New Health Law and Its Implications for Trustees of Special Needs Trusts

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INTRODUCTION

Put Your Hospital Bills Under a Microscope.
J. Brody, New York Times[1]

In times like these, the last thing you need is a hospital bill that can wreck an already fragile budget. This is often the fate of elderly patients who incorrectly assume that Medicare will cover everything.

Not so, as my aunt discovered early last year after a two-night, two-and-a-half-day stay at a for-profit hospital in Florida. There is a lesson for all of us from the following tale: no matter who is footing the bill, hospital charges should be carefully vetted by someone who, with the Internet and perhaps professional help, can decipher the codes and uncover unreasonable and erroneous charges.

My aunt, then 88, had fainted in her apartment and was taken to the hospital by ambulance. After an evaluation in the emergency room, she was admitted to the hospital for what turned out to be a side effect from a new medication.

Five months later, she received a bill stating that of total costs of $18,865 (which included $5,874 for a justifiable CT scan of her head and brain), she still owed $992.60 after Medicare and secondary insurance. The sum seemed prohibitive to my aunt, who lives on Social Security and a small pension.

$457 for Eye Drops?

But that is not what prompted her daughter to question the bill and carefully review the itemized charges. "What leaped out at me was a charge of $456.67 for the eye drops she uses once a day," my cousin told me. "My mother pays $85 for her prescription, which lasts about 40 days, and she had her own drops with her."

Further perusal revealed that each baby aspirin, each multivitamin, each 500-milligram tablet of vitamin C and each dose of stool softener was billed at $4.07, for a total of $40.70. She was also billed for six doses of a heart medication ($10.81 each), only two of which should have been administered.

When my cousin called the hospital to question the charges and explain her mother's limited finances, she was told that financial assistance is offered only if the bill exceeds $1,000. Instead, the hospital suggested an audit but warned that such investigations often leave the patient with a larger bill. My cousin refused to be intimidated and requested the audit, which resulted in the removal of nine erroneous medication charges and a bill reduced to $500.

And when she replied that this was still more than her mother could afford, the hospital lowered the bill to just $200 — as long as she paid it that day. There are reasons beyond greed that hospitals typically charge what look like outrageous prices for goods and services. Reimbursement rates are negotiated with insurers, and some are considerably less than what a

[1] Brody J., *Put Your Hospital Bills Under a Microscope*, New York Times, <http://www.nytimes.com/2010/09/14/health/14brod.html?_r=3>.

patient without insurance would be charged. And hospitals rely on insured patients to make up for those who fail to pay their bills — and for the rates paid by Medicaid, which may be considerably lower than actual hospital costs.

Uncovered Expenses

In recent years, hospitals have introduced a new source of potential financial disaster. To avoid federal penalties for the costly practice of readmitting patients after discharge, hospitals assign some patients to "observation" status, even if they occupy a hospital bed. Without formal admission, Medicare (and often private insurance as well) charges patients a 20 percent co-payment and does not cover the cost of post-hospital nursing care or rehabilitation.

Observation status, which theoretically should last no more than a day or two, has been on the rise for longer stays. Patients often don't know they were never admitted as inpatients until they leave the hospital and are slapped with a huge bill. For one 76-year-old Connecticut man "observed" in a hospital room for eight days, the charges not covered by Medicare were $36,000, and he was not covered for three months of rehabilitation services, Bloomberg Businessweek reported in July. Before an unmanageable hospital bill forces you or anyone you know into foreclosure or bankruptcy or into the clutches of an unrelenting collection agency, there are remedies worth knowing about. In fact, even if you can afford to pay the bill, a careful review is a good idea, if only to disclose errors and excesses that drive up the cost of medical care for all of us.

Errors are commonplace in hospital bills. A doctor may request a procedure or medication that is subsequently canceled or that the patient refuses, but it still goes on the bill. An entry error may result in a misplaced decimal point or an extra zero or two in the number of treatments, multiplying the cost 10 or 100 times. Check the dates for all procedures and medication; some may be listed as happening on a day or at a time you were not even in the hospital.

Listings of medications and treatments you don't understand can nearly always be found on the Internet, but mysterious codes — like "obs unit tell per hour," found on my aunt's bill — should be explained by the hospital's billing department.

Negotiation Tactics

As my cousin found, it is nearly always possible to negotiate a smaller bill as well as a payment plan of a certain amount each month. Hospitals will often reduce the bill by 40 percent or more if it is paid in cash within 30 days. But be sure to remain civil in your negotiations. Berating the institution or its agents can be counterproductive.

If negotiation by the patient, a family member or a friend is not possible, there are commercial services like Insnet that will do it for about a third of the ultimate savings. Other companies, like Medical Billing Advocates of America, can help with bill review.

Another useful tactic, if your hospitalization is not an emergency, is to comparison-shop beforehand. Even within the same ZIP code, hospital charges for various procedures and room rates can vary greatly (get free cost information at Health Care Blue Book's Web site.

In general, the costs at for-profit hospitals are greater than at nonprofits, and charges to patients at facilities outside the insurer's network will be much higher. And don't forget to check what the doctor and, if needed, the anesthesiologist will charge. Find out whether your insurance will be accepted and how much the co-pay is likely to be.

But whatever you do, don't ignore a medical bill you are unable or unwilling to pay. If it ends up in the hands of a collection service, it will damage your credit rating and could ultimately result in a lien on your property.

Trustees of SNTs, their attorneys, people with disabilities and their families have traditionally needed to practice "constant vigilance" to assure Medicaid and Medicare coverage is used to the maximum extent possible before accessing private funds. The extensive changes coming from the Affordable Health Care Act will result in extensive additional confusion and error…so in light of these changes and the need to protect private resources. Let's turn to the new health law and the changes which trustees of SNTs and their clients and advisors need to examine through a microscope.

1. Coordination of Benefits

Trustees of Special Need Trusts and/or parents of children with disabilities use Medicaid to pay for long-term care services like personal assistance services. Often, they maintain private health insurance coverage for traditional Acute Medical Care Coverage. Coordinating this has changed significantly because of the changes.

A. Keeping Young Adult on Parent's Insurance:

Health plans and health insurance issuer offering group or individual health insurance that provides dependent coverage of children must continue to make coverage available for an adult child until the child turns 26 years old. Health insurers are not required to cover a child of the adult child receiving dependent coverage.

- **Caution**: The provision that health insurers that cover dependent children must do so until the child turns 26 years of age; it does not affect the income tax exclusion or inclusion for employer-provided health benefits under the Internal Revenue Code.[2]
- Code definition of "dependent" for tax purposes is not changed (PHSA Sec. 2714(b) and (c), as added by Act Sec. 1001(5) of the Affordable Care Act).
    - This provision sets a nationwide standard to allow parents to cover their adult children younger than age 26, regardless of whether or not the dependent is a full-time student, disabled, or married. The young adult age group tends to have a large portion of uninsured individuals because either they work at a low-wage job that does not provide health insurance or the young adult cannot afford the insurance. [3]
    - Regulations to be issued. The U.S. Department of Health and Human Services will issue regulations to define dependent for purposes of this provision. The Internal Revenue Code definition of "dependent" for tax purposes is not changed (PHSA SEC. 2714(b) and (c), as added by Act Sec. 1001(5) of the Affordable Care Act).

[2] *CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act: Including Reconciliation Act Impact, Volume I*, 63 (Wolters Kluwer eds., Wolter Kluwer 2010).
[3] *Id.* at 64.

- **Effective date**: **September 23, 2010.**
  - Act Sec. 1001(5) of the Patient Protection and Affordable Care Act, adding Public Health Service Act Sec. 2714.
  - Act Sec. 2301(b) of the Health Care and Education and Education Reconciliation Act of 2010, amending PHSA Sec. 2714(a), as added by the Affordable Care Act 1001(5).[4]
- **Other Options:**
  - **Some SNT/families have paid extra for this coverage, what happens now? Refunds?**

B. Second Change: State Basic Health Programs for Low-Income Individuals on Medicaid and Other options

States are allowed to offer one or more basic health programs to provide health coverage to low-income individuals instead of offering those individual coverage through a Health Insurance Exchange. Individuals eligible to participate are those who are not eligible for Medicaid and who have household incomes that exceed 133% but do not exceed 200% of the federal poverty level (FPL). The HHS is required to certify that participating individuals do not have to pay more in premiums and cost-sharing than they would have paid under qualified health plans offered through an exchange. [5]

This should be considered an option for people on SSDI or waiting for Medicare.[6] There is an income limit, but is there an asset limit for this?

C. Third Change: Immediate Actions to Preserve and Expand Coverage

- High- Risk Pool
  - A temporary insurance program for high risk individuals with pre-existing conditions has been established for those who have been uninsured for six months or who have a pre-existing condition. Funding for this program is capped at five billion and it terminates on January 1, 2014.[7]
  - Within 90 days after the enactment date, the Secretary of HHS must establish a temporary high risk health insurance pool.
  - The law authorizes HHS to carry this program out either directly or through contracts with eligible entities.
  - An eligible entity is
    - *A state or nonprofit private entity;*

[4] *Id*. at 63-64.
[5] *Id*. at 161.
[6] Center for Medicare & Medicaid Services Letter, *RE: Options for Coverage of Individuals under Medicaid*, (April 9, 2010).
[7] *CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act: Including Reconciliation Act Impact, Volume I*, 85 (Wolters Kluwer eds., Wolter Kluwer 2010).

        - *Submits an application to the HHS Secretary; and*
        - Agrees to use contract funding to establish and administer a qualified high risk pool for eligible individuals.
    - **Eligibility for High Risk Pool[8]-** A person is considered an eligible individual if they are:
        - An American citizen or U.S national or is lawfully present in the U.S.;
        - Applying for coverage through the high risk pool after not being covered under creditable coverage during the six month period prior to the date of their application; and
        - Has a pre-existing condition that is determined under guidance issued by the HHS Secretary.
    - **Effective Date**: **The provision takes effect on March 23, 2010, the date of enactment (Act.Sec. 1004(b) of the Patient Protection and Affordable Care Act (P.L. 111-148).**
    - The Department of Health and Human Services (HHS) estimates that 31,000 to 71,000 children who have a preexisting condition and are uninsured will now be eligible for coverage. Many of these children are likely to have disabilities. The regulations also increase coverage for an estimated 90,000 children who have insurance but those plans have a clause that excludes coverage or benefits for a preexisting condition.
    - If a family or SNT trustee bought individual coverage for a child with a preexisting condition and the policy had language excluding the costs of treatment for a pre-existing condition, then the family may need to cancel the coverage and purchase a new policy to get around the exemption. The risk is the new plan price might be more than the price of the original plan.[9]
    - **Depending on the nature of the conditions of the person with a disability, the Trustee of the Special Needs Trust, Advocate/Family Member may need to consider using this right away to secure Health Care Coverage.**
    - An agreement, in Michigan, has been reached that will offer coverage to uninsured Michigan citizens who have been unable to obtain coverage because of pre-existing health condition. The coverage will be offered through Michigan-based HMO Physicians Health Plan of Mid-Michigan (PHP). PHP is directly contracted with HHS to administer this program. The enrollment period is scheduled to begin in August 31, 2010 and coverage to start October 1, 2010. [10]
    - Trustees/families and their advisors need to become aware on what their state is doing to determine best and most cost effective way to secure coverage for the person with a disability/beneficiary.
- **Additional Resources:**
    - Physicians Health Plan (PHP) will administer the Michigan high-risk pool.

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[8] *Id.* at 88.

[9] *How Will Health Insurance Reforms Affect Us?,* Disability Policy Collaboration, National Policy Matters for Chapters of the Arc and Affiliates of UCP, thearc.org, <http://www.thearc.org/document.doc?id=2679>.

[10] PHP to Administer Michigan High Risk Insurance Pool, *Uninsured consumers with pre-existing conditions will have access to quality, affordable health insurance through a Michigan-based HMO*, Jason Moon, Public Information Officer of the Office of Financial and Insurance Regulation.

- *Uninsured consumers with pre-existing condition will have access to quality, affordable insurance through a Michigan-based HMO,* Press release and List of Presumptive Pre-Existing Conditions, Jason Moon, Office of Financial and Insurance Regulation, State of Michigan. (Aug. 23, 2010). See Attachment #1.

- *High-Risk Pool Coverage is to Be Comprehensive,* Detroit Free Press, Freep.com, (Aug. 31, 2010) <http://www.freep.com/article/20100831/ NEWS06/8310332/ High-risk-pool-coverage-is-to-be-comprehensive >.
- *How Will Health Insurance Reforms Affect Us?,* Disability Policy Collaboration, National Policy Matters for Chapters of the Arc and Affiliates of UCP, thearc.org, <http://www.thearc.org/document.doc?id=2679>. See Attachment #2.
- Center for Medicare & Medicaid Services Letter, *RE: Options for Coverage of Individuals under Medicaid,* (April 9, 2010). See Attachment #3.

