

MEDICAID PROVISIONS AND ELDER LAW

(SECTION-BY-SECTION ANALYSIS)

(Information compiled from the Democratic Policy Committee (DPC) Report on The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. Available online at <http://dpc.senate.gov/healthreformbill/healthbill96.pdf>.)

Waiver

Sec. 1332. Waiver for State innovation. Beginning in 2017, allows States to apply for a waiver for up to 5 years of requirements relating to qualified health plans, Exchanges, cost-sharing reductions, tax credits, the individual responsibility requirement, and shared responsibility for employers. Requires States to enact a law and to comply with regulations that ensure transparency. Requires the Secretary to provide to a State the aggregate amount of tax credits and cost-sharing reductions that would have been paid to residents of the State in the absence of a waiver. Requires the Secretary to determine that the State plan for a waiver will provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as this title would provide; and that it will not increase the Federal deficit.

Electronic data exchange between Medicaid and other programs

Sec. 1413. Streamlining of procedures for enrollment through an Exchange and State Medicaid, CHIP, and health subsidy programs. Requires the Secretary to establish a system for the residents of each State to apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. The system will ensure that if any individual applying to an Exchange is found to be eligible for Medicaid or a State children's health insurance program (CHIP), the individual is enrolled for assistance under such plan or program.

Sec. 1414. Disclosures to carry out eligibility requirements for certain programs. Allows for limited disclosure of tax return information to carry out eligibility requirements for certain programs listed in the Act.

Sec. 1415. Premium tax credit and cost-sharing reduction payments disregarded for Federal and Federally-assisted programs. Precludes the premium assistance tax credits and cost-sharing reductions from being counted as income for purposes of determining eligibility for any Federal program or under any State or local program financed in whole or in part with Federal funds.

Health Information Technology

Sec. 1561. Health information technology enrollment standards and protocols. Requires the development of standards and protocols to promote the interoperability of systems for enrollment of individuals in Federal and State health and human services programs. These standards shall allow for electronic data matching, and electronic documentation. The Secretary may require State or other entities to incorporate such standards as a condition of receiving Federal health information technology funds.

Plan for Medicaid expansion

Sec. 2001. Medicaid coverage for the lowest income populations.

Eligibility. Creates a new State option to provide Medicaid coverage through a State plan amendment beginning on April 1, 2010, as amended by **Section 10201**. Eligible individuals include: all non-

elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents). Creates a new mandatory Medicaid eligibility category for all such “newly-eligible” individuals with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. Effective April 1, 2010, states have the option to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment.

Benefits. Newly-eligible, non-elderly, non-pregnant individuals would receive benchmark or benchmark-equivalent coverage consistent with the requirements of section 1937 of the Social Security Act. Benchmark and benchmark-equivalent coverage would be required to provide at least essential benefits (as defined for the Exchange) and prescription drugs and mental health services would be added to the list of services that must be covered at actuarial equivalence.

Increased Federal assistance. As amended by **Section 1201 of the *Reconciliation Act***, strikes the provision for a permanent 100 percent federal matching rate for Nebraska for the Medicaid costs of newly eligible individuals. Provides federal Medicaid matching payments for the costs of services to newly eligible individuals at the following rates: 100 percent in 2014, 2015, and 2016; 95 percent in 2017; 94 percent in 2018; 93 percent in 2019; and 90 percent thereafter. In the case of expansion states, additional federal support for covering nonpregnant childless adults is phased-in so that in 2019 and thereafter, expansion states would receive the same FMAP as other states for newly-eligible and previously-eligible nonpregnant childless adults.

Maintenance of income eligibility. States would be required to maintain the same income eligibility levels through December 31, 2013 for all adults. This “maintenance of effort” (MOE) requirement would be extended through September 30, 2019 for all children currently covered in Medicaid or CHIP. Between January 1, 2011 and January 1, 2014, a State would be exempt from the MOE requirement for optional, non-pregnant, non-disabled, adult populations whose family income is above 133 percent of FPL if the State certifies to the Secretary that the State is currently experiencing a budget deficit or projects to have a budget deficit in the following State fiscal year.

Sec. 2002. Income eligibility for nonelderly determined using modified adjusted gross income. Beginning January 1, 2014, States would be required to use modified adjusted gross income to determine Medicaid eligibility, the same measure used in the State Exchanges. Income disregards and asset tests would generally no longer apply in Medicaid, except for individuals eligible for long-term services and supports and individuals that are eligible for Medicaid through another program. As amended by **Section 1004 of the *Reconciliation Act***, applies a five percent income disregard for all Medicaid applicants.

