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HEALTH REFORM 2009 – 2010: IMPLEMENTATION DATES

Summaries of Key Provisions affecting States, and the corresponding Implementation Dates as of March 31, 2010

“Patient Protection and Affordable Care Act” provisions as amended by the “Heath Care and Education Reconciliation Act of 2010”	**Implementation Dates**
State Balancing Incentive Payments Program: Effective October 1, 2011 – September 30, 2015, selected states will receive an increased FMAP of 5 percent or 2 percent with respect to medical assistance expenditures for non-institutionally-based long-term services and supports provided under the state Medicaid program. States whose long-term services and supports (LTSS) Medicaid expenditures on home and community based services equal less than 25 percent of their total Medicaid LTSS are eligible for the 5 percent increase; states whose LTSS Medicaid expenditures on home and community based services equal less than 50 percent of their total Medicaid LTSS are eligible for the 2 percent increase. States must agree to make structural changes within 6 months including: no wrong door single-entry-point system; conflict-free case management services; core standardized assessment services. The Secretary shall select participating states from among the applicants. (HR 3590, Sec. 10202).	October 1, 2011: Until September 30, 2015, states may receive an enhanced FMAP for certain expenditures as part of the State Balancing Incentive Payments Program.
Money Follows the Person Rebalancing Demonstration: Effective 30 days following enactment, Money Follows the Person will be authorized for each of fiscal year 2011-2016. This section modifies eligibility requirements by reducing the institutional residency period to not more than 90 consecutive	30 days following enactment: Money Follows the Person will be authorized for each of fiscal years 2011-2106.

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days and by eliminating the state's flexibility in setting this residency period themselves. Currently, states set this requirement within DRA's guidelines, which require that individuals reside in a facility for not less than 6 months, and not more than 2 years. (HR 3590, Sec. 2403).	
Community-Based Care Transitions Program: This section creates a new five year, $500 million HHS program that will begin January 1, 2011. Selected hospitals with high readmission rates and qualifying community based organizations will receive funding to provide improved care transition services to high risk Medicare beneficiaries. The Secretary will have discretion in transferring the funds from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the CMS Program Management Account. (HR 3590, Sec. 3026).	January 1, 2011: The five-year program that provides funding for improved care transition services to high-risk Medicare beneficiaries begins.
CLASS Plan: The Community Living Assistance Services and Support (CLASS) program is to be a national, voluntary insurance program for purchasing community living assistance services and supports. The CLASS Independence Benefit Plan will include a five year vesting period and a three year work requirement for eligibility of benefits. Benefits will trigger for an individual when he or she is determined to have a qualifying functional limitation that is expected to last for a continuous period of more than 90 days. Eligible beneficiaries will receive a cash benefit of no less than an average of $50 per day, and the amount received will be scaled to correspond with the enrollee's functional ability. (HR 3590, Sec. 8002).	October 1, 2012: Designation by Secretary of CLASS Independence Benefit Plan, which shall be published in a final rule that allows for a period of public comment.
Nursing Home Transparency: Skilled nursing facilities (SNFs) and nursing	Within two years of Enactment: The Secretary will create final regulations

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facilities (NFs) will be required to disclose information relating to ownership, organizational structure and management of the facility. (HR 3590, Sec. 6101). SNFs and NFs will also be required to implement an ethics program for internal use (HR 3590, Sec. 11281).	for disclosure and reporting requirements, including a standardized format. Within 36 months of enactment: SNFs and NFs must implement an ethics program
Community First Choice Option: Gives states the option, beginning October 1, 2011, of amending their state Medicaid plans to provide home and community based attendant services and supports to (1) consumers eligible for medical assistance under the state plan whose incomes do not exceed 150 percent FPL, or, if greater, to (2) consumers who meet their state's nursing facility clinical eligibility standards. Available services include ADL task assistance, electronic service backup systems, and training on the management of attendants. Permissible services include transition costs from the facility to the community based home setting, and additional, qualifying, individual needs. Participating states will receive a 6 percentage point FMAP increase. The state must meet certain requirements for their amendment to be approved, such as maintaining or exceeding their previous fiscal year's medical assistance expenditure levels in the first full FY of the program's implementation. The services authorized under this section will be evaluated based on data provided to the Secretary by the states. (HR 3590, Sec. 2401, amended by HR 4872, Sec. 1205).	October 1, 2011: States will have the option to amend their state Medicaid plans to be able to provide home and community based services to qualifying consumers.
Protection for Recipients of HCBS against Spousal Impoverishment: For five years, beginning on January 1, 2014, states will be required to apply spousal impoverishment rules to HCBS beneficiaries. (HR 3590, Sec. 2404).	January 1, 2014: States must apply spousal impoverishment rules to HCBS beneficiaries for five years.

