IMPLEMENTING THE MEDICAID PROVISIONS OF THE AFFORDABLE CARE ACT IN MISSOURI: EARLY OBSERVATIONS, CHALLENGES AND OPPORTUNITIES

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The recently passed federal health care reform legislation, the Patient Protection and Affordable Care Act (hereinafter, the "Affordable Care Act" or "ACA"), makes sweeping changes to our nation's health care system that will have a profound impact on Missouri and its residents.[1] The Medicaid program is a critical component of the new law's expansion of health insurance coverage. Approximately 16 million people will be added to the program nationwide—roughly one-half of the 32 million uninsured who will be covered under the legislation.[2] The major coverage expansion provisions of the Act—both the Medicaid expansion and premium tax credits—do not go into effect until 2014. Nevertheless there are a wide range of issues to be addressed in the months and years ahead, well before those coverage provisions take effect.

This paper addresses some of the key issues for Missouri policymakers and advocates regarding implementation of the Medicaid provisions of the Affordable Care Act. An overarching theme is that there will be many issues to address in making the Medicaid provisions of ACA work effectively for low-income Missouri families. The State will need to carefully consider these issues and collaborate with the stakeholders affected by them. While state policymakers have significant expertise, they should nonetheless aggressively engage key stakeholders, including advocates for consumers and low-income individuals in particular. Moreover, given the great many issues to be addressed, it is not too early to begin work on the details of implementation, well in advance of 2014.

I. Medicaid Expansion, Maintenance of Effort and new Eligibility Rules

A. Significant Medicaid Expansion

The health reform legislation expands Medicaid eligibility to 133% of the poverty level for most low-income individuals under 65 who are not eligible for Medicare.[3] This means that Missouri's eligibility limits for low-income parents and caretakers will increase from about 19% of the federal poverty level (FPL) to 133% and that childless adults will receive Medicaid coverage for the first time in Missouri without regard to whether they have a disability.[4] The new law also *allows* states to enroll non-elderly adults with incomes *above* 133% of poverty in Medicaid through a Medicaid state plan amendment, although these individuals would also be eligible for the premium credits through the new health insurance exchanges established by the ACA.[5] The new law's enhanced federal Medicaid matching rates (discussed below) do not apply to individuals with incomes above 133% of the federal poverty level, so there is no enhanced financial incentive for states to voluntarily expand coverage to these individuals.

A recent Kaiser Commission report found that **Missouri's low-income uninsured (those with income less than 133% of the federal poverty level) will decrease by at least 208,000—or 46%—as a result of these Medicaid expansions alone**.[6] Beginning January 1, 2014, the State will receive an increased federal medical assistance percentage (FMAP) for these "newly eligible individuals."[7] While the federal government normally covers about 64% of Missouri's Medicaid costs, the new health reform law provides for

more substantial federal funding to cover the costs of the law's Medicaid expansion.[8] The FMAP structure for new eligibles through the ACA will be as follows:

- 100 percent in 2014-2016;
- 95 percent in 2017;
- 94 percent in 2018;
- 93 percent in 2019; and
- 90 percent in 2020 and each year thereafter.[9]

These FMAP increases will allow the State to cover significantly more people with a relatively low increase in spending. In fact, the ACA's **Medicaid expansion is expected to decrease Missouri's low-income uninsured by 46% while costing the state less than 2% more** than what it would spend in the absence of these changes.[10] The significant reduction in the number of uninsured at relatively low cost is a key benefit of the Medicaid reforms in the legislation.[11]

The "Welcome Mat" Effect: As more adults come forward to learn about new opportunities for coverage, many may find they are eligible for Medicaid under *current* program rules. The State will receive the regular FMAP for these individuals, who are new enrollees but not newly *eligible*. This phenomenon, sometimes referred to as the "welcome mat effect," may well result in an increase in the traditional Medicaid and CHIP populations as well as that of the new expansion group. This phenomenon occurred after implementation of CHIP in 1997 as families came forward to seek coverage for their children.[12] This effect is expected to be decidedly more pronounced under health reform due to the broader reach of the legislation and the individual mandate to purchase coverage.[13] The impact on parent coverage will likely be enhanced by a provision in the ACA requiring that **parents or caretakers of children under 19 cannot be enrolled in coverage unless the child is also enrolled in Medicaid or some other form of health coverage**.[14]

Early Implementation: While states must implement this expansion beginning January 1, 2014,[15] they can *elect* to provide coverage to this population earlier.[16] Such an early expansion would seem unlikely in Missouri (and most other states) in light of the state's current budget difficulties and the fact that the enhanced federal matching funds are not available until January 1, 2014.[17] For these reasons, the states implementing early expansions are most likely to be those with solely state-funded health coverage programs that can now be funded with federal Medicaid funds through early implementation of the expansion of coverage for childless adults.[18] Of course, a positive change in the economy and improvement in state budget revenues could change this scenario.

