State Legislators' Check List for Health Reform Implementation FY 2010

July 15, 2010

Rachel Morgan R.N., BSN, Senior Health Policy Specialist

National Conference of State Legislatures ***444 North Capitol Street, N.W., Suite 515*** ***Washington, D.C. 20001***

Table of Contents

INSURANCE REFORMS 2
HEALTH CARE COVERAGE 3
HEALTH CARE WORKFORCE/HEALTH CARE PROVIDERS 4
LONG-TERM CARE 7
MEDICAID 10
MEDICARE 28
QUALITY, PREVENTION & WELLNESS 33
AMERICAN HEALTH BENEFIT ECHANGE GRANT 38

FY 2010 TASKS				
INSURANCE REFORMS				
NOT STARTED	**IN PROGRESS**	**COMPLETED**	**Implementation Date**	
			September 2010	**Within 6 months of enactment analyze and conform as necessary state laws regulating insurance with the provisions in the new federal law including the following:**
☐	☐	☐		1. Prohibition on annual and lifetime limits on dollar value of coverage outside those limitations permitted by the secretary.
☐	☐	☐		2. Prohibition on rescission of coverage by insurers.
☐	☐	☐		3. Required coverage of preventive health services rated A or B by the U.S. Preventive Services
				4. Task Force without cost sharing.
☐	☐	☐		5. Extension of adult dependent coverage to age 26 by group and individual plans.
☐	☐	☐		6. Prohibition on the use of preexisting condition exclusions for children.
☐	☐	☐		7. Prohibition on discrimination based on salary.
☐	☐	☐		8. Plan incorporation of revised internal and external appeals process requirements.
☐	☐	☐		9. Assurances of plan and provider compliance with patient protections.
☐	☐	☐	**March 2010**	Establish a health insurance consumer assistance office and ombudsmen ($30 million in grant funding is available to states to establish and operate offices through HHS) (**effective upon enactment**)
☐	☐	☐	**FY 2010**	Establish a process for plan reporting requirements for annual review of premium increases **($250 million in grant funding is available to states over a 5-year period to assist rate review activities.)** (**effective during the 2010 plan year**)
☐	☐	☐		Determine funding needs for an expansion of **outreach to and education** of consumers regarding new protections and rights.

FY 2010 TASKS				
HEALTH CARE COVERAGE				
NOT STARTED	**IN PROGRESS**	**COMPLETED**	**Implementation Date**	
☐	☐	☐	**September 2010**	Requirements for plan information submission to the secretary and state for public use. (**effective 6 months after enactment**)
☐	☐	☐	**June 2010**	Determine the mechanism by which your state will comply with statutory requirements for a **high risk pool program** from the following options: 1. Operation of a new high risk pool alongside of an existing state high risk pool, 2. Establishment of a new high risk pool (in a state that does not currently have a high risk pool), 3. Build upon other existing coverage programs designed to cover high risk individuals, 4. Contract with a current HIPAA carrier of last resort or other carrier, to provide subsidized coverage for the eligible population, or 5. Do nothing, in which case HHS would carry out a coverage program in the state, (**Provides $5 billion to fund pools through 2013**) (**effective 90 days after enactment**)

FY 2010 TASKS				
HEALTH CARE WORKFORCE/HEALTH CARE PROVIDERS				
NOT STARTED	**IN PROGRESS**	**COMPLETED**	**Implementation Date**	
☐	☐	☐	**FY 2010**	**School-Based Health Clinic/ Center Grants (SBHCs)** *(Grant Opportunity)* Establishes a grant program for the establishment and operation of school-based health centers (SBHC). To be eligible for a grant an entity must: • Be a SBHC or a sponsoring facility of an SBHC, and • Submit an application containing information that awarded funds will only be used for authorized services or allowed by federal, state or local law. • In awarding grants preference will be given to SBHC that serve a large population of children eligible for medical assistance or the state child health plan. • Funds may be used for; • Facilities including acquisition or improvement of land, acquisition, construction, expansion, replacement, or other improvements of any building or other facility, • Equipment, or • Similar expenditures. • No funds may be used for personnel or to provide services. • Appropriates $50 million for fiscal years 2010 through 2013 • **No matching funds requirement is imposed.**
☐	☐	☐	**FY 2010**	**Continuing Educational Support for Health Professionals Serving in Underserved Communities** *(Grant Opportunity)* • Establishes grants for eligible entities including health professions schools, academic health centers, State or local governments, or other appropriate public or private nonprofit entities for the purpose of supportive activities to enhance education through distance learning, continuing educational activities, collaborative conferences, and electronic and tele-learning activities, with priority for primary care. • Authorizes $5 million for FY 2010 through 2014 and such sums as necessary for subsequent fiscal years.

FY 2010 TASKS				
HEALTH CARE WORKFORCE/HEALTH CARE PROVIDERS				
NOT STARTED	**IN PROGRESS**	**COMPLETED**	**Implementation Date**	
☐	☐	☐	**FY 2010**	**Issue of State Interest** **Funding for Public Health Service Act Nursing Programs** Authorizes $338 million for FY 2010 and sums as necessary for fiscal years 2011 through 2016 to fund the Public Health Service Act nursing development programs.
☐	☐	☐	**FY 2010**	**Issues of State Interest** **Nursing Student Loan Program** Raises the cap on the maximum annual loan amount each student may receive from $2,500 to $3,300, loan amounts for the final two academic years from $4,000 to $5,200, and raises the overall aggregate amount to $17,000 from $13,000 beginning in FY 2010 and 2011. After fiscal year 2011, the amounts will be adjusted to provide for a cost-of-attendance increase for the yearly loan rate.
☐	☐	☐		**Medical Residency Training** • Modifies rules governing when hospitals can receive indirect medical education (IME) and direct graduate medical education (DGME) funding for residents who train in a non-provider setting. • Modifies current law to allow hospitals to count resident time spent in didactic conference to IME costs in the provider setting and toward DGME in the non-provider setting. • Directs the secretary to redistribute medical residency slots from a hospital that closes on or after the date that is two years before enactment of health reform legislation.