D. Fourth Change: Reinsurance for Early Retirees

There are no programs relating to reinsurance for early retirees before this new law. This law establishes a temporary reinsurance program that begins 90 days after enactment and ends on January 1, 2014. This program reimburses part of the claims cost for participating employment-based plans that provide health insurance coverage for early retirees, eligible spouses, surviving spouses, and dependents of such retirees. [11]

- An early retiree is an individual who is 55 years or older, but not yet eligible for Medicare. This individual cannot be an active employee of an employer maintaining the plan or employer makes a substantial contribution to the fund for such plan.
- The employment-based plan must submit an application for certification to the HHS to participate in this reinsurance program.
- Upon submission of a valid claim, HHS will reimburse a plan for 80% of that portion of the costs attributable to such claims that are $15,000 or more but less than $90,000 (adjusted each fiscal year).
- **Effective Date**: **March 23, 2010.**
- Could this reinsurance be used for a person that is on SSDI and Waiting for Medicare Coverage or would receipt of SSDI disqualify them?
  - Need more research
  - Relates to other option discussed
  - **Additional Resources:**

- *Nearly 1,000 Additional Employers and Unions Will Receive Help Providing Health Coverage of Early Retirees and Their Families,* U.S. Department of *Health and Human Services,* <http://www.hhs.gov/news/press/2010pres/10/ 20101004a.html>, See Attachment #4.

[11] *CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act: Including Reconciliation Act Impact, Volume I,* 89 (Wolters Kluwer eds., Wolter Kluwer 2010).

E. **Other Changes:**

1. *Pre-Existing Conditions*

As of 2014 health insurers will no longer be able to discriminate against people due to disabilities or other pre-existing conditions, Health insurers will no longer be allowed to deny coverage, change higher premiums, exclude benefits relating to pre-existing conditions, rescind coverage after someone is injured acquires a new condition, or impose annual caps on benefits. Most of these provisions go into effect for children in September 2010.[12]

2. *Mental Health Coverage*

Your mental health is just as important to your quality of life as your physical health. For too long, mental health has taken a back seat to physical health in our health insurance system. Mental health parity laws, including rules issued by the Obama administration earlier this year, have taken important steps forward to stop the insurance company practice of arbitrarily limiting care for mental health or substance abuse disorders.

Unfortunately, it can be difficult for people with mental health and substance use disorders to find affordable, quality coverage in the health insurance marketplace. Right now, estimates show that one-fifth to one-third of the uninsured are people with mental and substance abuse disorders.

The Affordable Care Act takes steps to change that:

- Right now, if you haven't been able to find health insurance due to a pre-existing mental health condition, you may be able to access the new Pre-Existing Condition Insurance Plan. Be sure to check out this section on **HealthCare.gov** site; plans may vary depending on where you live.
- The first time you renew or purchase health coverage after September of this year, plans that offer coverage for dependents are required to extend that coverage until a young adult turns 26. Some plans are making this coverage available now, so you should check with your insurance company or employer.
- Starting in 2014, substance abuse or mental illness can no longer be used by insurers to deny coverage as a "pre-existing condition" – and insurers also won't be able to use those conditions to raise your premiums.
- Also in 2014, mental health and substance abuse disorder services will be part of the essential benefits package, a set of health care service categories that must be covered by certain plans, including all insurance policies that will be offered through the Exchanges, and Medicaid.
- These reforms all work to make the health insurance marketplace a more accessible, affordable place for people with mental health and substance abuse disorders.[13]

[12] Hyde, P., *The Affordable Care Act & Mental Health: An Update*, 2 (Aug. 2010),Healthcare.Gov, < http://www.healthcare.gov/news/blog/mentalhealthupdate.html>.

[13] *Id.* at 3.

- The law establishes a loan repayment program for pediatric subspecialists and providers of mental and behavioral health services in underserved areas, it offers loan repayment for public health students who work at least three years at a federal, state, local, or tribal public health agency. This may be helpful for staff.[14]
- **Additional Resource:**
  - *New Laws Expand Mental Health Coverage*, KHN Kaiser Health News, (October 5, 2010), <http://www.kaiserhealthnews.org /Features /Insuring-Your-Health/mental-health-coverage.aspx>.
  - *Wolters Kluwer, President Signs Health Care Reform, CCH Briefing Special Report.*

3. *Essential Benefits and Exchanges.*
   - For most health insurance plans (including plans offered in the exchanges and individual and small group plans but excluding grad-fathered individual and employer-sponsored plans) the law mandates coverage of at least the following essential benefits: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventative and wellness services and chromic disease management, and pediatric services including oral and vision care.

     HHS has the authority to further define essential benefits consistent with these required elements and is expected to do so. If HHS adds essential benefits, the law requires HHS to take into account the health care needs of people with disabilities and other diverse groups. We will continue to make our voices heard as HHS worker through the process of defining essential benefits.

     For people with Disabilities, it is a substantial improvement that rehabilitation and habilitation services are essential services. Many people with disabilities depend on this (e.g. to maintain muscle bulk and minimize spasticity), but pre-health care reform insurance policies did not cover them or severely limited the number of treatments.

     As we understand it, the term "devices" is meant to include all durable medical equipment (including wheelchairs), prosthetics, orthotics and supplies (DMEPOS). This provision would be stronger if it made this point more explicitly. Because (DMEPOS) are critically important to many people with disabilities, we are advocating that anticipated HHS regulations defining essential benefits will explicitly provide that all DMEPOS are included in the meaning of "devices" as essential medical benefits.

[14] Wolters Kluwer, *President Signs Health Care Reform*, CCH Briefing *Special Report*.

It is important that mental health and substance abuse services are included as essential benefits.[15]

- Within plans that will be offered in the exchange, the disability community secured important categories of essential benefits for individuals with disabilities, among which include the following:
  - rehabilitative and habilitative services and devices,
  - mental health and substance abuse disorder services,
  - preventative and wellness services and chronic disease management, and
  - pediatric services, including oral and vision care.
- Yet, continued advocacy will be needed during implementation to influence the specific definitions and scope of these benefits: for example, to ensure that "behavioral interventions" include positive behavioral approaches that can benefit individuals with autism and other developmental disabilities.[16]
- There are certain exclusions from the individual minimum coverage requirement regarding health insurance exchanges. Those exclusion include:
  - Undocumentated individuals in the U.S. are excluded from coverage.
  - Special rules apply for children under age 18 and incarcerated individuals;
  - Individuals who cannot afford coverage (generally where the individual's required contribution would exceed eight percent of household income for the taxable year);
  - Individuals with taxable income under 100% of the FPL;
  - Qualified members of Native American tribes; and
  - Certain hardship cases would be exempt.[17]
- **Effective Date**: **January 1, 2014.**[18]

4. Lifetime Annual Benefit Caps

- Lifetime caps on benefits are prohibited immediately. This will end the common insurance practice of imposing lifetime caps such as $1 million. Between now and 2014, the Secretary of Health and Human Services (HHS) may restrict annual caps on benefits. As of 2014, both lifetime and annual caps on benefits are prohibited.[19]

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[15] Hathaway, Morris, and Kornblau, *Impact of Health Care Reform on People with Disabilities*, NSCIA, Spinalcordadvocates.org, <http://www.spinalcordadvocates.org/impact-of-health-care-reform-on-people-with-disabilities/>.

[16] Joe Caldwell, *Implications of Health Care Reform for Individuals with Disabilities*, A journal of Policy, Practices, and Perspectives: Intellectual and Developmental Disabilities (Volume 48, No. 3, June 2010).

[17] Wolters Kluwer, *President Signs Health Care Reform*, CCH Briefing *Special Report*.

[18] *CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act: Including Reconciliation Act Impact, Volume I*, 63 (Wolters Kluwer eds., Wolter Kluwer 2010).

[19] Hathaway, Morris, and Kornblau, *Impact of Health Care Reform on People with Disabilities*, NSCIA, Spinalcordadvocates.org, 3, <http://www.spinalcordadvocates.org/impact-of-health-care-reform-on-people-with-disabilities/>.

5. *Limits on Cost Sharing*
    - The amount that people will have to pay out-of-pocket cannot be greater than the limits for health savings accounts. Small group market plans are prohibited from requiring deductibles greater than $2,000 for individuals and $4,000 for families. These maximums may increase only in accordance with increases in average per person health insurance premiums.[20]

With all this change– the challenge will be for Trustees, Families, or Advocates to make <u>informed</u> decisions related to the <u>best</u> or <u>most cost effective coverage</u> in the light of changes–

- ***Resources to assist in making decisions are:***
    a. ***Uniform Standards*** - The Secretary of Health and Human Services (HHS) has been ordered to develop standards for use by group health plans and health insurers in compiling and providing a summary of benefits and explanation of coverage. The summaries must be in a uniform format, using easily understood language, and must include uniform definition of standard insurance and medical terms. The explanation must also describe any cost-sharing exceptions, reductions, and limitations on coverage, and use examples to illustrate common benefits scenarios.[21]

    b. ***Internet Portal*** - The Secretary of HHS must establish an Internet portal by July 1, 2010 to help beneficiaries and small businesses identify affordable health insurance coverage options in each state.

    The Internet portal, to the extent practicable, must provide ways for residents of any State to receive information on at least the following coverage options: [22]
    - health insurance coverage offered by issuers (excluding coverage that only provides for the treatment of a single disease or conditions (i.e., cancer insurance); or an unreasonably limited set of diseases and conditions (as determined by the HHS);
    - Medicaid coverage;
    - coverage under the state Children's Health Insurance Program;
    - coverage under the state's health benefits high risk pool, if one exists in the state;

[20] *Id.* at 3.
[21] *CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act: Including Reconciliation Act Impact, Volume I*, 64 (Wolters Kluwer eds., Wolter Kluwer 2010).
[22] *Id.* at 91.

- coverage under the high risk pool, as created under Sec. 1101 of the Affordable Care Act; and
- coverage within the small group market for small businesses and their employees.

The website is required to provide information on:

- eligibility;
- availability;
- premium rates;
- cost sharing; and
- the percentage of total premium revenues spent on health care, rather than administrative expenses, by the issuer.
- **Effective Date**: **March 23, 2010.**
- Site was launched July 1, 2010. **See http://www.healthcare.gov/.**
- While determining best options – Other things to keep in mind:
  - Insurance Premium Rate Limitations;[23]
  - Guaranteed Availability and Renewal;[24] and
  - Prohibition of Discrimination Based on Health Status.[25]
    *__This will become a Civil Rights issue for advocacy__
    Except as provided elsewhere in the law, prohibits discrimination based on disability under any health program or activity which receives federal assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments) and provides Section 504 of the Rehabilitation Act as the enforcement mechanism for violations. The Secretary of HHS may promulgate regulations to implement this.[26]

2. Appeals

Just as the Trustee of a Special Needs Trust or Family/Advocate must assist in appealing inappropriate denial of public benefits. Similarly, advocacy will be needed with all health coverage now. The new rules are:

[23] *Id.* at 98.
[24] *Id.* at 100.
[25] *Id.* at 108.
[26] Hathaway, Morris, and Kornblau, *Impact of Health Care Reform on People with Disabilities*, NSCIA, Spinalcordadvocates.org, <http://www.spinalcordadvocates.org/impact-of-health-care-reform-on-people-with-disabilities/>.

A. A group health plan and a health insurer must implement an effective process for appeals of coverage determinations and claims. This process must include, at the minimum, the following:

- An established internal claims appeal process;
- A notice to participants, in a "culturally and linguistically appropriate manner (will need to be defined in regulations)," of available internal and external appeals processes, including the availability of assistance with the appeals processes; and
- A provision to allow the enrollee to review their file, to present evidence and testimony through the appeals process, and receive continued coverage during the appeals process.[27]
- If a plan offers voluntary levels of appeal, failure to use those levels will not exhaust normal administrative remedies and will not count against any statute of limitations regarding claims appeals.
- **Effective Date**: **September 23, 2010.**
- **What is happening in your state?**
- Michigan may be creating Health Insurance Ombudsman. May be separate entity, see below.