Sec. 2003. Requirement to offer premium assistance for employer-sponsored insurance. Requires States to offer premium assistance and wrap-around benefits to all Medicaid beneficiaries who are offered employer-sponsored insurance (ESI) if it is cost-effective to do so, based on current law requirements.

Foster care children

Sec. 2004. Medicaid coverage for former foster care children. As amended by **Section 10201**, Makes the State option to cover former foster children in Medicaid mandatory, moves the effective date up to 2014, and limits it to only those children who have aged out of the foster care system as of

the date of enactment. Children who qualify for Medicaid through this eligibility pathway would receive all benefits under Medicaid, including EPSDT.

CHIP

Sec. 2101. Additional Federal financial participation for CHIP. Upon enactment, States would be required to maintain income eligibility levels for CHIP through September 30, 2019. From fiscal year 2014 to 2019, States would receive a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent. CHIP-eligible children who cannot enroll in CHIP due to Federal allotment caps would be eligible for tax credits in the State Exchange. As amended by **Section 10203**, extends the current reauthorization period of CHIP for two years, through September 30, 2015. States will receive a 23 percentage point increase in their federal match rates beginning fiscal year 2016 through fiscal year 2019. This provision also increases outreach and enrollment grants by \$40 million, makes some children of public employees eligible for CHIP, and precludes transitioning coverage from CHIP to the Exchange without Secretarial certification. It also requires insurers in the Exchange to report to the Secretary on pediatric quality measures.

Sec. 2102. Technical corrections. Makes technical corrections to selected provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the American Recovery and Reinvestment Act of 2009 (ARRA).

Enrollment simplification

Sec. 2201. Enrollment Simplification and coordination with State Health Insurance Exchanges. Allows individuals to apply for and enroll in Medicaid, CHIP or the Exchange through a State-run website. Requires State Medicaid and CHIP programs and the Exchange to coordinate enrollment procedures to provide seamless enrollment for all programs.

Hospital presumptive eligibility

Sec. 2202. Permitting hospitals to make presumptive eligibility determinations for all Medicaid eligible populations. Allows any hospital the option, based off preliminary information, to provide Medicaid services during a period of presumptive eligibility to members of all Medicaid eligibility categories.

Free standing birth centers

Sec. 2301. Coverage for freestanding birth center services. Requires coverage of services provided by free-standing birth centers.

Concurrent care for children

Sec. 2302. Concurrent care for children. Allows children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness.

Family planning services

Sec. 2303. State eligibility option for family planning services. Adds a new optional categorically-needy eligibility group to Medicaid comprised of (1) non-pregnant individuals with income up to the highest level applicable to pregnant women covered under Medicaid or CHIP, and (2) individuals eligible under the standards and processes of existing section 1115 waivers that provide family planning services and supplies. Benefits would be limited to family planning services and supplies, including related medical diagnostic and treatment services.

Explore Medicaid options, including community first choice option

Sec. 2401. Community First Choice Option. Establishes an optional Medicaid benefit through which States could offer community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require the level of care offered in a hospital, nursing facility, or intermediate care facility for the mentally retarded. As amended by **Section 1205 of the Reconciliation Act**, October 1, 2011 is the effective date for this policy.

Sec. 1205 of Reconciliation. Delay in Community First Choice Option. Postpones from October 1, 2010 until October 1, 2011 the effective date of the option established for State Medicaid programs to provide community-based long term services and supports for individuals who require an institutional level of care.

State plan amendment to expand home and community based services

Sec. 2402. Removal of barriers to providing home and community-based services. Removes barriers to providing home and community based services (HCBS) by giving States the option to provide more types of HCBS through a State plan amendment to individuals with higher levels of need, rather than through a waiver, and to extend full Medicaid benefits to individuals receiving HCBS under a State plan amendment.

Money Follows the Person

Sec. 2403. Money Follows the Person Rebalancing Demonstration. Extends the Money Follows the Person Rebalancing Demonstration through September 30, 2016 and changes the eligibility rules for individuals to participate in the demonstration project by requiring that individuals reside in an inpatient facility for not less than 90 consecutive days.

Protection for home and community-based services against spousal impoverishment

Sec. 2404. Protection for recipients of home and community-based services against spousal impoverishment. Requires States to apply spousal impoverishment rules to beneficiaries who receive HCBS. This provision would apply for a five-year period beginning on January 1, 2014.