FY 2010 TASKS

HEALTH CARE WORKFORCE/HEALTH CARE PROVIDERS

Not Started	In Progress	Completed	Implementation Date	
☐	☐	☐	FY 2010	**Issues of State Interest** **Pediatric Specialty Loan Repayment Program** • Establishes a pediatric specialty loan repayment program. • Eligible recipients must agree to be employed full-time for a period of not less than two years providing pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care, including substance abuse prevention and treatment services. • Services will be provided in an area with a shortage of the specified services but with a sufficient pediatric population to support the subspecialty. • Payments will be made on behalf of the recipient by the Department of Health and Human Services on the principle and interest of undergraduate, graduate, or graduate medical education loans of not more than $35,000 per year for each year of service for a period of not more than three years. Preference will be given to applicants who are or will be working in a school setting, have familiarity with evidence-based methods, and cultural and linguistic competence health care services, and demonstrate a financial need. • Authorizes the appropriation of $30 million for fiscal years (FY) 2010 through 2014 for applicants in a pediatric medical subspecialty, pediatric surgical specialty, and $20 million for FY 2010 through 2013 for applicants in child and adolescent mental and behavioral health care, including substance abuse prevention and treatment.
☐	☐	☐		**Primary Care Student Loan Funds** • Amends existing agreement requirements of a federally supported student loan to include an option for repayment by a recipient to practice for 10 years, including residency training in primary health care, or until the date the loan has been repaid. • Establishes a payment penalty interest rate of two percent per year for noncompliance with the original agreement. • Revises current student loan guidelines pertaining to submission of parental financial information for an independent student to determine financial need to allow the determination of need to be at the discretion of the applicable school loan officer.

FY 2010 TASKS			
LONG-TERM CARE			
NOT STARTED	**IN PROGRESS**	**COMPLETED**	**Implementation Date**
☐	☐	☐	

Issue of State Interest

Sec. 8002 Community Living Assistance Service and Supports

- Establishes a new, voluntary, self-funded public long-term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations. Requires the Secretary to develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides cash benefit that is not less than an average of $50 per day. No taxpayer funds will be used to pay benefits under this provision.
- Creates a new national insurance program to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities.
- Financed through voluntary payroll deductions (with opt-out enrollment similar to Medicare Part B), this program will remove barriers to independence and choice (e.g., housing modifications, assistive technologies, personal assistance services, transportation) by providing a cash benefit to individuals unable to perform two or more functional activities of daily living.

Definitions

- "Active enrollee" means an individual who has enrolled and paid premiums to maintain enrollment. "Activities of daily living" include eating, toileting, transferring, bathing, dressing, and incontinence or the cognitive equivalent.
- An "eligible beneficiary" has paid premiums for at least 60 months and for at least 12 consecutive months. (§ 3203)l.

FY 2010 TASKS			
LONG-TERM CARE			
NOT STARTED	**IN PROGRESS**	**COMPLETED**	**Implementation Date**
☐	☐	☐	

Issue of State Interest

Sec. 8002 Community Living Assistance Service and Supports (continued)

CLASS Independent Benefit Plan

- Directs the Secretary of Health & Human Services to develop two alternative benefit plans within specified limits.
- The monthly maximum premiums will be set by the Secretary to ensure 75 years of solvency.
- There is a five year vesting period for benefit eligibility.
- The benefit triggers when an individual is unable to perform not less than two activities of daily living for at least 90 days.
- The cash benefit will be not less than $50 per day.

Not later than October 1, 2012, the Secretary will designate a CLASS benefit plan, taking into consideration the recommendations of the CLASS Independence Advisory Council.

Enrollment and Disenrollment

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

Benefits

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

FY 2010 TASKS			
LONG-TERM CARE			
NOT STARTED	**IN PROGRESS**	**COMPLETED**	**Implementation Date**
☐	☐	☐	

Issue of State Interest

Sec. 8002 Community Living Assistance Service and Supports (continued)

CLASS Independence Fund

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

CLASS Independence Advisory Council

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

FY 2010 TASKS MEDICAID Not Started	In Progress	Completed	Implementation Date	
				Analyze and conform as necessary state laws regulating the following provisions related to the State Medicaid programs:
☐	☐	☐	**FY 2010**	**Sec. 2001 Maintenance of Medicaid Income Eligibility (MOE)** **General Provisions** • Requires states to maintain existing income eligibility levels for all Medicaid populations upon enactment. The imposition of any changes in eligibility standards, methodologies or procedures that is more restrictive than those in place on the **date of enactment** will result in the loss of federal matching funding. • This maintenance of effort for eligibility (MOE) provision will expire when the HHS Secretary determines that the state health exchange is fully operational, except as it applies to coverage of: 1. individuals with income at or below 133 percent of FPL, for which it will continue through December 31, 2013; and 2. children under age 19 (or higher if provided for in the state plan), for which it will continue through September 30, 2019.
☐	☐	☐	**December 1, 2010**	**State Financial Hardship Exemption** • Between January 1, 2011 and January 1, 2014, a state is exempt from the maintenance of effort for optional nonpregnant, non-disabled adult populations above 133 percent of the federal poverty level if the state certifies to the Secretary that the state is currently experiencing a budget deficit or projects to have a budget deficit in the following state fiscal year. • **The state may make the necessary certification on or after December 1, 2010**.
☐	☐	☐	**April 1, 2010**	• **Mandating coverage of former foster care children through age 26.** (See Sec. 2004 for additional detail) (**effective April 1, 2010**),
☐	☐	☐	**March 2010**	• **Concurrent care for children** who are eligible for Medicaid or CHIP, to receive hospice services without forgoing any other service to which the child is entitled under Medicaid. (see sec. 2302 for additional detail) (**effective upon enactment**),
☐	☐	☐	**March 2010**	• **Optional Coverage for Freestanding Birth Center Services**- Makes coverage of services provided by free-standing birthing centers a mandatory benefit under Medicaid. (See Sec. 2301 for additional details) (**effective upon enactment**).