B. Health Insurance Consumer Information

- The Secretary of HHS must award grants to eligible States or Exchanges operating within a State to enable the State to establish (or expand) either an office of health insurance consumer assistance or a health ombudsman program. This will provide consumers with assistance in navigating health insurance requirements under Federal and State law. The health insurance consumer programs must:
  - help consumers file health insurance complaints and appeals;
  - collect, track, and quantify problems and inquiries encountered by consumers;
  - educate consumers on their rights and responsibilities;
  - assist consumers with enrollment in a group health plan or health insurance coverage; and
  - resolve consumers' problems with obtaining premium tax credits.
- Funding: funds to be appropriated to the Secretary to finance this provision are $30 million for the first fiscal year and as needed for the program's operation in subsequent years.[28]
- Data Collection: the health insurance consumer programs must collect and report data to the Secretary on the types of problems consumers encounter and

[27] *CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act: Including Reconciliation Act Impact, Volume I*, 78 (Wolters Kluwer eds., Wolter Kluwer 2010).
[28] *Id.* at 82.

the Secretary must use the data to identify areas where increased enforcement is necessary.

- **Effective Date**: **March 23, 2010.**
- Michigan because of lawsuit on constitutionality of individual mandate and lack of political will is not doing this via insurance commissioner; instead, private agency will be doing this and will be getting funding for this.
- For Michigan lawsuit pleadings, see, <http://www.pekdadvocacy.com/documents/pattispublications/Court/BriefinSupportofPetitionforJudicidal Review-redacted.pdf >
- **What is your state doing?**

3. Other Issues

A. Premium Assistance Tax Credit and Cost Sharing Disregarded for Federal Assistance Program

- PPACA, starting after 2013 tax year, authorizes premium assistance tax credits to help individuals pay for the cost of health insurance premiums. The premium assistance credits do not account for benefits mandated by the states.
- The Act states, for purpose of determining eligibility for benefits under a federal program or a state or local program financed with federal funds, any cost sharing reduction payment or advance payment of the credit under Code Sec. 36B shall be treated as made to the qualified health plan the person is enrolled in and not to that individual. [29]
- The cost-reduction payments will not be treated as income in determining the individual's eligibility for Federal assistance like food stamps, Section 8, etc.
- **Effective Date**: **March 23, 2010.**

B. Smaller Employer Health Insurance Credit

- **Special Need Trusts and/or Family may <u>employ</u> support staff for personal assistance services so Special Need Trust may qualify for this.**
- An eligible small employer may claim a 35% tax credit (25 percent in the case of a tax exempt eligible small employer) for premiums it pays for its employees in tax years beginning in 2010 through 2013.
- An eligible small employer is an employer that has no more than 25 full-time employees and the average annual compensation of these employees is not greater than $50,000.
- The credit is reduced by 6.667 percent for each full-time employee in excess of ten employees and by 4% for each $1,000 that average annual compensation paid to the employees exceeds $25,000.
- In tax years that begin after 2013, an employer must participate in an insurance Exchange in order to claim the credit.

[29] *Id.* at 207.

- The credit, however, may only be claimed in two tax years that begin after 2013. The credit rate for these two tax years is increased to 50% (35% in the case of a tax-exempt eligible small employer). In order to claim the credit, the employer must pay at least 50 percent of the premium cost.[30]
- The final legislation directs the U.S. Department of Health and Human Services (HHS) to develop new regulations concerning the designation of "medically underserved population." Although individuals with developmental disabilities meet the majority of current criteria, such as high rates of poverty and infant mortality, as a population, they have never been officially designated as "medically underserved." Designation is tied to 34 other federal programs and targeted training initiatives, which could help address health disparities and access. It will be critical for the disability community to seize this opportunity through public comment and representation on the negotiated rulemaking committee to ensure the needs of individuals with disabilities are recognized.[31]
- **Effective Date: The small employer health insurance credit and related amendments apply to amounts paid or incurred in tax years beginning after December 31, 2009 (Act Sec. 142(f)(1) of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by Act. Sec. 10105(e)(4) and Act Sec 10105(e). However, the provision treating the credit as a specified credit is effective for credits in tax years beginning after December 31, 2010, and to carry back of such credits (Act Sec. 1421(f)(2) of the Affordable Care Act, as amended by Act Sec. 10105(e)(4)).[32]**

C. Health Care Coverage Reporting – Please be aware that:

- Any person who provides minimum essential health care coverage to an individual during a calendar year is required to file a return reporting such coverage in the form and manner described by the Secretary of the Treasury.
- A person required to file a return under the new provision is also required to furnish a written statement to the individual with respect to whom information is reported, detailing the contents of the informational return.[33]
- **Effective Date: The amendments made by this provision apply to the calendar years beginning after 2013.**

D. Free Choice Voucher Employer Tax Credits

[30] *Id.* at 209.
[31] Joe Caldwell, *Implications of Health Care Reform for Individuals with Disabilities*, A journal of Policy, Practices, and Perspectives: Intellectual and Developmental Disabilities (Volume 48, No. 3, June 2010).
[32] *CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act: Including Reconciliation Act Impact, Volume I*, 217 (Wolters Kluwer eds., Wolter Kluwer 2010).
[33] *Id.* at 237.

- An employer is allowed a deduction for the amount of any free choice voucher provided, which is treated as an amount paid for compensation for personal services actually rendered. [34]
- Vouchers provided after December 31, 2013, employee's gross income does not include the amount of the voucher, up to amount actually paid for a qualified plan. In addition, employers can deduct, as compensation for personal services actually rendered, the full amount of the free choice voucher provided.
- Employers are required to provide notice that if any employee purchases a qualified health plan and the employer does not offer a free choice voucher, then the employee may lose the employer contribution to any health benefits plan offered by the employer.
- Starting after December 31, 2013, employers are required to report on their health insurance coverage, offering employers are defined as employers offering coverage if the required contribution of any employee exceeds eight percent of the employee's wages.
- **Effective Date**: **No specific date provided, therefore, the rules are effective on the enactment date, March 23, 2010. The rules excluding free choice vouchers from an employee's income under new Code Sec. 139D and the rules allowing a deduction to an employer for the amount of the provided free choice vouchers under Code Sec. 162 apply to vouchers provided after December 31, 2013.**
- Vouchers – Free Choice
    - **Trustee/family members or advisors should be aware what they are in case asking for one would work for beneficiary or offering one for staff helps keep good <u>support</u> staff.**

E. Penalty for Failing to Carry Health Insurance

What are liabilities or responsibilities for Special Needs Trust Trustee, Family, Agent under DPA, and Guardian/Conservator for <u>NOT</u> securing "minimum essential health coverage for themselves and their dependents? Could Guardians and/or SNT Trustee be charged the penalty?

- Beginning in 2014, a penalty is imposed on applicable individuals each month if they fail to have a minimum essential health coverage for themselves and their dependents.
- Penalty is called a "shared responsibility payment" (Code Sec. 5000A(d)(4), as added by the Affordable Care Act).[35]
- All persons are applicable individuals unless they are:
    - Prisoners.
    - Undocumented aliens.
    - Health care sharing ministry members.

[34] *Id.* at 220.
[35] *Id.* at 225.

- Religious conscience – members of and adherents of the established tenets of teaching conscientiously opposed to accepting benefits of any private or public insurance that makes payments toward the cost of, or provides services for medical care.

- Exemptions: Persons who are applicable individuals who are nonetheless exempt from penalty in the following circumstances:
  - Unaffordable coverage - an individual who cannot afford coverage.
  - Filing threshold - household income is below their income thresholds for filing income tax returns.
  - Native Americans,
  - Short Lapses - where applicable individual lacked minimum essential coverage for a period of less than three months.[36]
- Penalty is included with taxpayer's tax return for the year that includes the month for which the penalty is imposed - Two special rules apply:
  - Dependents - if taxpayer claims an applicable individual as a dependent, the taxpayer (rather than the dependent) is liable for any penalty.
  - Spouses - married taxpayers who file a joint return are jointly liable for the penalty that is imposed on either one of them.
- Grey area - statute does not define "for the month of." Presumably, the IRS will determine whether this means the penalty applies if there is no essential minimum health coverage for the entire month, at least half of the month, on the first day of the month, on the last day of the month, etc.[37]
- Monthly Penalty is equal to 1/12 of the greater of:
  - The flat dollar amount, which is equal to the applicable dollar amount for each of the individuals who were not properly insured by the taxpayer, up to a maximum of 300% of the applicable dollar amount, or
  - The applicable percentage of income (Code Sec. 5000A(c)(2), as added and amended by the Affordable Care Act.[38]
- **"Fundamentally, health reform can only succeed if it is more about culture and norms than it is about mandates and penalties."**

  Alan Weil, *State Policymakers' Priorities for Successful Implementation of Health Reform*. State Health Policy Briefing. Retrieved from http://nashp.org/ sites/ default/files/policymaker_0.pdf. See attachment #5.
- **Do we think this is even constitutional?**
  - Laszrus, S. *Mandatory Health Insurance: Is it Constitutional? American Constitution Society for Law and Policy Issue Brief.* (2009) Retrieved from www.nsclc.org/areas/.../mandatory-health-insurance-is-it-constitutional.

F. New groups required to be covered by Medicaid

[36] *Id.* at 226.
[37] *Id.* at 228.
[38] *Id.* at 230.

- Beginning January 1, 2014, states will be required to provide Medicaid benefits to individuals with household incomes up to 133% of FPL who are NOT:
    - Age of 65 or older,
    - Pregnant,
    - Entitled to or enrolled in Medicare Part A,
    - Enrolled under Medicare Part B, or
    - Described in any of the other mandatory groups in the statute (subclauses (1) – (VII) of section 1902(a)(10)(A)(i) of the Act), such as certain parents, children, or people eligible based on their receipt of benefits under the Supplemental Security Income (SSI) program.[39]
- They will be entitled to benchmark benefits only. States have the option to begin coverage for this group in any quarter beginning on or after January 1, 2011.[40]
- May apply to:
    - Many beneficiaries of Discretionary/not SNT per se…; and
    - Staff/family members of SNT beneficiaries.
- May overwhelm state Medicaid systems, which are already overwhelmed – wait far exceeds 90 days reasonable promptness standard.
- **Health coverage expansions will not create a provider supply problem, but they will highlight the problems states already have. "The goals of health reform will not be met if the newly insured find that their coverage is a hollow promise."[41]**
- With guidance from the federal government, states must completely redesign their eligibility systems, and processes to assure seamless transitions as families' incomes rise and fall; families are formed, grow, or dissolve; part time, seasonal, and migrant workers change status; and people move from one part of the state to another– or to another state entirely. This redesign must account for the need to continue administering fairly complex eligibility standards for some categories, such as people with disabilities and for the efforts many states have made in recent years to offer single entry points for access to a broad range of social services, including the Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps) and child care subsidies. This is a massive undertaking. If done well, it holds the promise of incredible efficiencies and dramatic improvements in customer service and ultimately, access to care.[42]
- Note regarding Medicare 2-year waiting period. Under existing law, people found eligible to receive disability benefits under Social Security's SSDI and other Title II programs must wait two years before they can receive Medicare benefits. In the meantime, many people with disabilities go without needed health care, which often causes dire consequences, including exacerbation of existing conditions and death.

  While health care reform does not directly address this problem, it mitigates it for some people in the two-year waiting period. They may be able to obtain health

[39] Center for Medicare & Medicaid Services Letter, *RE: Options for Coverage of Individuals under Medicaid*, 2 (April 9, 2010).
[40] *CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act: Including Reconciliation Act Impact, Volume I*, 259 (Wolters Kluwer eds., Wolter Kluwer 2010).
[41] Weil, Weil, A. (2004). *State Policymakers' Priorities for Successful Implementation of Health Reform*. State Health Policy Briefing. 3. Retrieved from http://nashp.org/sites/default/files/policymaker_0.pdf.
[42] *Id. at* 3.

coverage through the temporary high risk pool or through the health insurance exchanges once they go into effect (which cannot discriminate on the basis of pre-existing conditions) or they may qualify for Medicaid under its extended eligibility standards.[43]

- States will also have a significant new role regarding review of health insurance premium increases. States must scrutinize rating and marketing practices carefully inside and outside the exchange. State must monitor the status of grandfathered plans to assure that they do not become an opportunity for risk selection or risk segmentation. Regulation will also be necessary to determine if new benefits such as preventive services are being delivered.[44]
- We will have advocacy issues related to:
    1. **Due Process;**
    2. **Reasonable Promptness;**
        - May become Worse! **(I know Sandy hard to believe)**
    3. **Medicaid Enrollment or Simplification and Coordination**
        - State must meet certain requirements regarding the simplification of Medicaid and Children's Health Insurance Program (CHIP) enrollment procedures to obtain federal Medicaid financial participation. [45]
        - Background - Title XIX of the Social Security Act created the Medicaid program to provide health care benefits to certain individuals, including low-income children, pregnant women, and aged, blind and disabled individuals, Title XXI created the Children's Health Insurance Program to allow states to expand the provision of benefits to uninsured low-income children and pregnant women not otherwise qualified for state Medicaid programs. Often these families have incomes that are too high to meet Medicaid requirements but may be too low to afford private coverage.[46]
        - By January 1, 2014, States must create procedures:
            - For website enrollment, renewal or enrollment in, medical assistance under the state plan, or under a waiver of the plan, or consent to enrollment or re-enrollment through use of an electronic signature.
            - The website must allow eligible individuals for medical assistance under the state plan or approved waiver and eligible to obtain premium credit assistance for the purchase of qualified health plan offered through an exchange. The information must include, in the case of a child, a comparison of coverage provided through the state plan or waiver to that

[43] Hathaway, Morris, and Kornblau, *Impact of Health Care Reform on People with Disabilities,* NSCIA, Spinalcordadvocates.org, <http://www.spinalcordadvocates.org/impact-of-health-care-reform-on-people-with-disabilities/>.
[44] Weil, Weil, A. (2004). *State Policymakers' Priorities for Successful Implementation of Health Reform*. State Health Policy Briefing. 2. Retrieved from http://nashp.org/sites/default/files/policymaker_0.pdf.
[45] *CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act: Including Reconciliation Act Impact, Volume I*, 315 (Wolters Kluwer eds., Wolter Kluwer 2010).
[46] *Id.* at 315.

provided through enrollment in family coverage under the exchange plan and supplemented by the state plan or waiver.