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Coverage of Preventive Services: Coverage will be provided and cost-sharing will be eliminated for qualifying, evidence-based preventive services (HR 3590, Sec. 2713). Medicare beneficiaries will have access to an annual wellness visit, including a comprehensive health risk assessment and personalized prevention plan (HR 3590, Sec. 4103). Medicare payments for certain preventive services furnished on or after January 1, 2011, will be increased to 100 percent of actual charges or fee schedule rates (HR 3590, Sec. 4103). As of January 1, 2013, states providing medical assistance under Medicaid for qualifying preventive services and prohibiting cost-sharing for these services will receive a one percentage point FMAP increase in respect to the medical assistance furnished for these services (HR 3590, Sec. 4106).	Within six months of enactment: Qualified health plans must provide minimum coverage without cost-sharing for certain preventive services. Within 18 months of enactment: The Secretary will make a comprehensive needs assessment model available. January 1, 2011: With respect to qualifying services performed on or after this date, increased Medicare payments will apply. January 1, 2013: States providing medical assistance under Medicaid for qualifying preventive services may receive a one percentage point FMAP increase in respect to this assistance.
Hospital Readmissions Reduction Program: This provision directs CMS to track national and hospital-specific data on the readmission rates of Medicare participating hospitals for certain high-cost conditions that have high rates of potentially avoidable hospital readmissions (HR 3590, Sec. 3025, amended by Sec. 10309).	October 1, 2012: Payments for discharges may be reduced.
Medicaid Expansion: In 2013 and 2014, Medicaid payment rates for primary care doctors will be increased to equal Medicare reimbursement rates. States will receive 100 percent federal financing to pay for the increase (HR 4872, Sec. 1202). Medicaid will be expanded to include all individuals under age 65, including	January 1, 2013: Through January 1, 2015, Medicaid payment rates for primary doctors will be increased. January 1, 2014: Medicaid eligibility expands to include all individuals under age 65, including children, pregnant women, parents, and adults without dependent children, with incomes not exceeding 133 percent FPL.

children, pregnant women, parents, and adults without dependent children, with incomes not exceeding 133 percent FPL (HR 3590, Sec. 2001). Newly Medicaid eligible adults will be guaranteed a benchmark benefit package consistent with the requirements of Section 1937 of the Social Security Act. The package must at least provide the essential health benefits, which will be financed with 100 percent federal funding for 2014-2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent for 2020 and beyond (HR 4872, Sec. 1201). For states already covering adults with incomes up to 100 percent FPL, or "expansion states," they will received a phased-in FMAP increase for non-pregnant childless adults to the extent necessary so that in 2020, these states will receive the same 90 percent federal financing as non-expansion states. The federal government will not cover the entire cost of expanding Medicaid in Nebraska in perpetuity (HR 4872, Sec. 1201).	2014: Federal funding for the cost of covering newly eligible individuals begin, in both expansion and non-expansion states.
Maintenance of Effort: States must maintain current Medicaid eligibility levels for adults until the Exchanges are operational, expected to be in 2014 (HR 3590, Sec. 2001). States must maintain Medicaid and CHIP eligibility levels for children until 2019 (HR 3590, Sec. 2001). A state will be exempt from the MOE requirement for non-pregnant, non-disabled adults with incomes above 133 percent FPL for any year from January 1, 2011 through December 31, 2013 if, on or after December 31, 2010, the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year (HR 3590, Sec. 2001).	Date of Enactment: Until the Exchanges are fully operational, in order to receive quarterly federal funding under Sec. 1903(a), states must not enact Medicaid eligibility requirements that are more restrictive than those the state had in place at the date of enactment. These restrictions are applicable to children's eligibility under Medicaid and CHIP through October 1, 2019. December 31, 2010: States may apply qualify for an exemption from the MOE requirements with respect to certain individuals.