Yet even if states choose *not* to expand Medicaid any time soon, early implementation gives them the opportunity at least to *phase in* the Medicaid expansion before January 1, 2014, which will likely be a chaotic time for the State, with the implementation of the new exchanges and premium tax credits. The option to expand Medicaid early, even if only by a few months, could provide some administrative relief so that the Department of Social Services and other state agencies are less overwhelmed on January 1, 2014.

B. Limitations on the Medicaid Expansion

There are *some* limits to these eligibility expansions that are noteworthy for Missouri.

Seniors and People with Disabilities: The coverage expansion does not apply to "dual eligibles" (people eligible for both Medicare and Medicaid) which means that many seniors and individuals with disabilities will still be subject to the *traditional* income eligibility limits (85% of the federal poverty level in Missouri) and must rely on the "spenddown" program for Medicaid coverage. The failure to include dual eligibles in the new income category means that the impact of the 2005 Missouri Medicaid reductions—reducing the income eligibility standard from 100% to 85% of poverty and elimination of the MAWD program—will not be remedied entirely by the new health care law.[19] Thus, it will still be necessary for very low-income dual eligible individuals to "spend down" to the current income limit in order be eligible for coverage. The State, however, could still act to mitigate the burden of spenddown requirements for "dual eligibles." The ACA **does not *preclude* the State from expanding eligiblity for this group to 100% of poverty or greater,** or from broadening the scope of the current "Ticket to Work Health Assurance" program, but the new enhanced matching rates would not apply to such expansions.

Children's Coverage: Generally, the new law did not directly change children's Medicaid or CHIP coverage in a way that would affect Missouri, but the new health insurance exchanges and premium credits will have a significant impact on children and their families. Missouri's Medicaid and CHIP programs already cover children beyond the minimum requirements in the new health care law. For example, the new law increases minimum Medicaid income eligiblity for children ages six through 18 from 100 percent of the federal poverty level to 133% of the federal poverty level, but Missouri already uses CHIP funds to cover these children in its Medicaid program.[20] However, as noted above, the law's eligibility expansions for *parents* will likely create a "welcome mat" effect that improves children's participation.

The ACA requires states to **extend Medicaid coverage to children** who have "aged out" of the foster care system but are under the age of 26—another change that goes into effect in 2014. The Missouri legislature had previously authorized Medicaid coverage for children "aging out" of foster care up to the age of 21 years in 2007.[21] This coverage expansion in the federal health reform law thus furthers one of Missouri's own policy objectives while helping this group of very vulnerable children obtain health coverage as they transition to adulthood.

The new law also includes a provision enabling states to **enroll the *children of state employees* in CHIP** if certain conditions are met.[22] While CMS has yet to issue guidance on this new option, the State may want to consider exploring this approach in light of the substantial federal matching funds that come with CHIP coverage and the potential savings given the State's current fiscal environment. This option could also benefit some state employee families, for example, those paying more than five percent of their income

towards cost-sharing for state employee health insurance coverage who would pay less "out-of-pocket" if enrolled in CHIP.

Although the ACA did not expand CHIP *coverage*, the law will increase the states' FMAP for CHIP by 23 percentage points, up to a maximum of 100 percent in the years 2016-2019 (subject to CHIP being reauthorized).[23] In addition, the law provides an additional $40 million to states for outreach and enrollment grants as authorized by CHIPRA through 2015, and provides an opportunity for Missouri nonprofits to build on the State's existing grants for enrolling eligible uninsured children.[24]

The most important outreach and enrollment mechanisms for increasing children's health coverage continue to be those already available under the prior CHIPRA legislation.[25] **Missouri should take advantage of CHIPRA enrollment tools, which could still earn the state performance bonuses** from the federal government (for children enrolled through October 2013). Indeed, the State of Alabama earned more than $39 million in CHIPRA performance bonuses in 2009 by taking advantage of these new outreach and enrollment tools.[26]

With some minor modifications (i.e., adopting two additional CHIPRA options), Missouri could meet the requirements for earning the state performance bonuses while improving Missouri children's access to health care. The State should also reconsider its prior decision to hold off on implementing "Express Lane Eligibility," which authorizes states to enroll children in Medicaid or CHIP based on the eligibility findings of other public programs. The Missouri Department of Social Services had developed a plan to use "Express Lane Eligibility" to enroll children not already receiving Medicaid or CHIP who are already receiving food stamps or child care subsidies but it never implemented that plan.[27] In February 2010, the State of **Louisiana in fact implemented a nearly identical plan**, **enrolling 10,000 children** overnight based on eligibility findings of its SNAP (Food Stamp) program.[28] Surely, Missouri can do what Louisiana has done to improve coverage for its uninsured children who are *already* eligible for health coverage through Medicaid or CHIP. [29]