- Enroll individuals, identified by the state-established exchange as being eligible for medical assistance under the state plan or waiver or child health assistance under the plan or waiver or child health assistance under the state child health plan, without any further enrollment determination on the part of the state and through the website.
- Ensure that those individuals that apply for medical assistance under the state plan or waiver or for child health assistance but are found to be ineligible are screened for enrollment eligibility under qualified health plans offered through exchange and any applicable premium assistance (or advance payment under Sec. 1412 of the Affordable Care Act). If an individual is found to be eligible for another plan or assistance the state's procedures should ensure that he or she is enrolled in that plan without having to submit an additional or separate application. Those individuals should also receive information regarding any reduced cost-sharing for eligible individuals under Sec. 1402 of the Affordable Care Act and other assistance or subsidies available for exchange coverage.
- Ensuring that state Medicaid agencies, state child health plan agencies, and state exchange agencies utilize a secure electronic interface that is capable of making an eligibility determination for medical assistance, child health assistance, or premium assistance, or enrollment in the state plan or a qualified health plan, as applicable.[47]
- Coordinating:
    i. for individual enrolled in the state plan or waiver and enrolled in a qualified health plan offered through an exchange; and
    ii. for individuals enrolled in the state child health plan and enrolled in a qualified health plan the provision of medical assistance of child health assistance to qualified plan enrollees. The services should include those described in SSA Sec. 1905(a)(B), and those required by Sec 1902(a)(43) of the SSA.
- **Conduct outreach and enroll members of vulnerable and underserved populations that are eligible for medical assistance or child health assistance, including the following groups: children, unaccompanied homeless youth, with special health care needs, pregnant women, racial and ethnic minorities, rural populations, abuse and trauma victims, individual with mental health or substance related**

[47] *Id.* at 316.

disorders, and individuals with HIV/AIDS (Act Sec. 2201 of the Affordable Care Act, adding SSA Sec. 1943(b)(2)).[48] ***How do we advocate for our clients to access this?***

- ***Miscellaneous*** – SSA Sec. 1413[49] requires streamlined enrollment procedures for exchanges, Medicaid and CHIP, and state agencies must participate and comply with the requirements of the provision. This provision does not limit or modify a state's requirement to assess individuals to provide home and community based services under the state plan or waiver (Act Sec. 2201 of the Affordable Care Act, adding SSA Secs. 1943(b)(3) and (5)).
- **Effective Date: March 23, 2010.[50]**

4. Benchmark Benefits for Newly Medicaid Eligible

- On January 1, 2014, individuals who are "newly eligible" are entitled to benchmark or benchmark - equivalent coverage rather than full Medicaid benefits. Coverage of mental health services and prescription drugs is added to the requirements for benchmark-equivalent.[51]
- Scope of the mental health services required depends on the entity that issues the benefit package. Benchmark and benchmark equivalent packages NOT offered by Medicaid managed care organizations must meet the mental health parity requirements of Public Health Service Act Sec. 2705(a), specifically, that any mental health or substance benefits offered must be subject to the same limits and restriction as medical and surgical benefits (SSA Sec. 1937(b)6), as added by Affordable Care Act Sec. 2001(c)(2). For children entitle to early and periodic screening, diagnosis and treatment under SSA Sec. 1905(a)(4)(B), coverage under the State Medicaid Plan is deemed compliant with the requirement (SSA Sec. 1937(b)(6)(B), added by Affordable Care Act Sec, 2001(c)(2).[52]
- **Effective Date. New paragraph (5), added by paragraph (c)(3), is effective January 1, 2014. There is no effective date for the**

[48] *Id.* at 317.
[49] *Id*. at 120.
[50] *Id*. at 316-318.
[51] *Id.* at 261.
[52] *Id. at* 262.

remaining amendments, Therefore, they are considered effective upon the date of enactment.

5. Use of Modified Gross Income to Determine Income for Nonelderly

- States are required to use modified adjusted gross income to determine Medicaid eligibility.[53]
- The income definition is conformed to information that is currently reported on the Form 1040 and to the present law income tax return filing thresholds.
- **Income disregards and asset tests will no longer apply in Medicaid, except for long-term services and supports**.
- Existing Medicaid income counting rules will continue to apply for determining eligibility for certain *exempted groups*, including:
    - Individuals that are eligible for Medicaid through another program (e.g., individuals receiving SSI);
    - Individuals who have attained the age of 65 or SSDI beneficiaries;
    - The medically needy;
    - Enrollees in a Medicare Savings Program (e.g. Qualified Medicare Beneficiaries); and
    - The disabled.
    - Additionally, the provisions pertaining to the modified adjusted gross income counting rules will not affect income eligibility determinations for Express Lane, Medicare prescription drug low-income subsidies, or Medicaid long-term care services.
- An individual enrolled in Medicaid on January 1, 2014, who would have been ineligible under the new modified adjusted gross income counting rule, will remain eligible (and subject to the same premiums and cost sharing as applied to the individual on that date) until the later of March 31, 2014, or his or her next Medicaid eligibility redetermination date.[54]
- May impact beneficiary of SNT's family members and staff by allowing for an income spend down that was not available to this population before.

G. Premium Assistance Under Medicaid

- The option for states to offer premium assistance for children and families who have access to employer-sponsored insurance is clarified to require that the assistance be cost-effective. Medicaid and Children's Health Insurance Program (CHIP) have the same requirements for cost-effectiveness; specifically, the cost of

[53] *Id. at* 263.
[54] *Id.* at 264.

the subsidy is compared to the cost of providing assistance under CHIP or Medicaid to the child or family, including administrative costs.[55]

- **Effective date: This section is effective as if included in the enactment of CHIPPRA, which became effective April 1, 2009, except that the option to extend the premium assistance benefit to individuals other than children under 19 and their parents is effective January 1, 2014.[56]**
- Is this a "Buy-In Program"?
- I don't get this?
- **Law Source -**
  - Act Sec, 2003(a)(2) of the Patient Protection an Affordable Care Act (P.L. 11-1148),
  - Act Sec, 2003(a)(3) of the Act , amending SSA Sec. 1906A(d)(2) and (d)(3),
  - Act Sec, 2003(a)(4) of the Act , amending SSA Sec. 1906A(e),
  - Act Sec, 2003(b) of the Act, amending heading of SSA Sec. 1906A,
  - Act Sec, 10203(b)(4) of the Affordable Care Act, amending SSA Sec. 2105(c)(10),
  - Act Sec, 2003(c) of the Act, providing the effective date.

H. Mandatory Coverage of Former Foster Children

- Beginning January 1, 2014, former foster children under the age 26 MUST be covered by Medicaid if on the date that they reached 18 (or a higher age under the state's child welfare plan) they were:
  - In foster care under the responsibility of the state; AND
  - Enrolled in Medicaid or a waiver program.
- States must cover these individuals whether or not they also qualify for assistance under another subclass of SSA Sec. 1902(a)(10)(A)(i).
- Former foster children are entitled to full Medicaid benefits and are not limited to the benchmark or benchmark-equivalent coverage (SSA Sec. 1902(a)(10)(A), as amended by Affordable Care Act Secs. 2004 and 10201(a)(201).[57]
- **Effective date: This provision becomes effective January 1, 2014.[58]**
- **May cover children under Serious Emotional Disturbances (SED) Waiver**
- Children with Serious Emotional Disturbances Waiver:
  - The Michigan Department of Community Health (MDCH) received approval from the Centers for Medicare and Medicaid Services (CMS) for the Children's Home and Community-Based Services Waiver for Children with Serious Emotional Disturbance (SEDW), which began in October 2005. The SEDW is currently available in a limited number of counties and Community Mental Health Services Programs (CMHSPs).
  - The Children's SEDW provides services that are enhancements or additions to Medicaid State Plan coverage for children up to age 20 with SED, who are enrolled in the SEDW prior to their 18th birthday. The MDCH operates the

[55] *Id.* at 265.
[56] *Id*. at 266.
[57] *Id.* at 267.
[58] *Id.* at 68.

SEDW through contracts with the CMHSPs. The SEDW is a fee-for-service program administered by the CMHSP in partnership with other community agencies. The MDCH has a partnership with the Michigan Department of Human Services (MDHS) to serve children in MDHS foster care in eight of the SEDW counties.

- *Key Provisions* - The SEDW enables Medicaid to fund necessary home and community-based services for children with serious emotional disturbance who meet the criteria for admission to the state inpatient psychiatric hospital (i.e. Hawthorne Center) and are at risk of hospitalization without waiver services. The CMHSP is responsible for assessment of potential waiver candidates.
- Application for the SEDW is made through the CMHSP. The Wraparound Facilitator, the child and his/her family and friends, and other professional members of the planning team work together to identify the child/family's strengths, needs, interventions and outcomes following the wraparound practice model. The wraparound plan of service (POS) identifies all the services and supports necessary to meet the needs and outcomes.
- *Eligibility* -To be eligible for this waiver, the child must:
  - Meet current MDCH contract criteria for, and be at risk of, hospitalization in a state psychiatric hospital (i.e. Hawthorn Center)
  - Demonstrate serious functional limitations that impair his/her ability to function in the community. As appropriate for age, functional limitation will be identified using the the Child and Adolescent Functional Assessment Scale (CAFAS®) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS®):
    - CAFAS score of 90 or greater for children age 12 or younger; or
    - CAFAS score of 120 or greater for children age 13 to 18.
  - Be under the age of 18 when approved for the SEDW
  - Be financially eligible for Medicaid when viewed as a family of one (i.e., when parental income and assets are waived)
  - Be in need of and receive at least one waiver service per month.[59]
- This addresses very real problems illustrated in this Michigan case.

- **Additional Resources:**
  - *Children with Serious Emotional Disturbances Waiver,* MDCH, <http://www.michigan.gov/mdch/0,1607,7-132-2941_4868_7145-168285--,00.html>.
  - *Michigan Settles Reform Lawsuit, Agrees to Overhaul of Failing Child Welfare System,* Children's Rights, (July 3, 2008), <http://www.childrensrights.org/news-events/press/michigan-settles-reform-lawsuit/>.

I. Hospice of Children

[59] *Children with Serious Emotional Disturbances Waiver*, MDCH, <http://www.michigan.gov/mdch/0,1607,7-132-2941_4868_7145-168285--,00.html>.

- Children receiving Medicaid or coverage under the Children's Health Insurance Program (CHIP) what have been diagnosed with a terminal illness may receive both:
  - hospice care; and
  - treatment for the terminal illness concurrently.[60]
- **Effective date**: **March 23, 2010.**[61]

J. Elimination of Medicaid Exclusion of Certain Drugs

- States are prohibited from excluding the following drugs from Medicaid coverage:
  - Smoking cessation drugs;
  - Barbiturates; and
  - Benzodiazepines.
- **Effective Date: The provision is effective for services furnished on or January 1, 2014.**[62]

K. Medicaid Non-Payment for Health Care Acquired Conditions – PEKD loves this provision!

- Prohibited Medicaid payments for HACs
  - The Secretary of Heath and Human services is required to identify current state practices that prohibit payment for HACs and incorporate practices appropriate for application to the Medicaid program in regulations.
  - **Regulations must be in effect as of July 1, 2011, must incorporate the corresponding Medicare regulations pertaining to HACs, as appropriate and must prohibit payment.**[63]

L. Health Home Option for Medicaid Beneficiaries

- Beginning January 1, 2011.
- States have option of enrolling Medicaid beneficiaries with chronic conditions into a health home. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination.
- An eligible individual with chronic conditions is a an individual who:
  - Is eligible for Medicaid; and
  - Has at least:
    - two chronic conditions,

[60] *CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act: Including Reconciliation Act Impact, Volume I*, 274 (Wolters Kluwer eds., Wolter Kluwer 2010).
[61] *Id.* at 275.
[62] *Id.* at 296.
[63] *Id. at* 302.

