress the progress made in identifying quality measures and implementing them in each state's Medicaid program. ▪ Standardized reporting by the states would begin in 2013. ▪ States will have an opportunity to receive grant funding to support the development, collection, and reporting of quality measures. ▪ Appropriates $60 million for each FY 2010 through 2014. Total funds available for grants-$30 million

				through 2014.
FY 2011 TASKS				
MEDICARE				
NOT STARTED	**IN PROGRESS**	**COMPLETED**	**IMPLEMENTATION DATE**	
☐	☐	☐	**Jan., 1, 2011**	**ISSUE** **§3108. PERMITTING PHYSICIAN ASSISTANTS TO ORDER POST-HOSPITAL EXTENDED CARE SERVICES.** ▪ Adds physician assistances to the list of providers authorized to order (or certify) post-hospital extended care services for Medicare beneficiaries beginning January 1, 2011. ▪ May impact state dual eligible populations. **LEGISLATIVE CONSIDERATIONS** ▪ Conform as necessary the state Medicaid program criteria for authorization of post acute extended care with federal law.
☐	☐	☐	**July 1, 2011**	**ISSUE** **§3113. TREATMENT OF CERTAIN COMPLEX DIAGNOSTIC LABORATORY TESTS.** ▪ Directs HHS to conduct a demonstration project under part B under which separate payments may be made for complex diagnostic laboratory tests[4] to determine the impact on access to and quality of care, health outcomes, and expenditures. ▪ The demonstration project will be conducted over a two-year period beginning July 1, 2011. ▪ Payments may not exceed $100 million. **LEGISLATIVE CONSIDERATIONS** ▪ Consider impact on projected state expenditures for dual eligibles.

[4] "complex diagnostic laboratory tests' are defined as meaning a test: (1)that is an analysis of gene protein expression, (2) topographic genotyping, or a cancer chemotherapy sensitivity assay; (3) that is determined by the Secretary to be a laboratory test for which there is not an alternative test having equivalent performance characteristics; (4) which is billed using a Health Care Procedure Coding System (HCPCS) code other than a not otherwise classified code under such Coding System; (5) which is approved or cleared by the Food and Drug Administration or is covered under title XVIII of the Social Security Act; and (6) is described in section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3))

FY 2011 TASKS				
MEDICARE				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	Jan. 1, 2011	ISSUE **§3114. IMPROVED ACCESS FOR CERTIFIED NURSE-MIDWIFE SERVICES.** ▪ Amends the Social Security Act to increase coverage for certified nurse-midwife services to Medicare beneficiaries from 80 percent to full coverage as of January 1, 2011. LEGISLATIVE CONSIDERATIONS ▪ Consider impact on projected state expenditures for dual eligibles.
☐	☐	☐	Jan. 1, 2011	ISSUE **§3301. MEDICARE COVERAGE GAP DISCOUNT PROGRAM.** ▪ Effective January 1, 2011, the Discount Program will make manufacturer discounts available to applicable Medicare beneficiaries receiving applicable covered Part D[5] drugs while in the coverage gap. ▪ Drug manufacturer will be required to provide to Part D beneficiaries a 50 percent discount for brand-name drugs and biologics at point-of-sale. LEGISLATIVE CONSIDERATIONS Consider impact on projected state expenditures for dual eligibles and State Pharmaceutical Assistance Programs. RESOURCE DOCUMENTS ▪ **CMS memo** to plan sponsors April 30, 2010, Medicare Coverage Gap Discount Program beginning in 2011 https://www.cms.gov/PrescriptionDrugCovContra/Downloads/2011CoverageGapDiscount_043010v2.pdf ▪ **CMS memo** August 3, 2010, http://www.cms.gov/PrescriptionDrugCovGenIn/Downloads/CGDMemo_08.03.10.pdf ▪ **Medicare.gov:** Five Ways to Lower Your Costs During The Coverage Gap, http://www.medicare.gov/health-and-drugs/bridging-the-coverage-gap.aspx ▪ **CMS document**: Bridging the Coverage Gap, http://www.medicare.gov/health-and-drugs/bridging-the-coverage-gap.aspx .

[5] The Medicare Prescription Drug Benefit was enacted into law on December 8, 2003 the law re-designs Part D which establishes the Voluntary Prescription Drug Benefit Program. The Part D program is available for individuals who are entitled to Medicare Part A or enrolled in Medicare Part B. The Part D program became effective January 1, 2006. The prescription drug coverage is subject to an annual deductible, 25 percent coinsurance up to the initial coverage limit, and the greater of $2/$5 or five-percent catastrophic coverage for individuals that exceed the annual maximum true out-of-pocket threshold.