FY 2010 TASKS

MEDICAID

FUNDING

Not Started	In Progress	Completed	Implementation Date	
☐	☐	☐	**October 1, 2010**	• **Comprehensive Tobacco Cessation Services** - conform state laws as necessary to provide state Medicaid coverage for comprehensive tobacco cessation services for pregnant women without cost-sharing for the services as is mandatory in the. (**Effective October 1, 2010**)
				Analyze and respond as necessary according to state needs related to the State Medicaid programs:
☐	☐	☐	**January 1, 2011**	**State Financial Hardship Exemption** • Between January 1, 2011 and January 1, 2014, a state is exempt from the maintenance of effort for optional nonpregnant, non-disabled adult populations above 133 percent of the federal poverty level if the state certifies to the Secretary that the state is currently experiencing a budget deficit or projects to have a budget deficit in the following state fiscal year.
☐	☐	☐	**January 1, 2011**	**Sec. 2006 Special Adjustment to FMAP Determination for Certain States Recovering from a Major Disaster** • Reduces projected decreases in federal Medicaid matching funds as a result of the regular updating process, for states that have experienced major disaster. • To qualify as a "disaster recovery FMAP adjustment state", a state must have over the past seven fiscal years received a Presidential declaration of a major disaster under the provisions of sec. 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act **and** every county or Parrish in the state statewide was eligible for both individual and public assistance. **Effective Date** • January 1, 2011.

FY 2010 TASKS

MEDICAID

TREATMENT OF PUERTO RICO AND THE TERRITORIES

Not Started	In Progress	Completed	Implementation Date	
☐	☐	☐	**January 1, 2011**	**Sec. 2005 Puerto Rico and the Territories** • Beginning in January 1, 2011, and for each fiscal year thereafter, all territories' FMAP rate and spending caps will be increased. • Requires territories in 2014 to provide coverage to childless adults who met income eligibility standards consistent with those already established for parents by the territories. • Provides that the cost of providing coverage to newly eligible individuals will not count towards the spending cap. **Territories and the Health Insurance Exchanges** • Each territory will have a one-time option to "opt-in" to state (or territory)-based insurance exchanges in 2014.

FY 2010 TASKS

MEDICAID

DUAL-ELIGIBLES

Not Started	In Progress	Completed	Implementation Date	
☐	☐	☐		**Sec. 2601-Waiver Authority for Dual-Eligible Demonstrations** • Clarifies that Medicaid demonstration authority for coordinating care for dual-eligibles is as long as five years.
☐	☐	☐	**March 1, 2010**	**Issue of State Interest** **Sec. 2602-Improved Coordination and Protection for Dual-Eligibles** **Federal Coordinated Health Care Office (CHCO)** • Establishes the Federal Coordinated Health Care Office (CHCO) within the Centers for Medicare & Medicaid Services (CMS) **no later than March 1, 2010**. • The CHCO would report directly to the CMS Administrator. The purpose of the CHCO would be to bring together officials of the Medicare and Medicaid programs at CMS to (1) more effectively integrate benefits under the Medicare and Medicaid programs, and (2) improve the coordination between the Federal and state governments for individuals eligible for benefits under both such programs in order to ensure that such individuals get full access to the items and services to which they are entitled. • Establishes the specific responsibilities of the CHCO as follows: 1. Providing states, specialized MA plans for special needs individuals; physicians and other relevant entities or individuals with the education and tools necessary for developing programs that align benefits under the Medicare and Medicaid programs for dual eligible individuals. **2.** Supporting state efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program. **3.** Providing support for coordination of contracting and oversight by states and the CMS with respect to the integration of the Medicare and Medicaid programs in a manner that is supportive of the goals described above. • Requires the Secretary, as part of the budget, to submit to Congress an annual report containing recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.

FY 2010 TASKS

MEDICAID

EXPANSION OPTIONS

Not Started	In Progress	Completed	Implementation Date	
				Determine participation in state optional expansions as follows:
☐	☐	☐	**April 1, 2010**	**Optional Eligibility Expansion to Childless Adults** • Permitting states to extend Medicaid coverage to non-elderly, non-pregnant adults through a state plan amendment (SPA) at their current matching rate. • States may phase-in coverage based on income. • Lower income individuals must be phased-in first. • If a state expands eligibility they are required to extend coverage to individuals with lower incomes before extending coverage to individuals with higher incomes. • **Effective April 1, 2010**.
☐	☐	☐	**April 1, 2010**	**Treatment of Individuals with Incomes above 133 Percent of FPL** • States may provide Medicaid coverage to individuals with a Modified Adjusted Gross Income (MAGI) above 133 percent of FPL through traditional Medicaid or in the form of supplemental wrap benefits. Individuals with MAGI above 133 percent of FPL who receive only a benefit wrap from Medicaid may be eligible for tax credits in the state exchange. • States may phase-in coverage based on categorical group, provided that lower income individuals are phased-in first. • States must ensure that all children of parents who choose state exchange coverage will continue to receive the benefits, including early and periodic screening, diagnostic, and testing benefits (EPSDT), that they were entitled to receive under Medicaid. The Medicaid cost-sharing rules and the out-of-pocket limit of five percent of family income would continue to apply for children. • **Effective April 1, 2010**.

FY 2010 TASKS

MEDICAID

EXPANSION OPTIONS

Not Started	In Progress	Completed	Implementation Date	
☐	☐	☐	**March 2010**	**Determine participation in state optional expansions as follows:**

New Optional Eligibility Category

- State option to add a new categorically-needy eligibility group to Medicaid.
- The new group would be comprised of:
  1. non-pregnant individuals with income up to the highest level applicable to pregnant women covered under the Medicaid or CHIP state plan, and
  2. at state option, individuals eligible under the standards and processes of existing section 1115 waivers that provide family planning services and supplies.