        - one chronic condition and is a risk of having a second chronic condition; or
        - one serious persistent mental health condition.
    - For purposes of determining eligibility for health home services Secretary of HHS may establish a high number of severity of chronic or mental health conditions. A chronic condition, as defined by the Secretary of HHS, includes but is not limited to the following:
        - a mental health condition;
        - substance use disorder;
        - asthma;
        - diabetes;
        - heart disease; and or
        - being overweight as evidenced by having body mass index over 25.[64]
    - A health home is a designated provider or a health team selected by an eligible individual with chronic condition to provide health home services. Health home services are comprehensive and timely, high-quality services that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team. Such services are:
        - comprehensive care management;
        - care coordination and health promotion;
        - comprehensive transitional care form inpatient to other settings, including appropriate follow-up care;
        - patient and family support (including authorized representatives);
        - referral to community and social support services, if relevant; and
        - use of health information technology to link services feasibly and appropriately.[65]
    - May work for folks waiting for children's waivers.

4. Long Term Care Changes

A. What it is <u>NOT</u> MICASSA or The Choice Act!

Excerpt from Disability 101: Fighting For Independence
I cling fiercely to my independence.
I can be demanding about it.
I can be obnoxious about it.
I can be offensive about it.

Those who are offended, challenge me to behave in a more socially acceptable fashion. Those who care for me, encourage me to let my guard down, worried that I'm setting a standard for myself that's difficult to maintain.

Many people without a disability simply don't get it. They don't understand that the stakes are high. I'm fighting for my life here.

[64] *Id. at* 303.
[65] *Id. at* 304.

People with disabilities have a choice to make: fight for every bit of independence we can maintain or allow ourselves to sink into a world where there are no choices and we lose our sense of self.

My MS is a degenerative disability. Fortunately, at the moment I am stable. Always hovering over my shoulder is the specter of my symptoms getting worse and my life changing all over again.

Many people with MS wind up in nursing homes. We are living in a society that prefers to spend huge amounts of money providing services to people with disabilities in nursing homes, even though it would cost significantly less money to provide services in a community setting. Medicaid pays for nursing homes. Medicaid is not required to pay for services that would allow people with disabilities to remain in their homes. (Can you say "institutionalization"?) ADAPT is currently working to pass the Community Choice Act which would allow people with disabilities to receive services in their homes and which would actually save Medicaid a great deal of money.

Now I'm in a race. Which will happen first, the Community Choice Act or my MS getting worse?

I live in terror of nursing homes. I am single. I have two adult children but if you think they are going to be able to afford the services

I am likely to need in the future, guess again. No matter how much money they earn in their careers, I will become more expensive than they can afford.

Community Choice Act or my MS getting worse?

I have never been in a nursing home, but I know people who have. Their stories terrify me. Stories about nursing home attendants pulling residents out of their beds and leaving them in wheelchairs all night so the attendants didn't have to be bothered to check on the residents during the night. Stories about residents who did not behave in an approved fashion being restrained in their beds and tied up like animals.

In every nursing home, residents are expected to check their identity at the door. Residents are expected to forego personal choices, to forego personal opinions, yield to the schedule and do as they are told. It's too bad if you don't like the lousy food or if you don't want to turn your lights out early at night. If you have a need at a time that doesn't fit into the schedule, too bad.

Community Choice Act or my MS getting worse? I will fight for my independence. I will keep taking care of myself and earning my own paycheck just as long as I possibly can. Bear in mind I am not afraid of my disability. I'm afraid of our society's expectation that people with severe disabilities must be in a nursing home.

Today you are eager to help me by pushing my wheelchair or opening the door. Forget that. I'll push my own chair and open my own door. If you really want to help me, pass the Community Choice Act.[66]

- This is what we got instead…
- **Sense of the Senate Regarding Long Term Care**
  - The sense of the Senate is that Congress, during the 111th session of Congress, should address long-term services and supports in a comprehensive way that

[66] *Disability 101: Fighting For Independence*, Summit Daily News, (Oct. 4, 2010), <http://www.hhs.gov/news/press/2010pres/10/20101004a. html>.

guarantees elderly and disabled individuals the care they need, in the community as well as institutions.

- Background -
  - In September 1990 a U.S. bipartisan commission on Comprehensive Heath Care, known as the "Pepper Commission" released a blueprint for health reform that aimed to ensure all Americans health insurance in an efficient healthcare system. However, in the 20 yrs since those recommendations were made, Congress never acted on the report.
  - In 1999, in ***Olmstead v L.C.,*** the US Supreme Court ruled that individuals have the right to choose to receive long-term care services and support in the community, rather than in an institutional setting (527 U.S. 581 (1999).
  - Despite resulting efforts directed at supporting states to, and among other things, assist people with disabilities to make a successful transition from nursing homes and other institution into the community, the Patient Protection and Affordable Care Act (P.Pl. 111-148) stated that long-term care provided to the elderly and disabled individuals has not improved and in many instances, has worsened.
  - In 2007, 69% of Medicaid long-term care spending for elderly and disabled individuals were for institutional services. [67]
  - According to data included in a 2008 AARP Public Policy Institute report, only five states directed at least 50% of their total Medicaid LTSS expenditures toward HCBS in 2006 (Oregon, New Mexico, Washington, Alaska and California). When the data was analyzed narrowly for state spending on HCBS for individuals 65 years and older and adults with physical disabilities, it showed only four states spending at least 50% (Oregon New Mexico, Washington, and Alaska), and only 12 others spending at least 25%.[68]
  - The disparity of long-term care spending between HCBS and institutional care persists, despite estimate that Medicaid dollars can support nearly three elderly and disabled individuals in HCBS for every individual in a nursing home. While every state has chosen to provide certain service under HCBS waivers, such services are unevenly available among the states, and reach a small percentage of eligible individuals (Act Sec. 2406(a) of the Affordable Care Act). [69]
- **Effective Date: March 23, 2010.[70]**
- **Additional Resources:** *Disability 101: Fighting For Independence*, News, (Oct. 4, 2010), <http://www.hhs.gov/news/press/2010pres/10/20101004a.html>. See attachment #6.

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[67] *CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act: Including Reconciliation Act Impact, Volume I*, 292 (Wolters Kluwer eds., Wolter Kluwer 2010).
[68] NSCLC, *Medicaid Long-Term Services and Supports Provisions in the Health care Reform Law*, 2 (Apr. 2010) <http://www.nsclc.org/areas/medicaid/health-reform-ltss/at_download/attachment>.
[69] *CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act: Including Reconciliation Act Impact, Volume I*, 292 (Wolters Kluwer eds., Wolter Kluwer 2010).
[70] *Id. at* 293.

- *Community Choice Act (CCA), A Community-Based Alternative to Nursing Homes and Institutions For People With Disabilities*, <http://www. adapt.org/cca.php>. See attachment #7.
- *$68 Million in Grants Help Seniors and Disabled Navigate Options*, Spectrum Online, (October 3, 2010), <http://senior-spectrum. com/news01_100510/>.

B. Community First Choice Option

- Prior to CCA, there have been certain pilot programs that have encouraged the use of home-based services for disabled Medicaid beneficiaries, but there was no widespread federal option for home-based care **until now**.
- **Beginning October 1, 2011,** the Community First Choice Option gives state Medicaid programs the option to 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 home, intermediate care facility for the mentally retarded, or an institution for mental diseases.
- **We should track this important advocacy issue.**
- Additional services and supports will include:
  - acquisition and enhancement of skills necessary to accomplish activities of daily living, instrumental activities of daily living, and health-related tasks;
  - back-up systems or mechanisms such as beeper to ensure continuity of services and supports; and
  - training on how to select, manage, and dismiss attendants (SSA Sec. 1915(k)(1)(B), as added by Affordable Care Act Sec 2401).
- Services and supports that are permissible include:
  - expenditures for transition costs, such as rent and utility deposits, bedding and other necessities required for an individual to transition to a community-based home setting from a nursing home **[PKD wants you to know– Why this is such a horrible requirement],** institution for mental diseases, or intermediate care facility for the mentally retarded; and
  - expenditures relating to a need identified in an individual's person centered plan of services that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for the human assistance (SSA Sec. 1915(k)(1)(d), as added by Affordable Care Act Sec. 2401).
  - Services and supports that are NOT included in the Community First Choice Option are:
    - room and board costs (same as home and community – based waivers);
    - special education and related services;
    - certain assistive technology devices and services;

- medical supplies and equipment; and
- home modifications.

- States that choose the Community First Choice Option will be eligible **for an enhanced federal match rate** of an additional 6% for reimbursable expenses in the program.[71]
  - Not an entitlement…only state option, or state plan benefit.
  - Creates a new Medicaid benefit for individuals with an institutional level of need who want to remain in their homes or other community based setting. States choosing to make the service part of their State Plan will receive a 6% increase in their federal Medicaid reimbursement rate for the services delivered through the benefit. States may offer coverage for the benefit beginning October 2011.[72]
- States must ensure that home and community-based attendant services and supports comply with the **Fair Labor Standards Act of 1938,** and federal and state law regarding income and payroll taxes, unemployment and workers compensation insurance, general liability insurance, and occupational health and safety.
- In addition, states must provide the HHS Secretary with the following information each fiscal year such services and supports are provided:
  - The number of individuals estimated to receive home and community-based attendant services and supports during the fiscal year;
  - The number of individuals that received such services and supports during the preceding fiscal year;
  - The specific number of individuals served by type of disability, age, gender educational level, and employment status; and
  - Whether the specific individuals have been previously served under any other home and community - based services program under Medicaid (SSA Sec. 1915(K)(5), as added by Affordable Care Act Sec. 2401.[73]
- The HHS Secretary is required to evaluate the community-based attendant services and supports and to submit to Congress and make available to the public:
  - The interim findings of the evaluation by December 31, 2013, and

[71] *Id.* at 279-280.
[72] NSCLC, *Health Care and Reform & Low-Income Older Adults: An Overview*, 1 (Apr. 2010) <http://www.nsclc.org/areas/medicare-part-d/health-reform-overview/at_download/attachment>.
[73] *CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act: Including Reconciliation Act Impact, Volume I*, 280-281 (Wolters Kluwer eds., Wolter Kluwer 2010).

        - The final report on the findings of the evaluation by December 31, 2015 (SSA Sec. 1915(k)(5), as added by Affordable Care Act Sec. 2401).
    - **Effective Date: March 23, 2010.** The provision also directs that the community-based attendant services be provided in the "most integrated setting appropriate to the individual's needs." This may ultimately require States to examine the community character of the facility in which an individual is receiving community-based attendant services. In regulations it has proposed for the HCBS State Plan benefit, CMS has suggested that, where a prospective recipient is living in a residence with four or more persons unrelated to the proprietor, states evaluate whether the location is a "community" one relative to the person's needs. CMS has also recently proposed developing regulations that would more specifically define the nature of community-based residences for purposes of all Medicaid HCBS programs and services, even though most of the statutory provisions authorizing them only identify what may not be a community-based residence (e.g., a hospital, nursing facility, or intermediate care facility for the mentally retarded). The specific reference to "most integrated setting" in the provision seems to be in the same vein as the recent CMS proposals.[74]
    - **[PKD – mention current case on point].**
- *Community Choice Act (CCA): A Community-Based Alternative To Nursing Homes And Institutions For People With Disabilities*[75]

  For decades, people with disabilities, both old and young, have wanted alternatives to nursing homes and other institutions when they need long term services. Our long term care system has a heavy institutional bias. Every state that receives Medicaid MUST provide nursing home services, but community based services are optional. Sixty seven (67%) percent of Medicaid long term care dollars pay for institutional services, while the remaining thirty three (33%) must cover all the community based waivers, optional programs, etc.

  Families are in crisis. When support services are needed there are no real choices in the community. Whether a child is born with a disability, an adult has a traumatic injury or a person becomes disabled through the aging process, they overwhelmingly want their attendant services provided in their own homes, not nursing homes or other institutions. People with disabilities and their families will no longer tolerate being forced into selecting institutions. It's time for Real Choice.