FY 2011 TASKS				
Medicare				
NOT STARTED	IN PROGRESS	COMPLETED	IMPLEMENTATION DATE	
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** **§4103. MEDICARE COVERAGE OF ANNUAL WELLNESS VISIT PROVIDING A PERSONALIZED PREVENTION PLAN.** ▪ Amends the Social Security Act to require that Medicare Part B cover once a year, without cost sharing, 'personalized prevention plan services[6],' including a comprehensive health risk assessment. **LEGISLATIVE CONSIDERATIONS** ▪ Consider impact on projected state expenditures for dual eligibles.
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** **§4104. REMOVAL OF BARRIERS TO PREVENTIVE SERVICES IN MEDICARE.** ▪ Amends the Social Security Act to define preventive services covered by Medicare to mean a specified list of currently covered services, including colorectal cancer screening services even if diagnostic or treatment services were furnished in connection with screening ▪ Waives beneficiary coinsurance requirements for most preventive services, requiring Medicare to cover 100% of the costs. ▪ Specifies that services for which no coinsurance would be required are the initial preventive physical examination (IPPE), personalized prevention plan services, any additional prevention service covered under the authority of HHS, and any currently covered preventive service (including medical nutrition therapy, and excluding electrocardiograms) if it is recommended with a grade of A or B by the U.S. Preventive Services Task Force (USPSTF)[7] **LEGISLATIVE CONSIDERATIONS** ▪ Consider impact on projected state expenditures for dual eligibles.
☐	☐	☐		**ADDITIONAL RESOURCE DOCUMENTS** ▪ **Agency on Aging Document: Affordable Care Act Opportunities for the Aging Network,** http://www.aoa.gov/Aging_Statistics/docs/AoA_Affordable_Care.pdf .

[6] "Personalized prevention plan services" means the creation of plan for an individual: (1) that includes a health risk assessment of the individual that is completed prior to or part of the same visit with a health professional; and (2) that takes into account the results of the health risk assessment.

[7] See the U.S. Preventive Services Task Force, http://www.ahrq.gov/clinic/uspstfix.htm .

FY 2011 TASKS				
Quality, Prevention & Wellness				
NOT STARTED	**IN PROGRESS**	**COMPLETED**	**IMPLEMENTATION DATE**	
☐	☐	☐	**Jan. 1, 2011**	**ISSUE** **§3011. NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE.** ▪ Directs the secretary to establish a national strategy for quality improvement in healthcare. ▪ The secretary must collaborate with state agencies responsible for administering the Medicaid and CHIP programs with respect to developing and disseminating strategies, goals, models, and timetables. ▪ The deadline for the initial submission of the strategy is no later than January 1, 2011. *HEALTH CARE QUALITY INTERNET WEBSITE* ▪ Directs the secretary to create an internet website to make public information regarding the national priorities for healthcare quality improvement, agency specific strategic plans, and other pertinent information the secretary deems appropriate. ▪ Implementation must be no later than January 1, 2011. **LEGISLATIVE CONSIDERATIONS** ▪ Consider the state needs for dissemination of information beyond electronic means. **RESOURCE DOCUMENTS** ▪ **OCIIO Interim Final Rules with Request for Comments**, September 23, 2010, http://www.healthcare.gov/center/regulations/prevention/regs.html . ▪ **HHS Proposed National Health Care Quality Strategy and Plan**: http://www.hhs.gov/news/reports/quality/nationalhealthcarequalitystrategy.pdf.

FY 2011 Tasks			
State Employee Benefit Changes			
Not Started	In Progress	Completed	Implementation Date
☐	☐	☐	Jan. 2011

Issue

Title IX—Revenue Provisions.

Imposes various restrictions on tax-advantaged accounts which are used to pay for unreimbursed medical expenses: health care Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs), Health Savings Accounts (HSAs), and Medical Savings Accounts (MSAs).

Legislative Considerations

Analyze and conform as necessary state employee benefit structures with the provisions in the new federal law concerning the following changes:

- **Distribution for medicine qualified only if for prescribed drug or insulin**
  § 9003—Staring in 2011, the PPACA will prohibit using funds from FSA, HAS, and MSA accounts for over-the-counter (OTC) medications (except insulin) unless they are prescribed by a physician beginning taxable years after December 31, 2010.
- **Increases in additional tax on distributions from HSAs and Archer MSAs not used for qualified medical expenses**
  § 9004—Increases the penalties imposed for account withdrawals for nonmedical purposes for those under age 65 in two accounts. The penalty for nonmedical withdrawals from HSAs will increase to 20% from 10%, and the penalty for nonmedical withdrawals from MSAs will increase to 20% from 15%.

Resource Documents

- **IRS Document**: Sample article for organizations to use to reach customers and taxpayers http://www.irs.gov/pub/irs-utl/oc_-_sept-mid_aca_cust_091710.pdf