Benefits

- Benefits would be limited to family planning services and supplies and would also include related medical diagnosis and treatment services.

Presumptive Eligibility

- States may make a presumptive eligibility determination for individuals eligible for these services through the new optional eligibility group. This means that states may enroll these individuals for a limited period of time before completed Medicaid applications are filed and processed, based on a preliminary determination by Medicaid providers of likely Medicaid eligibility.
- States will not be allowed to provide Medicaid coverage through benchmark plans unless the coverage includes family planning services and supplies.

Effective Date

Effective upon enactment and applicable to services provided on or after that date.

FY 2010 TASKS

MEDICAID

DEMONSTRATION PROJECTS/ PILOT PROGRAMS

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date	
☐	☐	☐	**January 1, 2010**	**Pediatric Accountable Care Organization (ACO) Demonstration Program** • Establishes a demonstration project, authorizing participating states to allow pediatric medical providers who meet certain criteria to be recognized as accountable care organizations (ACOs) for the purposes of receiving incentive payments, in the same manner as an ACO would be recognized and provided with incentive payments under Medicare (as provided for in section 3022 of the bill). • Requires the Secretary, in consultation with states and pediatric providers, to develop performance guidelines to ensure that the quality of care delivered to individuals by the ACOs would be at least as high as it would have been absent the demonstration project. • Requires participating states, in consultation with the Secretary, to establish an annual minimum level of savings in expenditures for items and services covered under Medicaid and CHIP that would need to be achieved by an ACO in order for the ACO to receive an incentive payment. • Provides that ACOs that meet the performance guidelines established by the Secretary and achieve savings greater than the annual minimal savings level established by the state will receive an incentive payment for the year equal to a portion (as determined appropriate by the Secretary) of the amount of the excess savings. • Authorizes the Secretary to establish an annual cap on incentive payments for an ACO. **Authorizes the demonstration from January 1, 2010 through December 31, 2016.**
☐	☐	☐	**FY 2010**	**Medicaid Global Payments Demonstration** • A demonstration project available to 5 states which establishes the Medicaid Global Payment System Demonstration Project, which creates an alternative payment methodology for safety net hospital systems. • Participating states must adjust their payments made to an eligible safety net hospital system or network from a fee for- service payment structure to a global, capitated payment model. • Operation during fiscal FY 2010 to FY 2012.

FY 2010 TASKS

MEDICAID

DEMONSTRATION PROJECTS/ PILOT PROGRAMS

NOT STARTED	IN PROGRESS	COMPLETED	Implementation Date	
☐	☐	☐	**April 2010**	**Money Follows the Person Rebalancing Demonstration** • Extends the authorization for the Money Follows the Person Rebalancing Demonstration through September 30, 2016. • Changes the eligibility rules for individuals to participate in the demonstration project by requiring that individuals reside in an inpatient facility for not less than 90 consecutive days. • Excludes Medicare-covered short-term rehabilitative services from the counting of the 90-day period. **Effective 30 days after enactment**.

FY 2010 TASKS

MEDICAID

PROMOTING DISEASE PREVENTION AND WELLNESS

Not Started	In Progress	Completed	Implementation Date	
☐	☐	☐	**January 1, 2011**	**Program for Healthy Lifestyles** (*Grant Opportunity)* Sec. 4108 **c**reates a **grant program for states** to provide incentives to Medicaid beneficiaries who participate in a program to develop a healthy lifestyle. These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions. **(Appropriates $100 million for this purpose, and grant awards will be awarded beginning January 1, 2011)**. Grants will be awarded over a five-year period, and the program must be carried out by a State within a three-year period.
☐	☐	☐		**State Plan Option Promoting Health Homes for Enrollees with Chronic Conditions** (*Grant Opportunity)* • Creates a new Medicaid state plan option under which Medicaid enrollees with at least two chronic conditions or with one chronic condition and at risk of developing another chronic condition, could designate a provider as their health home. • Requires qualifying providers to meet certain standards established by the Secretary, including demonstrating that they have the systems and infrastructure in place to provide comprehensive and timely high-quality care either in-house or by contracting with a team of health professionals. • The designated provider or a team of health professionals will offer the following services: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; and referral to community and social support services, if relevant and as feasible use health information technology to link such services. • Teams of providers could be free-standing, virtual, or based at a hospital, community health center, clinic, physician's office, or physician group practice. • Requires designated providers to report to the state on all applicable quality measures in the state Medicaid program.

FY 2010 TASKS

MEDICAID

PROMOTING DISEASE PREVENTION AND WELLNESS

Not Started	In Progress	Completed	Implementation Date
☐	☐	☐	**January 1, 2011**

State Plan Option Promoting Health Homes for Enrollees with Chronic Conditions (continued)

- Directs the state to develop a mechanism to pay the health home for services rendered. The state plan amendment will include a plan for tracking avoidable hospital readmissions and plan for producing savings resulting from improved chronic care coordination and management.

Federal Match Payments

- Provides an **enhanced match of 90 percent** FMAP for two years for states that take up this option.
- In addition, small planning grants may be available to help states intending to take up this option. Regular FMAP rules would apply.

Effective Date

- **The state option would be available beginning on January 1, 2011**.

FY 2010 TASKS

MEDICAID

LONG-TERM CARE SERVICES AND SUPPORTS

Not Started	In Progress	Completed	Implementation Date	
☐	☐	☐	**FY 2010**	**Removal of Barriers to Providing Home and Community-Based Services (HCBS)** • Applies specific measures to remove barriers to providing HCBS. • These measures include: 1. state-level oversight and assessment of HCBS resources, 2. coordination of HCBS across all providers, and 3. procedures for patients to file complaints. • **Gives 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. • Permits states to extend full Medicaid benefits to individuals receiving HCBS under a state plan amendment. • Provides that states will not be required to comply with requirements for state wideness and will be able to phase-in services and eligibility as they become available, targeting the services to specific populations. • **Effective** on the first day of the first fiscal year quarter that begins after the date of enactment of this Act.
☐	☐	☐		**Aging and Disability Resource Centers** • Allocates $10 million each fiscal year, beginning in FY 2010 - FY 2014 to continue funding ADRCs.