  The Community Choice Act provides an alternative and will fundamentally change our long term care system and the institutional bias that now exists. Building on the Money Follows the Person concept, the two million Americans currently residing in nursing homes and other institutions would have a choice. In addition, people would not be forced into institutions order to get out on community services; once they are deemed eligible for the institutional

[74] NSCLC, *Medicaid Long-Term Services and Supports Provisions in the Health care Reform Law*, 4 (Apr. 2010) <http://www.nsclc.org/areas/medicaid/health-reform-ltss/at_download/attachment>.

[75] *Community Choice Act: A Community-Based Alternative To Nursing Homes And Institutions For People With Disabilities,* Adapt Free Our People, < http://www.adapt.org/cca.php>.

services, people with disabilities and their families will be able to choose where and how they receive services. Instead of making a new entitlement, the Community Choice Act, makes the existing entitlement more flexible.

The Community Choice Act establishes a national program of community-based attendant services and supports for people with disabilities, regardless of age or disability. This bill would allow the dollars to follow the person, and allow eligible individuals, or their representatives, to choose where they would receive services and supports. Any individual who is entitled to nursing home or other institutional services will now be able to choose where and how these services are provided.

- **Additional Resource:**
  - NSCLC, *The Medicaid Long-term Services and Supports Provisions in the Health Care Reform Law* (Apr. 2010) <http://www.nsclc.org/areas/medicaid /health-reform-ltss/at_download/attachment>. See Attachment #7.
  - *Community Choice Act: A Community-Based Alternative To Nursing Homes And Institutions For People With Disabilities,* ADAPT Free Our People, <http://www.adapt.org/cca.php>.
    - *Community Choice Act (CCA): Summary,* ADAPT Free Our People, <http://www.adapt.org/cca-summary.php>.
    - *Database for Community Choice Act Alerts,* ADAPT, <http://adaptold. adapt.org/commchoice/>.
    - *Summary of CCA,* Flyer, ADAPT, <http://www.adapt.org/freeour people/ download/CCAsum08a.pdf>.
    - *Become a Supporter of The Community Choice Act (CCA),* ADAPT, <http://www.adapt. org/casa/ support.htm>.
    - *The Community Choice Act Talking Points,* ADAPT, <http://www. adapt.org/cca-talkingpts.php>.
    - *Principles of the Community Choice Act,* ADAPT, <http://www.adapt. org/cca-principles.php>.
    - *Research Results (PDF) New Cost Estimate for CCA,* ADAPT, <http://www.adapt.org/freeourpeople/download/estimating%20expens e.pdf>.
    - *Congress Introduced the Community Choice Act on March 24. Press Statement,* ADAPT, <http://adaptold.adapt.org/commchoice/index. php? mode=A&id=189;&sort=D>.
    - *Webcast of CCA Introduction to Congress,* ADAPT, < http://www.tv worldwide.com/events/cca_intro/090324/>.
    - *Congressional Testimony given by ADAPT,* ADAPT, <http://www. adapt.org/testimony.php>.
    - *Community First Choice Summary Option Proposal for Health Care Reform,* ADAPT, <http://www.adapt.org/cfc.php>.
  - NSCLC, *The Medicaid Long-term Services and Supports Provisions in the Health Care Reform Law* (Apr. 2010) <http://www.nsclc.org/areas/ medicaid/health-reform-ltss/at_download/attachment>. See Attachment #8.

C. Removal of Barriers to Home and Community-Based Services (HCBS)[76]

- Barriers to providing home and community-based services (HCBS) are removed 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.
- States may also extend full Medicaid benefits to individuals receiving HCBS under a state plan amendment.
- Background
  - Social Security Act Sec. 1915 authorizes the Secretary of HHS to waive certain Medicaid statutory requirements to enable state Medicaid agencies to cover a broad array of HCBS as an alternative to institutionalization. An HCBS services waiver offers the state broad discretion not generally afforded under the State Plan to address the needs of individuals who would otherwise receive costly institutional care provided under the State Medicaid Plan. Some of the services most commonly provided are:
    - Home health visits;
    - Durable medical equipment;
    - Adult day care;
    - Training in life skills;
    - Personal assistance of personal care;
    - Homemaker or chore services;
    - Respite care;
    - Counseling;
    - Assistive devices or technology; and
    - Case management of service coordination.
  - The contents of a state application for a HCBS waiver must describe the class of individual to be served and the services provided. The group served must be included in the State Plan. If the services to be offered are included in the State Plan, the waiver documents must describe the differences in amount, duration, and scope between the waiver services and services under the Plan.
  - HCBS must be available throughout the state (also referred to as the "state-wideness" requirement), and must be comparable in amount, duration, and scope to services available to medically needy Medicaid beneficiaries (SSA Secs. 1902(a)(1) and 1902(a)(10)(B)). A state may have the state-wideness requirement and subsequently focus HCBS to a limited, select group of eligibles, such as the developmentally disabled (SSA Sec. 1915(i)(3)).
  - HCBS waivers are commonly used to provide services to:
    - The aged (65 and older);
    - The individuals who are physically disabled;
    - Individuals with developmental disabilities, such as mental retardation;
    - Patients infected with HIV or diagnosed with AIDS;
    - Individual with chronic mental illness;
    - Individuals with a traumatic brain injury;

[76] *CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act: Including Reconciliation Act Impact, Volume I*, 281-282 (Wolters Kluwer eds., Wolter Kluwer 2010).

        - Patients dependent on ventilators or other medical technology, sometimes referred to as "medically fragile;" and
        - The frail elderly.
- New Law – Expanded HCBS
    - The Secretary of HHS is directed to promulgate regulations to ensure that all states develop home and community based services (HCBS) systems that:
        - Allocate resources for services responsively to the changing needs and choices of beneficiaries who receive non-institutionally-based long-term services and supports, and provide strategies to maximize the independence of beneficiaries receiving such services;
        - Provide the support and coordination needed to design an individualized, self directed, community-supported life for a beneficiary of such services (and his or her family caregiver or representative, if applicable); and
        - Improve coordination and regulation of all HCBS providers under federally and state funded programs to:
            a) achieve consistent administration of policies and procedures in all relevant HCBS programs; and
            b) oversee and monitor al service system functions to ensure coordinated and effective eligibility determinations and individual assessments, a complaint system, a management system, a system to qualify and monitor providers, systems for role setting and individual budget determination, and qualified direct care workers to provide self direct personal assistance service (Act Sec. 2402(a) of Patient Protection and Affordable Care Act (P.L. 111-148)).
    - *State Options*.
        - A state that provides HCBS to individuals who satisfy the needs-based criteria for HCBS eligibility may elect to provide HCBS to eligible individuals under an approved waiver to provide such services (Social Security Act Sec. 1915 (i)(6)(A), as added by Affordable Care Act Sec. 2402(b)).
            - » This option applies only to individuals whose income is equal to or less than 300% of SSI benefit rate established under SSA Sec. 1611(b)(1).
            - » The state must apply same requirements to individuals who satisfy the needs based criteria as other individuals who qualify for HCBS (SSA Sec. 1915(i)(6)(B), as added by Affordable Care Act Sec. 2402(b)).
            - » Notably, the state may offer HCBS to individual that differ in type, amount, duration, and scope from the HCBS offered for individuals that satisfy the needs-based criteria, so long as such services are HCBS services for which the Secretary of HHS has the authority to approve a waiver and do not include room or board (SSA Sec. 1915(i)(6)(C), as added by Affordable Care Act Sec. 2402(b)).

- A state may also elect in a State Plan Amendment to target the provision of HCBS to specific population and to vary the type, amount, duration, and scope of such services to such specific populations (SSA Sec. 1915(i)(7)(A), as added by Affordable Care Act Sec. 2402(b)).
  - This election will be for a five-year period (SSA Sec. 1915(i)(7)(B), as added by Affordable Care Act Sec. 2402(b)).
  - During the first 5-year period, the state may phase in the enrollment of eligible individuals, the provision of services, or both, so long as all eligible individuals for such services are enrolled and all such services are provided before the end of the initial five-year period.
  - The state may renew its election for additional five-year terms if the Secretary of HHS determines, prior to the beginning of the renewal period, that the state has adhered to the relevant requirements in providing HCBS and met the state's objectives with respect to quality improvement and beneficiary outcomes (SSA Sec.1915(i)(7)(C), as added by Affordable Care Act Sec. 2402(b)).

- *Limitations on scope of services is removed.*
  - The limitation on the scope of HCBS that has been subject to the discretion of the Sec. of HHS is eliminated (SSA Sec. 1915(i)(1), as added by Affordable Care Act Sec. 2402(c)).
- *Optional eligibility category to provide Medicaid benefits.*
  - Medicaid eligibility is expanded to individuals who are eligible for HCBS under the needs-based criteria and who will receive HCBS pursuant to a State Plan Amendment (SSA Sec. 1902(a)(10)(ii) and1905(a), as added by Affordable Care Act Sec. 2402(d)).
- *Optional Limitation on eligibility of individuals eliminated.*
  - A state no longer has the authority to limit the number of individuals who are eligible for HCBS or to establish waiting lists for the receipt of such services (SSA Sec. 1915(i)(1)(C), as added by Affordable Care Act Sec. 2402(e)).
  - In the instance where a state modifies the eligibility criteria for HCBS, individuals who receive HCBS, individuals who receive HCBS under previous HCBS eligibility criteria may continue to be eligible for HCBS after the effective date of the modification until the individual no longer meets the pre-modified criteria (SSA Sec. 1915(i)(1)(D)(ii)(II), as added by Affordable Care Act Sec. 2402(e)).
- *Option to waive state-wideness eliminated; option to waive comparability added*
  - A state may no longer waive the statewideness requirement with respect to HCBS. A state that provides HCBS may, however, waive the comparability requirement (SSA Sec. 1915(i)(3), as added by Affordable Care Act Sec. 2402(f)).

- **Effective date. Act Sec. 2402(a) of the Patient Protection and Affordable Care Act (P.L. 111-148) is effective upon enactment (March 23, 2010). The provisions in Act Secs. 2402(b) through (f) are effective on the first day of the first fiscal year quarter beginning after the date of the enactment (June 1, 2010).**
- Important advocacy issues.
  - Examples:
    - Wait lists; limits of enrollment, capitated; contracts; limited communities.

- **Additional Resource:**
  - *NASHP Details State Options for Home and Community-Based Services,* The Henry J. Kaiser Family Foundation Health Reform Source. (October 5, 2010). <http://healthreform.kff.org/scan/2010/october/state-options-for-home-and-community-based services.aspx?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+source%2Fscan+%28The+Scan+From+Kaiser%27s+Health+Reform+Source%29>.

D. Optional Coverage

- **New optional group** - Beginning January 1, 2015 state Medicaid programs are required to cover anyone whose income does not exceed 133% of FPL, even where none of the traditional categories of eligibility apply.[77]
  - As of the same date, states may choose to cover individuals with incomes **above** that limit.
  - **The statute does not set an upper income limit.**
  - State may phase in the eligibility group.
    - If it does, eligibility may not be available to individuals with higher incomes before individuals with lower incomes.
    - Any individual who is a parent or caretaker relative of an eligible child may not be enrolled unless the eligible child is enrolled or has other insurance coverage.
    - *Annual Reports* - Beginning January 2015, states must submit reports to HHS Secretary on their Medicaid enrollment for the period preceding September 30. The reports must include the number of beneficiaries enrolled and the number newly enrolled, sorted by categories:
      - » Children;
      - » Parents;
      - » Individuals with disabilities;
      - » The elderly;
      - » Adults up to 64 without children who are not pregnant or disabled; and

[77] *Id. at* 285.

        - » Any other categories or subcategories covered by the State Plan or any waiver.[78]
      - The report also must describe the state agency's outreach and enrollment for the same period; this data also may be sorted by population.
  - **Effective Date: March 23, 2010.[79]**

E. Money Follows Person Rebalancing Demonstration (MFPRD)

- MFPRD is extended through September 30, 2016.
- Eligibility rules for individuals to participate in the demonstration project have been changed to require individuals to reside in inpatient facility **for not less than 90 days**.
- The 90-day period excludes any days that an individual resides in an institution solely for short-term rehabilitative services for which payment is limited to Medicare.
- **Effective date**: **March, 23, 2010.[80]**
- Any practical experience out there?
- Prior to this wait to get out of nursing home in many states took years.