Five-Year Waiting Period for Legal Immigrants: The new health care reform law did not eliminate the five-year waiting period for lawfully residing immigrants to obtain coverage through Medicaid or CHIP. While CHIPRA gave states the option to waive this waiting period for children and pregnant women, Missouri has not yet done so.[30] Legal immigrants will eventually be able to obtain coverage through the health insurance exchanges and receive premium tax credits and cost-sharing protections based on income.[31] However, because that option does not go into effect until 2014, the State should exercise the option to provide Medicaid and CHIP without a five-year waiting period. Undocumented immigrants are *not* eligible for coverage through either Medicaid/CHIP or the exchange under the new health care reform law.[32]

C. Expansion of Presumptive Eligibility

For states like Missouri that already provide presumptive eligibility (PE) for pregnant women or children, the ACA allows them to extend PE to the new expansion and Section 1931 (family-based) Medicaid populations as well.[33] Missouri currently allows federally funded health clinics and hospitals to "presumptively" enroll children in Medicaid and CHIP pending the State's determination of their ongoing eligibility for these programs.

Additionally, the law allows Medicaid-participating hospitals to make PE determinations for all populations *regardless of whether the State Agency chooses to expand presumptive eligibility*.[34] This provision could potentially give many more low-income individuals access to Medicaid-covered services at the point of service—their local hospitals—many of which already have "outstationed" Family Support Division caseworkers to assist with the Medicaid/CHIP application process.[35] Missouri already allows hospitals to determine presumptive eligibility for children, but this option would allow them to make PE determinations for parents and childless adults as well. While the ACA allows hospitals to proceed without state approval, the success of this new option would still seem to depend on the State's involvement and cooperation in assisting hospitals with implementation. Nevertheless, these provisions provide an excellent opportunity for Missouri to improve outreach and enrollment well beyond its current presumptive eligibility program for children.

D. Maintenance of Effort and Protecting Services

In order to prevent states from reducing Medicaid eligibility levels until January 14, 2014 (the effective date of expansion), the ACA includes a "maintenance of effort" (MOE) provision. Specifically, the State cannot implement "eligibility standards, methodologies, or procedures" under the state plan that are more restrictive than those in place on March 23, 2010.[36] Effectively this means that Missouri cannot apply more restrictive rules than those employed in its *current* Medicaid and CHIP programs. Protections for children's coverage apply until October 1, 2019 while Medicaid coverage for adults is protected until January 1, 2014, or whenever the Secretary determines that the State's exchange is fully operational, if not by January 1, 2014.[37]

While this "maintenance of effort" protects Medicaid *eligibility*, it does *not* prevent the State from decreasing services or reducing provider reimbursement rates, which could still be the focus of Missouri's efforts to balance the budget as they have been in recent years. Advocates will also need to watch out for additional state efforts to reduce access to home and community based services (e.g., through caps on services or more restrictive assessments) which may well run afoul of the Americans with Disabilities Act and *Olmstead* requirements *even if* they do not violate the MOE requirements of the Affordable Care Act.[38] As discussed below in Section V, there will be new opportunities under the ACA to *expand* access to home and community based services for people with disabilities to which disability advocates and policymakers should pay close attention.[39] Disability advocates will also need to pay attention to further efforts to place people with disabilities in mandatory Medicaid managed care which is clearly not prohibited by the MOE provisions of the health reform law.[40]

E. Income Eligibility under the Affordable Care Act

Modified Adjusted Gross Income Test: The ACA changes the way eligibility for Medicaid will be determined by establishing a new income test. Beginning January 1, 2014, Medicaid eligibility will be determined by using "modified adjusted gross income" (MAGI) for individuals and "household income" for families.[41] Eligibility determinations for premium tax credits and cost-sharing through the new *health insurance exchanges* will also use MAGI[42] based on income information from the *previous* taxable year.[43] In contrast, income eligibility for the Medicaid expansion population will be based on an individual's income and resources at the "point in time" at which an application is filed or redetermined (as it is in the current Medicaid program).[44] The new law prohibits the use of an asset test for the new expansion group as well as children and family coverage under current eligibility categories.[45]

This new income test simplifies the eligibility determination process[46] but raises the potential that some individuals eligible under the current system will not qualify under MAGI. For instance, MAGI will not include disregards currently allowed in Missouri such as the earned income disregard and disregards for child care that help low-income working families obtain much needed access to health care through Medicaid.[47] While the ACA replaces these disregards with a 5% income disregard of all income, this amount may not fully offset the loss of the current disregards, particularly the disregard for child care expenses.[48] In Missouri, the higher income limit (133% of poverty) should make up for the loss of income disregards for most families, but individuals eligible under this new standard could potentially have a lesser benefits package than what they have now, depending on how Missouri defines "benchmark" benefits, discussed below. Individuals in the new income eligibility group are not automatically entitled to the traditional benefits package that is currently required for low-income parents and caretakers, and which will continue to be required for individuals with incomes under Missouri's TANF income eligibility limit (currently 19% of the federal poverty level).