CHIP: States must maintain the current income eligibility levels for children in CHIP until 2019 (HR 3590, Sec. 2101). States must extend funding for CHIP through 2015, and the CHIP benefit package and cost-sharing rules will continue under current law (HR 3590, Sec. 10203). In 2015, states will receive a 23 percentage point increase in the CHIP match rate, with a cap of 100 percent (HR 3590, Sec. 2101, as amended by HR 3590 Sec. 10203). Children otherwise eligible for CHIP but who are unable to participate due to enrollment caps will be eligible for tax credits in the state Exchanges (HR 3590, Sec. 2101 as amended by HR 3590, Sec. 10203).	Date of Enactment: Until September 30, 2019, states must continue their eligibility standards for children's CHIP enrollment in a manner that is no less restrictive than the standards existed at the date of enactment. 2015: States will receive a 23 percentage point increase in their CHIP FMAP 2019: States may change their eligibility levels for children enrolled in Medicaid and CHIP
Creation and Structure of the Exchanges: By January 1, 2014, states must establish an American Health Benefit Exchange, the "Exchange" that will be administered by a government agency or non-profit organization and meets certain criteria, such as including a manner for establishing Small Business Health Options Program (SHOP) Exchanges. (HR 3590, Sec. 1311). Funding will be available through Planning and Establishment grants for states to establish the Exchange. (HR 3590, Sec. 1311). When first operational, the Exchanges will serve as gateways through which individuals and small businesses with up to 100 employees can purchase qualified coverage HR 3590, Sec. 1311). States will be able to allow businesses with more than 100 employees to purchase coverage in the Exchange beginning in 2017 (HR 3590, Sec. 1312).	Within one year of enactment: Until January 1, 2015, funding will be available through Planning and Establishment grants for states to establish the Exchange January 1, 2014: Each state must have established an American Health Benefit Exchange. 2017: States may allow large employers to purchase coverage in the Exchange

State Innovation Waivers: State plan years beginning January 1, 2017 are eligible for State Innovation Waivers. Under these waivers, a state may enact a law to waive, for five years, any of the health insurance requirements within the state. Waivers will only be granted if the state's coverage plan is at least as comprehensive, affordable and widespread as the qualified plans offered through the Exchange that the state plan will replace. The state plan must also not increase the federal deficit (HR 3590, Sec. 1332).	Within 180 days of Enactment: The Secretary will promulgate rules relating to the waivers. 2017: State plan years beginning January 1, 2017 are eligible for waivers.
Special adjustment to the FMAP for certain states recovering from a major disaster: Beginning January 1, 2011, qualifying states will receive increased FMAPs. Eligible states are those in which during the seven preceding fiscal years, the President has declared the state to be a major national disaster, and as a result of this disaster, every county or parish in the state warranted federal government assistance (HR 3590, Sec. 2006).	January 1, 2011: States may receive an FMAP adjustment
Dual Eligibles: No later than March 1, 2010, there will be a new office, the Federal Coordinated Health Care Office for Dual Eligible Beneficiaries, within the Centers for Medicare and Medicaid services (CMS) to more effectively integrate Medicare and Medicaid benefits and to improve coordination between the federal government and states in order to improve access to and quality of care and services for dual eligibles (HR 3590, Sec. 2602). By January 1, 2011, the Center for Medicare and Medicaid Innovation within CMS will be established to, in part, test innovative payment and service delivery models to reduce program expenditures while simultaneously preserving or enhancing the quality of care furnished. The Center allows states to test and evaluate models for fully integrating care for dual eligibles within the state, as well as payment reform models for the medical care residents of the state,	March 1, 2010: the Federal Coordinated Health Care Office for Dual Eligible Beneficiaries will be established January 1, 2011: the Center for Medicare and Medicaid Innovation will be established January 1, 2012: Cost-sharing for certain dual eligibles will be eliminated