F. Temporary Protection from Spousal Impoverishment

- During a **five-year period** beginning January 1, 2014, the spousal impoverishment provisions are expanded to include institutionalized persons who:
  - Are in a medical institution or nursing facility;
  - Are eligible for medical assistance for home and community-based services under a waiver approved by the Secretary of HHS for purposes of performing demonstration projects;
  - Are eligible for medical assistance under the state's optional eligibility requirements or on the basis of a reduced based on costs incurred for medical or other remedial care; or
  - Are eligible for medical assistance for home and community-based attendant services and support.
- **Effective Date: March 23, 2010.[81]**
- For situations when a person with disabilities is married.
  - While current federal law requires that states extend the spousal impoverishment protection to spouses of nursing facility residents (i.e.,

[78] *Id. at* 285.
[79] *Id. at* 286.
[80] *Id.* at 286.
[81] *Id. at* 290.

community spousal shares, including higher share for community spouses threatened with "significant financial distress"), the law makes the extension of protections to spouses of HCBS waiver enrollees discretionary for states.[82] CMS has taken the position that where a state does choose to include the protections in an HCBS waiver the spouses of waiver participants who qualify as medically needy are prohibited from being extended the protections. Section 2404 of the PPACA, Protection for Recipients of Home and Community Against Spousal Impoverishment ***mandates*** that states include the spousal impoverishment protection in their waiver programs, and that the spouses of *all* HCBS waiver participants, including those who qualify as medically needy, have the protections as well.[83]

- *Elimination of Part D co-payments for individuals receiving Medicaid home and community-based services.* Currently, full dual eligibles living in institutional settings (e.g., nursing facilities) do not owe any co-payments for Part D covered drugs. Individuals receiving Medicaid funded long-term care services at home; however, do have to pay co-payment. The new law addresses this imbalance by eliminating co-payments for individuals receiving Medicaid funded home and community based services. Individuals receiving services through an HCBS waiver or through a state plan amendment are included. CMS will determine through regulation when the provision will take effect, but it cannot take effect any earlier than January 1, 2012.[84]
- *Temporary Expansion of Spousal Impoverishment Protections (Section 2404)* Federal law requires that the spouse of any Medicaid-enrolled nursing facility resident be allowed to keep a minimum share of the couple's combined income and assets. For 2010, the "community" spouse is entitled to at least $1,821 of the couple's combined monthly income, or a maximum of $2,739, although the amount may be even higher where the community spouse is threatened with "significant financial duress."

  With regard to assets, the community spouse is entitled to either a minimum of $21,912 (in 2010) or 50% of the couple's combined assets, whichever is greater (up to a maximum in 2010 of $109,560). While current federal law requires that states extend the spousal impoverishment protections to the spouses of nursing facility residents, the law makes the extension of the protections to the spouses of HCBS waiver enrollees discretionary for states. Additionally, CMS has recently taken the position that, where a state does choose to include the protections in an HCBS waiver, the spouses of waiver participants who qualify as medically needy are prohibited from being extended the protections.24

  Section 2404 of the PPACA, "Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment," modifies the spousal impoverishment statute to mandate that states include the spousal

[82] 42 U.S.C. §1396r-5, 42 U.S.C. §1396r-5(e)(2)(B), and 42 U.S.C. §1396r-5(h)(1).
[83] NSCLC, *Medicaid Long-Term Services and Supports Provisions in the Health care Reform Law*, 9 (Apr. 2010) <http://www.nsclc.org/areas/medicaid/health-reform-ltss/at_download/attachment>.
[84] NSCLC, Health Care Reform, *Dual Eligibles & Coverage Expansion*, 2 (Apr. 2010), <http://www.nsclc.org/areas/medicare-part-d/health-reform-duals/at_download/attachment>.

impoverishment protections in their waiver programs, and that the spouses of all HCBS waiver participants, including those who qualify as medically needy, have the protections available. Additionally, the PPACA mandates that the protections be extended to the HCBS state plan benefit, as well as the community-based attendant services benefit that is created by the law. All of the changes in this provision; however, will not become effective until January 1, 2014, and will end December 31, 2019, at which point the current language of the statute will become effective again (meaning, that it would no longer be mandatory that states extend the protections to HCBS waiver enrollees, and the protections would not be available to the HCBS State Plan service or community-based attendant service recipients).

The application of the spousal impoverishment protections to individuals seeking coverage for a discrete State Plan benefit would be new. Generally, the spousal impoverishment protections, at least as they pertain to income, are grafted into the unique post-eligibility income treatment applied by the federal regulations to Medicaid-enrolled nursing facility residents and HCBS waiver enrollees. In this evaluation, specific portions of an enrollee's monthly income are allocated between a personal maintenance allowance, a community spouse maintenance allowance, and the enrollee's share of the cost of the covered services. But a Medicaid enrollee not in a nursing facility or HCBS waiver and receiving State Plan services, such as the HCBS State Plan benefit, may have co-pays for services he or she receives, but will not be subject to the same income allocations as nursing home facility or HCBS waiver enrollees. Thus, CMS will have to help states walk through this process of the recipients of the State Plan benefits referenced in this section.

One clear benefit of extending the spousal impoverishment protections to individuals seeking coverage for HCBS State Plan services or community-based attendant services is that the income of the individual's spouse will not be counted in determining eligibility. Generally, the income of a Medicaid applicant's spouse is deemed available to the applicant in evaluating his financial eligibility, but the spousal impoverishment statute mandates that the income of spouses be treated separately. Because both the HCBS State Plan and community-based attendant service benefits have income ceilings, the separate treatment of income that will apply by virtue of application of the spousal impoverishment protections will benefit an individual whose spouse's income would, if deemed available, otherwise render the applicant ineligible.

Comment – By mandating that states extend impoverishment protections to spouses of institutionalized Medicaid enrollees but not for HCBS waiver enrollees, the current spousal impoverishment statute provides a stark example of Medicaid's institutional bias. The PPACA will therefore take a critical step toward reducing this bias when its spousal impoverishment provisions become effective in 2014. Of equal importance is that the law will ensure that spouses of Medicaid HCBS enrollees who qualify as medically needy are not discriminated against in the extension of the protections in waiver programs, which is the upshot of CMS' current reading of the statute. Finally, by also adding the mandate that spouses of recipients of the HCBS

state plan and community-based attendant services receive the protections, the sum of the changes in Section 2404 stand out in their degree of beneficiary friendliness. The only drawback of the changes in this section is that they will sunset after five years.[85]

G. State Aging and Disability Resource Centers

- Ten million dollars is appropriated to the Secretary of Human Services for each of fiscal years 2010-2014 to carry out Aging and Disability Resource Center (ADRC) initiatives.
- Background - The ADRC program is jointly funded by the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) is streamlined to access to long-term care.
- ADRC grants are used to develop ADRC programs to provide citizen-centered "one-stop" entry points into the long-term support system and will be based in local communities.[86]
- Do they know who they are in their states? **[PKD]**
- **Effective date: March 23, 2010.**
- Single points of entry to nowhere – failed in Michigan!
- **Additional Resources:**
  - *New Health Care Education Grants Available from HHS.* <http://jfactivist.typepad.com/jfactivist/2010/10/for-jfa-new-health-care-education-grants-available- from-hhs.html>, See Attachment #9.

H. Demonstration Projects to Improved Quality of Medicaid

- Four demonstration projects are established to improve quality for Medicaid patients and providers:
  - A demonstration project is established to evaluate integrated care around a hospitalization by studying the use of bundled payment for hospital and physician services under Medicaid. This demonstration project begins on January 1, 2012, and ends on December 31, 2016.
  - A Medicaid global payment system demonstration project is established, in coordination with the CMS Innovation Center, that would allow participating states to adjust their current payment structure for safety net hospital from a fee-for-service model to a global capitated payment structure.
  - A Pediatric Accountable Care Organization demonstration project is established to allow qualified pediatric providers to be recognized and

[85] NSCLC, *Medicaid Long-Term Services and Supports Provisions in the Health care Reform Law*, 9 (Apr. 2010) <http://www.nsclc.org/areas/medicaid/health-reform-ltss/at_download/attachment>.
[86] *CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act: Including Reconciliation Act Impact, Volume I*, 291 (Wolters Kluwer eds., Wolter Kluwer 2010).

receive payments as Accountable Care Organizations (ACO) under Medicaid. The Pediatric ACO would be required to meet certain performance guidelines. Pediatric ACOs that meet these guidelines and provide services at a lower cost would share in those savings.

- A Medicaid emergency psychiatric demonstration project is established in which participating states would be required to reimburse certain institutions for mental disease 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.[87]

- **Effective Date: March 23, 2014.[88]**

I. Dual Eligibility Under Medicare and Medicaid: Five-Year Period for Demonstration Projects

- People eligible for both Medicare and Medicaid account for 42% of total Medicaid spending. This group of frail elders and subset of people with disabilities experiences poorly coordinated care and high costs. Improvements in care for those who are dually eligible has long been a priority for states.[89]
- With respect to HCBS, HCBS for the elderly, AIDS-infected or drug-dependent children, or demonstration projects, that provides medical assistance for dual eligible individuals (including waivers under which non-dual eligible individuals may be enrolled) are not subject to the two-year limitation set forth in Social Security Act 1915(h) and in addition, may be:
  - Conducted for a period of five years; and
  - Extended for additional five-year periods upon request of the state, unless the Secretary of Human Services determines that, for the previous waiver period, the waiver conditions were not met.
- Dual eligible individual is defined an individual who is:
  - Entitled to, or enrolled for, benefits under Medicare A, or enrolled for benefits under Medicare Part B; and
  - Eligible for Medicaid under the State Plan or under a waiver of such plan (Social Security Act Sec. 1915(h), as amended by Patient Protection and Affordable Care Act Sec. 2601(a) (P.L. 111-148);(SSA Secs. 1915(b), (c)(3), (d)(3), 1115(e)(2), (f)(6), as amended by Affordable Care Act Sec. 2601(b)).

[87] *Id. at* 306-307, 308.
[88] *Id. at* p.311.
[89] Weil, Weil, A. (2004). *State Policymakers' Priorities for Successful Implementation of Health Reform*. State Health Policy Briefing. 2. Retrieved from http://nashp.org/sites/default/files/policymaker_0.pdf.

- **Effective date: March 23, 2014.**[90]
- *Closing the 'Donut Hole'*- The Part D donut hole will be phased out by 2020. Individuals who reach the donut hole in 2010 will receive a $250 rebate to help cover drug costs.[91]
- **How does this work with PACE?? Anyone know yet?**

J. Community Living Assistance Services and Support (CLASS) Act

- Consumer-funded and voluntary long-term care insurance program providing a benefit not less than $50 per day, with a five-year vesting period for eligibility.
  - Premiums will be paid through payroll deductions from wages or self-employed income. Individuals who are unemployed, Health and Human Services (HHS) needs to devise a premium payment method.
  - This is an important program because individuals with functional impairments depend on Medicaid to pay for long-term care costs.
  - HHS will determine monthly premiums with younger participants paying less than older participants. Individuals with incomes below FPL and full-time students who are actively employed will pay nominal premiums.
  - Unlike Social Security, there are no retroactive benefits.
  - If an individual is eligible for CLASS and long-term services under Medicaid, CLASS benefits will offset the costs of Medicaid.
  - HHS Secretary maintains discretion in implementing this program, but it is the broadest reaching effort since Medicare program to provide care for the aging population[92]
  - To be eligible for enrollment individuals must:
    1. Be age 18 or older;
    2. "Actively at work";
       a. Includes part-time workers and self-employed.
       b. The Secretary will develop the details of the actively-at-work requirement.
       c. Employment is defined by the I.R.S. definition of employment and by the Social Security Administration's rules on how to qualify for a quarter of earnings;
    3. Not be a patient in a hospital or nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases and receiving medical assistance under Medicaid; and
    4. Not be confined to prison.
  - An individual with a pre-existing condition cannot be excluded from enrollment.
  - Premium cost are not yet known.

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[90] *CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act: Including Reconciliation Act Impact, Volume I*, 311-312 (Wolters Kluwer eds., Wolter Kluwer 2010).
[91] NSCLC, *Health Care and Reform & Low-Income Older Adults: An Overview*, 3 (Apr. 2010) <http://www.nsclc.org/areas/medicare-part-d/health-reform-overview/at_download/attachment>.
[92] *Community Living Assistance Services and Support (CLASS) Act Summary),* <http://www.aahsa.org/classact.aspx>.