Aging and disability resource centers

Sec. 2405. Funding to expand State Aging and Disability Resource Centers. Appropriates, to the Secretary of HHS, \$10 million for each of FYs 2010 through 2014 to carry out Aging and Disability Resource Center (ADRC) initiatives.

Prescription drug coverage

Sec. 2501. Prescription drug rebates. The flat rebate for single source and innovator multiple source outpatient prescription drugs would increase from 15.1 percent to 23.1 percent, except the rebate for clotting factors and outpatient drugs approved by the Food and Drug Administration exclusively for pediatric indications would increase to 17.1 percent. The basic rebate percentage for multi-source, non-innovator drugs would increase from 11 percent to 13 percent. Drug manufacturers would also be required to pay rebates for drugs dispensed to Medicaid beneficiaries who receive care from a Medicaid managed care organization (MCO). Total rebate liability would be limited to 100 percent of the average manufacturer price (AMP). Additional revenue generated by these increases will be remitted to the federal government. As amended by **Section 1206 of the Reconciliation Act**, for purposes of applying the additional rebate, narrows the definition of a new formulation of a drug to a line extension of a single source or innovator multiple source drug that is an oral solid dosage form of the drug.

Sec. 1206 of Reconciliation. Drug rebates for new formulations of existing drugs. For purposes of applying the additional rebate, narrows the definition of a new formulation of a drug to a line extension of a single source or innovator multiple source drug that is an oral solid dosage form of the drug.

Sec. 2502. Elimination of exclusion of coverage of certain drugs. Beginning with drugs dispensed on January 1, 2014, smoking cessation drugs, barbiturates, and benzodiazepines would be removed from Medicaid's excludable drug list.

Sec. 2503. Providing adequate pharmacy reimbursement. Requires the Secretary to calculate the Federal upper limit (FUL) as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies.

Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)

Sec. 2551. Disproportionate share hospital payments. As amended by Section 10201, States' disproportionate share hospital (DSH) allotments are reduced once a state's uninsured rate decreases by 45 percent. The initial reduction for states that spent 99.90 percent of their allotments over the five-year period of 2004 through 2008 would be 50 percent, unless they are defined as low DSH states, in which case they would receive a 25 percent reduction. The initial reduction for states that spent greater than 99.90 percent of their allotments would be 35 percent, or 17.5 percent for low DSH states in this category. As the uninsured rate continues to decline, states' DSH allotments would be reduced by a corresponding amount. At no time could a state's allotment be reduced by more than 50 percent compared to its FY2012 allotment. In addition, this section gives Hawaii a Medicaid Disproportionate Share Hospital allotment.

Sec. 1203 of Reconciliation. Disproportionate share hospital payments. Lowers the reduction in federal Medicaid DSH payments from \$18.1 billion to \$14.1 billion and advances the reductions to begin in fiscal year 2014. Directs the Secretary to develop a methodology for reducing DSH allotments to all states in order to achieve the mandated reductions. Extends through FY 2013 the federal DSH allotment for a state that has a \$0 allotment after FY 2011.

Sec. 2801. MACPAC assessment of policies affecting all Medicaid beneficiaries. Clarifies the topics to be reviewed by the Medicaid and CHIP Payment and Access Commission (MACPAC) including Federal Medicaid and CHIP regulations, additional reports of State-specific data, and an assessment of adult services in Medicaid. The provision would also authorize \$11 million to fund MACPAC for FY2010.

Protections for American Indians and Alaska Natives

Sec. 2901. Special rules relating to Indians. Prohibits cost-sharing for Indians enrolled in a qualified health benefit plan in the individual market through a State Exchange. Also, facilities operated by the Indian Health Service (IHS) and Indian, Tribal, and Urban Indian facilities (I/T/Us) would be added to the list of agencies that could serve as an "Express Lane" agency able to determine Medicaid and CHIP eligibility.

Power of attorney

Sec. 2955. Inclusion of information about the importance of having a health care power of attorney in transition planning for children aging out of foster care and independent living programs. Enables children aging out of the foster care system to have the opportunity to designate a medical power of attorney prior to emancipation from foster care. States must supply information and an opportunity for the child to designate another individual to make medical decisions on their behalf should they be unable to participate in such decision making process as part of the transition process for children expected to age out of the foster care system.