FY 2010 TASKS

MEDICAID

LONG-TERM CARE SERVICES AND SUPPORTS

Not Started	In Progress	Completed	Implementation Date	
			FY 2010	**Budget Item**
				Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers
☐	☐	☐		• conduct screening and criminal history background checks;
☐	☐	☐		• monitor compliance by LTC facilities and providers;
☐	☐	☐		• provide for a provisional period of employment of a direct patient access employee, as specified;
☐	☐	☐		• provide procedures for an independent process by which a provisional employee or an employee may request an appeal, or dispute the accuracy of, the information obtained in a background check, as specified;
☐	☐	☐		• provide for the designation of a single State agency with specified responsibilities;
☐	☐	☐		• determine which individuals are direct patient access employees;
☐	☐	☐		• as appropriate, specify disqualifying offenses, including convictions for violent crimes; and
☐	☐	☐		• describe and test methods that reduce duplicative fingerprinting, as specified.
☐	☐	☐		• **Requires states to guarantee** (directly or through donations from public or private entities) a designated amount of nonfederal contributions to the program. **The federal government will provide a match equal to three times the amount a state guarantees.**
☐	☐	☐		• Federal funds will not exceed $3 million for newly participating states and $1.5 million for previously participating states.
☐	☐	☐		• Requires the Secretary of the Treasury to transfer to HHS an amount specified by the HHS Secretary as necessary (not to exceed $160 million) to carry out the nationwide program for FY 2010 - FY 2012. Amounts provided will remain available until expended.

FY 2010 TASKS

MEDICAID

PROGRAM INTEGRITY

Not Started	In Progress	Completed	Implementation Date	
				Requires States to implement fraud, waste, and abuse programs before January 1, 2011 as follows:
☐	☐	☐	**January 1, 2011**	**Sec. 10201 Waiver Transparency -** Applies to applications for or renewal of experimental projects, pilots or demonstration projects under Section 1115 of the Social Security Act.
☐	☐	☐		**Sec. 6401 Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP-** establishing procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP.
			January 1, 2011	**Sec. 6402 Enhanced Medicare and Medicaid program integrity provisions;**
☐	☐	☐		• **Overpayments -** Requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report was due, whichever is later
☐	☐	☐		• **National Provider Identifier -** Requires the Secretary to issue a regulation mandating that all Medicare, Medicaid, and CHIP providers include their NPI on enrollment applications.
☐	☐	☐		• **Medicaid Management Information System** - Authorizes the Secretary to withhold the Federal matching payment to States for medical assistance expenditures when the State does not report enrollee encounter data in a timely manner to the State's Medicaid Management Information System (MMIS).
☐	☐	☐	**January 1, 2011**	**Sec. 6411 Expansion of the Recovery Audit Contractor (RAC) program -** Requires States to establish contracts with one or more Recovery Audit Contractors (RACs). These state RAC contracts would be established to identify underpayments and overpayments and to recoup overpayments made for services provided under state Medicaid plans as well as state plan waivers.
☐	☐	☐	**January 1, 2011**	**Sec. 6501 Termination of provider participation under Medicaid if terminated under Medicare or other State plan -** Requires States to terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another state's Medicaid program.
☐	☐	☐	**January 1, 2011**	**Sec. 6502 Medicaid exclusion from participation relating to certain ownership, control, and management affiliations** Requires Medicaid agencies to exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that: (1) has failed to repay overpayments during the period as determined by the Secretary; (2) is suspended, excluded, or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.

FY 2010 TASKS

MEDICAID

PROGRAM INTEGRITY

Not Started	In Progress	Completed	Implementation Date	
				Requires States to implement fraud, waste, and abuse programs before January 1, 2011 as follows: (continued)
☐	☐	☐	**January 1, 2011**	**Sec. 6504 Requirement to report expanded set of data elements under MMIS to detect fraud -** Requires states and Medicaid managed care entities to submit data elements from MMIS as determined necessary by the Secretary for program integrity, program oversight, and administration.
☐	☐	☐	**January 1, 2011**	**Sec. 6505 Prohibition on payments to institutions or entities located outside of the United States -** Prohibits states from making any payments for items or services provided under a Medicaid state plan or waiver to any financial institution or entity located outside of the United States.
☐	☐	☐	**January 1, 2011**	**Sec. 6506 Overpayments -** Extends the period for states to repay overpayments to one year when a final determination of the amount of the overpayment has not been determined due to an ongoing judicial or administrative process. When overpayments due to fraud are pending, state repayments of the Federal portion would not be due until 30 days after the date of the final judgment.

FY 2010 TASKS

MEDICAID

PROGRAM INTEGRITY

Not Started	In Progress	Completed	Implementation Date	
☐	☐	☐	**October 1, 2010**	**Sec. 6507 Mandatory State use of National Correct Coding Initiative (NCCI) –** • Requires states to use the National Correct Coding Initiative (NCCI) in Medicaid. • Amends the Medicaid statute to require states to have an MMIS that, effective for claims filed on or after October 1, 2010, incorporates compatible elements of the NCCI (or any successor initiative) and other elements of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with specified requirements. • **Provides that not later than September 1, 2010**, the Secretary will be required to: 1. identify those methodologies of the NCCI (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under Medicaid; 2. identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under Medicaid with respect to items and services for which no national correct coding methodologies have been established under such Initiative with respect to Medicare; 3. notify states of the elements identified (and of any other national correct coding methodologies identified) and how states are to incorporate such elements (and methodologies) into claims filed under Medicaid; and **4.** submit a report to Congress that includes the notice to states and an analysis supporting the identification of the elements (or methodologies). **Rule for changes requiring State legislation** If the Secretary determines that state legislation is required in order for a Medicaid state plan to meet the additional requirements imposed by the provision, the state plan will not be regarded as failing to comply before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment. In the case of a state that has a 2-year legislative session, each year of the session would be considered a separate regular session of the state legislature.