- People with low income will pay a special low premium price such as $5 per month.[93]
- It states that an individual must earn $1,100 in 2010 to qualify for one quarter of Social Security coverage, which would be $4,400 for annual earnings for 2010.
- To be eligible for disability benefits, a person must be unable to engage in substantial gainful activity (SGA). A person earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The amount set for the CLASS Act appears to be a lower threshold amount then SGA.
- The program does have provisions for non-working spouses or other non-working individuals to enroll this program; however, they must have been actively employed for a minimum of 3 years during at least the first 5 years of enrollment to be eligible for the benefits later.
- Individuals with low income who meet the active employment requirements, and full-time students.[94]
- Statute states that an enrollee is presumed to be eligible for benefits if the enrollee is a patient in a hospital (provided the hospitalization is for long-term care), a nursing facility, an ICF, or an institution for mental diseases, and is in the process of, or about to begin the process of, planning to discharge from the facility or within 60 days of discharge. Enrollees can also become eligible for benefits in the alternative (i.e. community based) settings.

- *The New CLASS Act: The Community Living Assistance Services and Supports Act – the CLASS Act – is a significant long-term care initiative included in the health care legislation Congress enacted last Spring*.[95]
  Top Tips:
  - Consider including an express provision in your durable power of attorney which states that the agent may not enter into an arbitration agreement with skilled nursing facilities.
  - SNTs should contain provisions allowing the beneficiaries to have the right to enforce the terms of the SNT.
  - "Thinking Ahead – My life at the End" is a document containing words, symbols, and pictures that facilitate discussion with and decision-making by persons with developmental disabilities about their own values, goals, and treatment preferences at the end of life. A DVD is available that serves as an instruction manual. Available in different languages, http://finalchoices.org/thinking-ahead.php.
- *The CLASS Act: What Does it Mean for Private Long-Term Care Insurance?*[96]
  - Premiums:
    - Special rules limit the premiums that can be charged to the poor or students.

[93] *Id.*
[94] *Id.*
[95] Morris Klein, *The New CLASS Act: The Community Living Assistance Services and Supports Act – the CLASS Act – is a significant long-term care initiative included in the health care legislation Congress enacted last Spring*, NAELA News.
[96] Craig R. Springfield, Randolf H. Hardock, Vanda B. McMurty, *The CLASS Act: What Does it Mean for Private Long-Term Care Insurance?*, Journal of Financial Service Professionals (September 2010, Vol. 64, No. 5).

        - Individuals whose income does not exceed the poverty line and actively employed full-time students who have not attained the age 22, the monthly premium cannot exceed $5, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for years after 2009.
        - Premiums are recalculated once an individual no longer satisfies the full-time student criteria for a nominal premium.
        - There does not appear to be any recalculation mechanism for individuals with a nominal premium based on poverty apart from certain generally applicable circumstances where premiums may be recalculated.
        - The CLASS Act does not identify any particular premiums to be charged.
- Vesting:
    - A requirement for the three (or more) alternative benefit plans is that each must provide a five-year vesting period before an enrollee is eligible for benefits.
    - An individual generally is considered actively employed if he or she is
        - » reporting for work at a usual place of employment or at another location to which the individual is required to travel by reason of such employment (or in the case of an individual who is a member of the uniformed services, is on active duty, and is physically able to perform the duties of the individual's position) and
        - » is able to perform all the usual and customary duties of the individual's employment on the individual's regular work schedule.
- Underwriting
    - May not be used to prevent an individual from enrolling in the CLASS program.
- Benefit Trigger under CLASS Act
    - Any third benefit trigger under the CLASS Act must be similar to either the Activities of Daily Living (ADL)-based benefit trigger or cognitive impairment trigger, whereas the third trigger under the tax law must be similar to the ADL-based trigger
- Personal Care Attendant Workforce
    - The CLASS Act includes a number of provisions designed to ensure the adequacy of the personal care attendant workforce.
    - Efforts include:
    - The establishment of a Personal Care Attendants Workforce Advisory Panel for purposes of advising the Secretary of HHS on workforce issues related to personal care attendant workers.
- National Clearinghouse for LTC Information
    - CLASS Act requires that information regarding the CLASS program be included in the National Clearinghouse for Long-Term Care Information.

        - Resource is provided at www.longterm-care.gov and provides information to assist individuals in planning for the future possible need of LTC.
        - **Effective Date: October 1, 2012**
    - Individuals 18-65 years old who at the time of enrollment meet or soon will meet the CLASS Act's Benefit Triggers
        - CLASS program restriction that performs an underwriting role is the 60-month vesting period, which makes the CLASS program unattractive for those with very limited life expectancies.
        - Less attractive to prospective enrollee being Medicaid eligible because of primary payor rules which generally require 95% of CLASS program benefits of an institutionalized individual to be paid to the facility and 50% of CLASS program benefits for an individual receiving home care to be provided to the state.
        - These primary payor restrictions are only relevant if the eligible beneficiary is receiving Medicaid assistance. For uninsurable individuals who are not receiving such assistance and have substantial life expectancies, the CLASS program may offer a very material benefit in return for a modest premium investment.
    - Individuals over Age 65
        - For older age, individuals who have retired and do not yet have any signs of functional or cognitive impairment may have little incentive to once again begin working for wages or self-employment income that would entitle them to participate in the CLASS program.
        - Few elderly retired individuals are likely to newly enroll in the CLASS program and those who do are more likely to already be showing signs of impairment.
    - Although only about one quarter of adults with developmental disabilities are competitively employed (Butterworth et al., 2008), the work requirement is minimal enough to allow many of these individuals to enroll. Individuals below the poverty level will pay only a nominal premium.
    - The CLASS Act will help relieve pressure on Medicaid.[97]
- **Additional Resources:**
    - Kenneth M. Coughlin, *The New Health Reform Law's Impact on the Elderly*, The Elder Law Report, (newsletter of Aspen Publishers, Wolters Kluwer) 1 (Volume XXI Number 10, May 2010).
    - Morris Klein, *The New CLASS Act: The Community Living Assistance Services and Supports Act – the CLASS Act – is a significant long-term care initiative included in the health care legislation Congress enacted last Spring*, NAELA News.
    - Craig R. Springfield, Randolf H. Hardock, Vanda B. McMurty, *The CLASS Act: What Does it Mean for Private Long-Term Care Insurance?*, Journal of Financial Service Professionals (September 2010, Vol. 64, No. 5)[98]

[97] Weil, Weil, A. (2004). *State Policymakers' Priorities for Successful Implementation of Health Reform*. State Health Policy Briefing. 3. Retrieved from http://nashp.org/sites/default/files/policymaker_0.pdf.
[98] Craig R. Springfield, Randolf H. Hardock, Vanda B. McMurty, *The CLASS Act: What Does it Mean for Private Long-Term Care Insurance?*, Journal of Financial Service Professionals (September 2010, Vol. 64, No. 5).

- *Community Living Assistance Services and Support (CLASS) Act Summary*, **(http://www.aahsa.org/classact.aspx).**
- *Community Living Assistance Services and Support (CLASS) Act Summary)*, **(http://www.cahealthadvocates.org/advocacy/2010/class.html).**

K. Information Disclosure and Quality of Care

- Nursing home compare website
  - **www.medicare.gov/nhcmpare**
  - Each state is required to develop and maintain a consumer-oriented website providing useful information regarding each of the state's nursing facilities corresponding plan of correction[99]
    - **Are any states up yet?**
- *Quality of Care Enforcement*
  - *Reductions for self-reported violations* - The health care reform law authorizes CMS to reduce a money penalty against a nursing facility by up to 50% if the facility self-reports the violation and then corrects the deficiency within ten days of the penalty's imposition. Such reductions are not available if a penalty for the same violation had been reduced under this procedure within the preceding year, or if the penalty had been imposed for a deficiency that had caused a pattern of harm, immediately jeopardized a resident's health or safety, or caused a resident's death.[100]
  - *Standardized Complaint Form* - CMS must establish a quality assurance and performance improvement program for nursing facilities.
  - *Complaint resolution* - Each state must develop a complaint resolution process to assure that a facility does not retaliate against a resident's family members and friends.[101] **[HA!]**
  - ***Nationwide program of background checks*** – CMS is required to establish a program to develop a process for nationwide background checks for direct-care employees
    - Program will be conducted through agreements between CMS and states.
    - Checks will be used for nursing facilities, and also for home health agencies, hospice agencies, long-term care hospitals, adult day health care providers, assisted living facilities providing a level of care

[99] NSCLC, *Health Care and Reform & Long-Term Care Facilities*, 5 (Apr. 2010) <http://www.nsclc.org/areas/long-term-care/NursingFacilities/health-reform-ltc-facilities/at_download/attachment>.
[100] *Id.* at 5.
[101] NSCLC, *Health Care and Reform & Low-Income Older Adults: An Overview*, 1 (Apr. 2010) <http://www.nsclc.org/areas/medicare-part-d/health-reform-overview/at_download/attachment>.

determined by CMS, and other appropriate care providers as determined by the state.
        - Background checks will require fingerprint checks.
        - Systems must have a "rap back" capacity so that subsequent criminal convictions automatically are reported to CMS, and then to the states and the long-term care employer.
        - States must provide processes to allow for appeals by disqualified persons, and those appeals must give consideration to the passage of time, extenuating circumstances, demonstration of rehabilitation, and the relevance of the disqualifying event, given the person's current employment.[102]
    - ***Incentives for employment in long-term care direct services*** – CMS will provide incentives to support direct-care workers in long-term care.
        - CMS will coordinate with the Labor department to attract and train long-term care staff *and* make grants to eligible entities to provide training and to provide bonuses to employees who achieve certifications. The goal is to create career ladders for direct-care employees.
        - CMS also will provide grants to entities to promote management practices designed to retain direct-care employees. Such practices include but are not limited to the promotion of a culture that respects caregivers and residents, and policies that reward high performance.
        - CMS grants also are authorized to long-term care facilities to implement electronic health record. In a related matter, CMS is directed to adopt electronic standards for the exchange of clinical data by nursing facilities.
        - For these activities, $20 million is authorized for fiscal year 2011, with slightly lesser amounts authorized for each of the three following years.[103]
- **For Additional Information:**
    - *CMS Doubles Funding for Senior Medicare Patrol Program Activities*, McKnight's Long-Term Care News, <http://www.mcknights. com/cms-doubles-funding-for-senior-medicare-patrol-programactivities/ article/180228/>, See Attachment #10.

5. Additional Resources

1. *Impact of Health Care Reform on People with Disabilities,* Spinalcordadvocates.org, <http://www.spinalcordadvocates.org/impact-of-health-care-reform-on-people-with-disabilities/>.
2. *CCH Briefing: President Sign's Health Care Reform* –Wolter Klumer, Special Report, (2010).

[102] NSCLC, *Health Care and Reform & Long-Term Care Facilities,* 8 (Apr. 2010) <http://www.nsclc.org/areas/long-term-care/NursingFacilities/health-reform-ltc-facilities/at_download/attachment>.
[103] *Id.* at 9.

3. Joe Caldwell, *Implications of Health Care Reform for Individuals with Disabilities*, A journal of Policy, Practices, and Perspectives: Intellectual and Developmental Disabilities (Volume 48, No. 3, June 2010).
4. New Health Care Provisions Now in Effect, Bazelon Center for Mental Health Law, <http://campaign.r20.constantcontact.com/render?llr=iri69ddab&v= 0012ndadPBmR-JYG P6HJ7WpYM0A0t4mBX7bYRwQ_WyjS6a7nTEqPwuVq 2ezIdZolkru AW mAnnlKdDI1x74GwyjraDYX8QvqMtrftlcsofUV8lNv GYYB BW-gT1la6VxLXY>.
5. Hathaway, Morris, and Kornblau, *Impact of Health Care Reform on People with Disabilities*, NSCIA, Spinalcordadvocates.org, <http://www.spinalcordadvocates .org/impact-of-health-care-reform-on-people-with-disabilities/>.
6. NSCLC, *The Medicaid Long-term Services and Supports Provisions in the Health Care Reform Law* (Apr. 2010) <http://www.nsclc.org/areas/medicaid/health-reform-ltss/at_download/attachment>.
7. Memorandum from Jane Perkins, National Health Law Program, to Health Advocates, Patient Protection Act, *Clarifies the Meaning of* "*Medical Assistance*" (March 31, 2010) (on file with National Health Law Program, and National Senior Citizens Law Center).
8. Office of Consumer Information and Insurance Oversight, <http://www.hhs.gov/ ociio/ regulations/index.html>.
9. Vivki Gottlich, Esq., *Affordable Care Act and Medicare: 5 Points Elder and Special Needs Law Attorneys Should Know*, NAELA News (Volume 22, Issue 3, 2010). Timeline by Mary WanderPolo, *Health Care Reform Timeline*, NAELA News (Volume 22, Issue 3, 2010).
10. *White House Will Delay W-2 Insurance Reporting Requirement, Other Health Reform News*, KHN Kaiser Health News, (October 13, 2010), <http://www.Kaiser healthnews.org/Daily-Reports/2010/October/13/Health-Care-Implementation.aspx>.