Dual-eligibles

Sec. 3306. Funding outreach and assistance for low-income programs. Provides \$45 million for outreach and education activities to State Health Insurance Programs, Administration on Aging, Aging Disability Resource Centers and the National Benefits Outreach and Enrollment.

Sec. 3309. Elimination of cost sharing for certain dual-eligible individuals. Eliminates cost sharing for beneficiaries receiving care under a home and community-based waiver program who would otherwise require institutional care.

Adult preventive services

Sec. 4106. Improving access to preventive services for eligible adults in Medicaid. The current Medicaid State option to provide other diagnostic, screening, preventive, and rehabilitation services would be expanded to include: (1) any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force and (2) with respect to adults, immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration. States that elect to cover these additional services and vaccines, and also prohibit cost-sharing for such services and vaccines, would receive an increased Federal medical assistance percentage (FMAP) of one percentage point for these services.

Tobacco cessation

Sec. 4107. Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid. States would be required to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use. Such services would include diagnostic, therapy and counseling services, and prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration for cessation of tobacco use by pregnant women. This section would also prohibit cost-sharing for these services.

Healthy lifestyle initiatives

Sec. 4108. Incentives for prevention of chronic diseases in Medicaid. The Secretary would award grants to States to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions.

Nursing home complaint resolution process

Sec. 6105. Standardized complaint form. Requires the Secretary to develop a standardized complaint form for use by residents (or a person acting on a resident's behalf) in filing complaints

with a State survey and certification agency and a State long-term care ombudsman program. States would also be required to establish complaint resolution processes.

Background checks for direct patient access employees

Sec. 6201. Nationwide program for National and State background checks on direct patient access employees of long-term care facilities and providers. Requires the Secretary to establish a nationwide program for national and State background checks on direct patient access employees of certain long-term supports and services facilities or providers. This program is based on the background check pilot program in the Medicare Modernization Act.

Elder justice

Sec. 6703. Elder Justice. Requires the Secretary of HHS, in consultation with the Departments of Justice and Labor, to award grants and carry out activities that provide greater protection to those individuals seeking care in facilities that provide long-term services and supports and provide greater incentives for individuals to train and seek employment at such facilities. Owners, operators, and certain employees of these facilities would be required to report suspected crimes committed at a facility. Owners or operators of such facilities would also be required to submit to the Secretary and to the State written notification of an impending closure of a facility within 60 days prior to the closure. In the notice, the owner or operator would be required to include a plan for transfer and adequate relocation of all residents.

State balancing incentive program

Sec. 10202. Incentives for States to offer home and community based services as a long-term care alternative to nursing homes. Adds a new policy that creates financial incentives for States to shift Medicaid beneficiaries out of nursing homes and into home and community based services (HCBS). The provision provides Federal Medical Assistance Percentage (FMAP) increases to States to rebalance their spending between nursing homes and HCBS.

CHIP Funding

Sec. 10203. Extension of funding for CHIP through fiscal year 2015 and other CHIP-related provisions. Extends the current reauthorization period of CHIP for two years, through September 30, 2015.

Income definitions

Sec. 1004 of Reconciliation. Income definitions. Modifies the definition of income that is used for purposes of tax credit and subsidy eligibility and the individual responsibility requirement. The modifications conform the income definition to information that is currently reported on the Form 1040 and to the present law income tax return filing thresholds. The provision also extends the exclusion from gross income for employer provided health coverage for adult children up to the end of the calendar year in which the child turns age 26.

Federal funding for states

Sec. 1201 of Reconciliation. Federal funding for States. Strikes the provision for a permanent 100 percent federal matching rate for Nebraska for the Medicaid costs of newly eligible individuals. Provides federal Medicaid matching payments for the costs of services to newly eligible individuals at the following rates: 100 percent in 2014, 2015, and 2016; 95 percent in 2017; 94 percent in 2018; 93 percent in 2019; and 90 percent thereafter. In the case of expansion states, additional federal support for covering nonpregnant childless adults is phased-in so that in 2019 and thereafter,

expansion states would receive the same FMAP as other states for newly-eligible and previously-eligible nonpregnant childless adults.

Increase rates to primary care doctors

Sec. 1202 of Reconciliation. Payments to primary care physicians. Requires that Medicaid payment rates to primary care physicians for furnishing primary care services be no less than 100% of Medicare payment rates in 2013 and 2014. Provides 100% federal funding for the additional costs to States of meeting this requirement.