FY 2010 TASKS

MEDICAID

PRESCRIPTION DRUG PROVISIONS

Not Started	In Progress	Completed	Implementation Date	
☐	☐	☐	**January 1, 2011**	**Medicaid Pharmacy Reimbursement (AMP Fix)** • Changes the Federal upper payment limit (FUL) to no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recent AMPs for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies. • **Effective** on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.
☐	☐	☐		**Sec. 2501-Increase Minimum Rebate Percentage for Single Source Drugs** • Increases the minimum manufacturer rebate for brand-name drugs purchased by state Medicaid programs from 15.1% of average manufacturer price to 23.1% of average manufacturer price **Increase Minimum Rebate Percentage for Clotting Factors and Drugs Approved by the FDA for Pediatric Use Only** • Increases the minimum manufacturer rebate for brand-name drugs purchased by state Medicaid programs from 15.1% of average manufacturer price to 17.1% of average manufacturer price **Limit on Total Rebate Liability** • Limits total rebate liability on an individual single source or innovator multiple source drug to 100 percent of AMP for that drug product. Other features of the drug rebate program, such as the Medicaid's best price provision, would remain unchanged.
☐	☐	☐		**Sec. 2501-Increase Minimum Rebate Percentage for Generic Drugs** • Increases the minimum manufacturer rebate for non innovator, multiple source drugs to 13% of average manufacturer price (AMP). • Requires the Comptroller General to review state laws that have a negative impact on generic drug utilization in federal programs due to restrictions such as but not limited to limits on pharmacists' ability substitute a generic drug or carve-outs of certain classes of drugs from generic substitution.

FY 2010 TASKS

MEDICAID

PRESCRIPTION DRUG PROVISIONS

Not Started	In Progress	Completed	Implementation Date	
☐	☐	☐		**Sec. 2501-Increase Minimum Rebate Percentage for Generic Drugs** (continued) **Limit on Total Rebate Liability** • Limits total rebate liability on an individual single source or innovator multiple source drug to 100 percent of AMP for that drug product. Other features of the drug rebate program, such as the Medicaid's best price provision, would remain unchanged.
☐	☐	☐		**Application of Rebates to New Formulations of Existing Drugs** For purposes of applying the additional rebate, the bill narrows the definition of a new formulation of a drug to a line extension (i.e., extended release formulations) of a single source or innovator multiple source drug that is an oral solid dosage form of the drug.
☐	☐	☐		**Sec. 2503 Medicaid Pharmacy Reimbursement (AMP Fix)** • Changes the Federal upper payment limit (FUL) to no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recent AMPs for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies. • Clarifies what transactions, discounts, and other price adjustments were included in the definition of AMP. • Clarifies that retail survey prices do not include mail order and long term care pharmacies. • Expands the disclosure requirement to include monthly weighted average AMPs and retail survey prices.

FY 2010 TASKS

MEDICAID

QUALITY INITIATIVES

Not Started	In Progress	Completed	Implementation Date	
☐	☐	☐		**Sec. 2701 Quality Measures for Maternity and Adult Health Services under Medicaid and CHIP** • Similar to the quality provisions enacted in CHIPRA, directs the HHS Secretary, in consultation with the states, to develop an initial set of health care quality measures specific to adults who are eligible for Medicaid. • Establishes the Medicaid Quality Measurement Program which will expand upon existing quality measures, identify gaps in current quality measurement, establish priorities for the development and advancement of quality measures and consult with relevant stakeholders. • Requires the Secretary, along with states, to regularly report to Congress the progress made in identifying quality measures and implementing them in each state's Medicaid program. • States would receive grant funding to support the development and reporting of quality measures.

FY 2010 TASKS				
MEDICARE				
Not Started	**In Progress**	**Completed**	**Implementation Date**	
☐	☐	☐	**FY 2010**	**Sec. 3106 Extension for Certain Payment Rules for Long-term Care Hospital Services (LTCHs) and of Moratorium on the Establishment of Certain Hospitals and Facilities** • Extends the moratorium on the application of payment policies for certain LTCHs which began in 2007. This moratorium will permit LTCH facilities to receive full payment for patients admitted to their facilities until December 29, 2012 that are over a threshold set by CMS.
☐	☐	☐	**January 1, 2011**	**Conform state standards of practice for physician assistants to include the following:** **Sec. 3108 Permitting Physician Assistants to Order Post-Hospital Extended Care Services** **On or after January 1, 2011**, physician assistance will be permitted to certify the need for post hospital extended care services for Medicare payment.
☐	☐	☐	**March 2010**	**The following provisions may impact the coverage provided to dual eligibles** **Sec. 3110 Part B Special Enrollment Period for Disabled TRICARE Beneficiaries** Creates a special twelve-month special enrollment period (SPE) for military retirees, their spouses (including widows/widowers) and dependent children, who are eligible for TRICARE and entitled to Medicare Part Abased on disability or ESRD, but who have been declined Part B. The twelve-month SPE would be available once in their lifetime and begin on the day after the last day of the initial enrollment period and may choose Part B coverage retroactively to the first month of the enrollment period. **Effective on enactment**.
☐	☐	☐	**March 2010**	**Sec. 3111 Payment for Bone Density** Medicare will pay for a bone density study (DXA) 70 percent of the 2006 reimbursement rates once every two years, or more frequently if the procedure is determined to be medically necessary during.
☐	☐	☐	**March 2010**	**Sec. 3114 Improved Access for Certified Nurse-Midwife Services** Amends the Social Security Act by adding that services provided on or after January 1, 2011, the fee schedule for certified nurse-midwife services would not be allowed to exceed 100 percent of the amount provided for the same service performed by a physician. This amount is an increase from the 80 percent previously covered.