including dual eligibles. Payment models will be implemented on a nationwide basis, with exceptions for states demonstrating that such implementation would not be feasible or appropriate to the health care delivery system of that state (HR 3590, Sec. 3021). No earlier than January 1, 2012, cost-sharing will be eliminated for dual eligibles receiving home and community based services who would otherwise be institutionalized (HR 3590, Sec. 3309).	
Payment Reform/Bundling: By January 1, 2013, the Secretary must develop and implement a National Pilot Program on Payment Bundling for integrated care focusing on coordination, quality and efficiency improvement. The pilot program will be conducted for five years and will include the use of bundled payment models (HR 3590, Sec. 3023). The Secretary may extend the pilot program after January 1, 2016, if such expansion is expected to improve quality and reduce costs (HR 3590, Sec. 10308). A Medicaid demonstration project, to last from January 1, 2012 through December 31, 2016. The purpose will be to study and evaluate the use of bundled payments for hospital and physician services under Medicaid. Up to eight states will be selected by the Secretary to participate in the project (HR 3590, Sec. 2704).	January 1, 2013: The Secretary will establish a five year bundled payment program under Medicare January 1, 2016: The Medicare bundling program may be extended. January 1, 2012: Until December 31, 2016, a demonstration project to evaluate bundled payments under Medicaid will be in effect
Expansion of the Recovery Audit Contractor Program: By December 31, 2010, states must have programs contracting with Medicare Recovery audit contractors to identify, and recoup where necessary, underpayments and overpayments with respect to services (HR 3590, Sec. 6411).	December 31, 2010: States must have established a RAC program

Elimination of Part D Cost Sharing for selected non-institutionalized Dual Eligibles: Makes cost-sharing for full benefit dual eligible individuals receiving home and community based care equal to the cost-sharing for those receiving institutionalized care. Effective no earlier than January 1, 2012 (HR 3590, Sec. 3309).	January 1, 2012: Cost-sharing for certain dual eligibles will be eliminated
Medicare Advantage Payment Plans: Medicare Advantage payments will freeze in 2011. In 2012, the benchmarks will be reduced, and the payments will be set to different percentages of fee-for-service rates. These payments will vary from 95 percent of Medicare spending in high-cost areas to 115 percent of Medicare spending in low-cost areas (HR 4872, Sec. 1102). Beginning in 2011, this restructured payment system will be phased in over three years in most areas, with longer phase-in periods in other areas, depending on the level of payment reductions (HR 4872, Sec. 1102). Beginning in 2014, the plans will be required to spend at least 85 percent of revenue on medical costs or activities improving quality of care (HR 4872, Sec. 1103).	2011: Medicare Advantage payments will freeze, and a phased-in restructured payment system will be in effect. 2012: Benchmarks will be reduced, and the payments will be set to be phased in over a varying number of years with varying percentages for fee-for-service rates. 2014: Medicare Advantage plans must spend at least 85 percent of revenue on medical costs
Medicaid DSH: Effective as of October 1, 2011, and beginning in 2014, Medicaid DSH allotments to states will be reduced; by $.5 billion in 2014, $.6 billion in 2015, $.6 billion in 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019, and $4 billion in 2020. The most reductions will occur in states with the lowest uninsured rates, as well as those that do not target DSH	2014: Medicaid DSH allotments to states will begin a phased-in reduction 2020: The reductions end

payments (HR 3590, Sec. 2551, as amended by HR 3590 Sec. 10201 and HR 4872, Sec. 1203).	
Medicaid Health Home: Effective January 1, 2011, states will have the option to amend their plans to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. States who choose to amend their plans allowing for this option will receive a 90 percent FMAP for two years for payments made in provision of the health home (HR 3590, Sec. 2703).	January 1, 2011: The Secretary can award planning grants to states for developing this state plan amendment. If chosen, this new Medicaid state plan option will allow states to receive an enhanced FMAP for the first two years the amendment is in effect.