FY 2010 TASKS				
MEDICARE				
Not Started	**In Progress**	**Completed**	**Implementation Date**	
☐	☐	☐	**FY 2010**	**New Medicare Category** **Sec. 10323 Medicare Coverage Pilot Program for Individuals Exposed to Environmental Health Hazards** • Adds to the existing list of **individuals eligible for coverage under Medicare** individuals exposed to environmental health hazards. • An individual with one or more specified lung diseases or type of cancer who lived for six months during a specified period prior to diagnosis in an area subject to a public health emergency declaration by the Environmental Protection Agency (EPA) as of June 17, 2009, would be deemed entitled to benefits under Part A and eligible to enroll in Part B. • Also authorizes the secretary to deem any other individual diagnosed with an illness caused by an environmental hazard to which an EPA emergency declaration has occurred to be held under the same criteria as eligible. • Defines an infected individual as follows: **1.** Being diagnosed with one or more of the following diagnosis: ▪ Asbestosis, pleural thickening, or pleural plaques, ▪ Mesothelioma, or malignancies of the lung, colon, rectum, larynx, stomach, esophagus, pharynx, or ovary, or as specified by the Secretary concerning a diagnosis caused by the exposure. 2. Has been present for an aggregate total of six months in the geographic area subject to an emergency declaration during a period not less than 10 years prior to the diagnosis, and prior to removal actions. 3. Has filed an application for benefits, and 4. Is determined to meet the criteria. • Grants authority for determinations of eligibility to the Commissioner of Social Security, in consultation with the Secretary of Health and Human Services.

FY 2010 TASKS				
MEDICARE				
Not Started	**In Progress**	**Completed**	**Implementation Date**	
☐	☐	☐	**FY 2010**	**Sec. 2009 Program for Early Detection of Certain Medical Conditions Related to Environmental Health Hazards** (*Grant Opportunity)* • Establishes a program of competitive **grants** for the purpose of screening at-risk individuals for environmental health conditions, and • Development and dissemination of public information concerning the availability of screening, treatment, and Medicare coverage under the program. **Eligible Entities** • Entities eligible to apply for this grant include: 1. A hospital or community health center, **2.** A federally qualified health center (FQHC), **3.** A facility of the Indian Health Service, **4.** A National Cancer Institute-designated cancer center, **5. An agency of any state or local government**, **6.** A nonprofit organization, and **7.** Any other entity the secretary determines appropriate. **Funding** • Appropriates $23 million for FY2010 through 2014, and • $20 million for each five fiscal year period thereafter.
☐	☐	☐		**Sec. 3139 Payment for Biosimilar Biological Products** • Permits a Part B biosimilar product approved by the Food and Drug Administration to be reimbursed at the average sales price (ASP) of the reference drug.

FY 2010 TASKS				
MEDICARE				
Not Started	**In Progress**	**Completed**	**Implementation Date**	
☐	☐	☐	**FY 2010**	**Sec. 3205 Extension for Specialized Medicare Advantage Plans for Special Needs Individuals** • Extends special needs plans (SNPs) authority created in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 through December 31, 2013. • Directs the secretary to establish a frailty payment adjustment, similar to PACE[1], for fully-integrated dual-eligible SNPs. • Authorizes the secretary to adjust payments to dual-eligible SNP when those plans had fully integrates Medicare and Medicaid benefits, including long-term care, and met other criteria. • Temporarily extends authority through the end of 2012 for SMPs that do not contract with state Medicaid programs to continue to operate, but not to expand their area of operation. • Provides for a transition process for SNP beneficiaries that do not qualify as special needs individuals, to fee-for-service Medicare and other Medicare Advantage plans. • Provides an exception process for beneficiaries who lose Medicaid coverage to reapply for benefits.
☐	☐	☐	**January 1, 2011**	**Sec. 3314 Including Costs Incurred By AIDS Drug Assistance Programs and Indian Health Service In Providing Prescription Drugs Toward The Annual Out of Pocket Threshold Under Part D** • Allows costs paid by the Indian Health Service or under an AIDS Drug Assistance Program to count toward the out-of-pocket threshold for costs incurred on or after January 1, 2011.
				Implications for Medicare Assistance Programs
☐	☐	☐	**FY 2010**	**Sec.3315 Immediate Reduction in Coverage Gap in 2010** • Increases the 2010 standard initial coverage limit from $2,830 to $3,330, decreasing the period of time a Part D beneficiary would need to be in the coverage gap.

[1] Program of All Inclusive Care for the Elderly (PACE) is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The program is modeled on the system of acute and long term care services developed by On Lok Senior Health Services in San Francisco, California. The model was tested through CMS (then HCFA) demonstration projects that began in the mid-1980s. The PACE model was developed to address the needs of long-term care clients, providers, and payers.

FY 2010 TASKS				
MEDICARE				
Not Started	**In Progress**	**Completed**	**Implementation Date**	
				Title IV—Prevention of Chronic Disease and Improving Public Health **Subtitle B-Increasing Access to Clinical Prevention Services** **Conform state Medicaid program payment policies to accommodate for benefit changes in the Medicare program for dual eligibles.**
☐	☐	☐	**January 1, 2011**	**Sec.4103 as modified by 10402(b). Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan** • Amends the Social Security Act to require that Medicare Part B cover, without costs sharing, personalized prevention plan services including a comprehensive health risk assessment beginning on January 1, 2011.

FY 2010 TASKS			
QUALITY, PREVENTION & WELLNESS			
NOT STARTED	**IN PROGRESS**	**COMPLETED**	**Implementation Date**
☐	☐	☐	

PREVENTIVE SERVICES

Conform state insurance laws to reflect the following;

Sec. 1001 Regarding Coverage of Preventive Services

- Requires the group and individual health market to cover the following preventive services without cost-sharing requirements:
    1. Items or services with a grade of A or B as recommended by the U.S. Preventive Services Task Force (UCPSTF),
    2. Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP),
    3. For infants, children and adolescents, preventive care and screenings provided for in comprehensive guidelines supported by HRSA,
    4. For women, such additional preventive care and screenings not described by the USPSTF as provided in comprehensive guidelines supported by HRSA.

FY 2010 TASKS				
QUALITY, PREVENTION & WELLNESS				
Not Started	**In Progress**	**Completed**	**Implementation Date**	
☐	☐	☐	**September 2010**	**Provide budget support sufficient to conduct the following required assessment:** **Sec. 2951 Maternal, Infant, and Early Childhood Home Visiting Programs** • Requires each state to conduct an assessment of needs within six months of enactment and separate from the needs assessment conducted as a condition for receipt of maternal child block grant funding that identifies: 1. Communities with a concentration of a. premature birth; b. low birth weight infants; c. at-risk for infant death due to neglect, or prenatal, maternal , newborn or child health; d. poverty; crime; domestic violence; e. high rates of high-school drop-outs; f. substance abuse; unemployment, or g. child maltreatment, 2. The quality and capacity of existing programs or initiatives for early childhood home visitation in the state including a. the number and types of individuals and family who receive services under the programs; b. the gaps in early childhood home visitation in the state, and c. the extent to which the initiatives are meeting the needs of eligible families in the state. 3. The state's capacity for providing substance abuse treatment and counseling services to individuals and families in need of treatment or services. • Directs each state to coordinate with other assessments including the assessment for the Maternal Child Block grant, the communitywide strategic planning and needs assessment for the Head Start Act, and inventory of current unmet needs. • Directs each state to submit with the assessment a description of how the state intends to address the needs identified, which may include an application for a grant to conduct an early childhood home visitation program.

FY 2010 TASKS				
QUALITY, PREVENTION & WELLNESS				
NOT STARTED	**IN PROGRESS**	**COMPLETED**	**Implementation Date**	
☐	☐	☐	**September 2010**	**Sec. 2951 (continued) Grants for Early Childhood Home Visitation Programs** (*Grant Opportunity)* ▪ Authorizes the secretary to award grants to states for the purpose of establishing an early childhood home visitation program to promote the following: 1. Improvements in maternal and prenatal health, 2. Infant health, 3. Child health and development, 4. Parenting related to child development outcomes, and 5. School readiness in child abuse, neglect and injuries ▪ Authorizes grant awardees to use funds in the initial six month period for the purpose of for planning and implementation activities to assist with the establishment of the program. ▪ Program requirements include: 1. Quantifiable, measurable improvements in benchmark areas for eligible families participating in the program in each of the following areas: ▪ Improved maternal newborn health, ▪ Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits, ▪ Improvement in school readiness and achievement, ▪ Reduction in crime or domestic violence, ▪ Improvements in the coordination and referral of community resources and supports. ▪ Awardees are expected to develop and implement a plan to improve outcomes in each of the areas listed. ▪ Directs states to file a report with the secretary information demonstrating improvements in at least four of these areas after the end of the first three year period. Failure to comply or demonstrate improvement will result in termination of the grant.

FY 2010 TASKS QUALITY, PREVENTION & WELLNESS				
Not Started	In Progress	Completed	Implementation Date	
☐	☐	☐	**September 2010**	**Sec. 2951 (continued) Grants for Early Childhood Home Visitation Programs** (*Grant Opportunity)* ▪ Requires submission of a final report to the secretary no later than December 31, 2015. ▪ Core Program Components 1. Service Delivery Model or Models ▪ Requires that the model conforms to a clear consistent home visitation model that has been in existence for at least three years and is researched-based, grounded in empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education with quality home visitation program standards, with demonstrated positive outcomes, or ▪ The model conforms to a promising and new approach to achieve the benchmark areas specified and the participant outcomes and has been developed or identified by a national organization or institute of higher education, and will be evaluated through a well-designed and rigorous process. 2. Majority of grant funding is used for evidence-based models. Prohibits the use of more than 25 percent of awarded funding to in a given fiscal year for operation of the service delivery model program. 3. Criteria for evidence of effectiveness of models. Directs the secretary to establish criteria for evidence of effectiveness of the service delivery models. ▪ Requires that the program employ well-trained staff such as nurses, social workers, educators, and child development specialists.

FY 2010 TASKS QUALITY, PREVENTION & WELLNESS				
Not Started	In Progress	Completed	Implementation Date	
☐	☐	☐	**September 2010**	**Sec. 2951 (continued) Grants for Early Childhood Home Visitation Programs** (*Grant Opportunity)* ▪ Service Priorities 1. Eligible families in the community in need of services as identified by the state needs assessment, 2. Low-income families, 3. Families including those, ▪ who are pregnant women under age 21, ▪ with a history of child abuse or neglect, ▪ with a history of substance abuse, ▪ who are users of tobacco products at home, ▪ have children with low student achievement, ▪ have children with developmental delays, and ▪ include individuals who are serving or have formerly served in the Armed Forces. ▪ **Maintenance of Effort Requirement**–Requires states to maintain funding for other sources for early childhood home visitation programs and initiatives. ▪ **Funding**–Appropriates $100 million for fiscal year (FY) 2010, $250 million for FY 2011, $350 million for FY 2012, $400 million for FY 2013, and $400 million for FY 2014. Reserves three percent of available funding for grants to Indian tribes. ▪ Eligible entities are defined as meaning a state, an Indian tribe, tribal organization, or urban Indian organization, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa

FY 2010 TASKS				
American Health Benefit Exchange				
Not Started	**In Progress**	**Completed**	**Implementation Date**	
☐	☐	☐	**March 2011**	**SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS** (*Grant Opportunity)* **State Planning Grants** ▪ Authorizes the Secretary of Health and Human Services to award grants to states to support planning efforts in the establishment of the American Health Benefit Exchange. ▪ Grants must be awarded within one year of enactment of the Affordable Care Act, March 2011. ▪ The amount of the grants to each state will be determined by the secretary. ▪ Planning grant recipients may renew the grant if the recipient— 1. is making progress toward establishing an Exchange; and implementing the insurance reforms that comply with the provisions within the health reform law; and 2. is meeting any benchmarks as established by the Secretary. ▪ **No grants may be awarded after January 1, 2015**.