Tax Rules Apply: Another concern with MAGI is that it defines family size as "equal to the *number of individuals for whom the taxpayer is allowed a tax deduction*."[49] Thus, a step-parent or grandparent will be included in the family and their income counted if they are claiming the child as a dependent, whereas, under current Medicaid rules these individuals and their income can be excluded from the family unit. The new rules also would suggest that *non-custodial* parents who list children as dependents on their tax forms will have their income counted in determining Medicaid eligibility of the child even though their income would be excluded under current law. This change would thus have far-reaching implications for decisions that low-income families make regarding their tax filing units and would require proper outreach to ensure that families are aware of the health consequences of the decisions they make regarding their taxes.

On the other hand, MAGI *changes what constitutes countable gross income* by excluding SSI and Social Security Survivors benefits in certain circumstances and child support.[50] Finally, because the new law will apply tax rules for defining income rather than the traditional Medicaid income methodologies, it will become more advantageous for low-

income workers to participate in "pre-tax" programs for child care, transportation or other such plans in order to lower their "net income" for determination of eligibility under MAGI.

While many of these issues will require CMS guidance before Missouri can address them, they illustrate the challenges the State is likely to face in reconciling the new rules with traditional Medicaid eligiblity requirements.

It is important to note that **the new income rules (and the elimination of the asset test) do not apply to certain populations such as elderly, blind and disabled individuals,** individuals in nursing homes and individuals for whom Medicaid is paying Medicare cost-sharing (including Qualified Medicare Beneficiaries). Eligibility for these groups will still be determined under traditional Medicaid financial eligibility requirements.[51] Thus, the State computer systems may need to have the capability of determining eligibility using both the new and old income eligibility rules and State eligiblity workers will likely have to be trained on both sets of rules.

F. "Basic Health Program" Alternative

In addition to giving states the option to expand Medicaid above 133% of poverty, the ACA gives the states the option of establishing a "Basic Health Program" for low-income individuals not eligible for Medicaid as long as their household incomes are under 200% of the federal poverty level—a provision modeled after a public health insurance program in the State of Washington.[52] Under this approach, the State would contract *directly* with private plans to provide coverage much as the State does in its current Medicaid managed care program, even though this is not a *Medicaid* expansion per se. The State would receive 95% of the federal subsidies that would have been paid to individuals who receive premium credits for coverage in the new exchanges. Basic Health Plans must include at least the "essential health benefits" available through the exchanges (discussed in the next section).[53] Such a program could resemble some of the recent Missouri initiatives such as Governor Blunt's *Insure Missouri* proposal or the "Show-Me Health Initiative" (proposed in the Missouri Senate in 2009) or even the Commonwealth Health Insurance Program in Massachusetts, although the plan would not be funded by Medicaid dollars.

The State may want to explore this approach for low-income people under 200% of poverty level if it is determined to be more efficient and cost-effective than having these individuals purchase coverage through the new health insurance exchanges. This approach might ensure more seamless coverage for families that experience an increase in income that makes them ineligible for Medicaid while allowing them to remain enrolled in a similar form of publicly subsidized coverage with a similar benefits package (depending on how the State designed the program).[54]

Missouri could also set up its "Basic Health program" so as to allow parents and children to be covered under the *same health plans*. Missouri could use the same plans in both its Medicaid/CHIP program and its "Basic Health program" so that a family could

potentially enroll in "family coverage," or at least have coverage that includes the same provider network and/or cost sharing system for children (who are on Medicaid/CHIP) and their parents (who are ineligible for Medicaid but meet the eligibility requirements for "Basic Health"). Such plans might well be easier for families to understand and use, which would thereby improve their access to health care.

II. Medicaid Benefits Package and People with Disabilities

A. Benchmark Coverage

Medicaid coverage for the newly eligible will be "benchmark" or "benchmark equivalent" coverage.[55] Benchmark coverage is a concept that was created by the Deficient Reduction Act of 2005 and applied by a limited number of states but which becomes far more significant under the Affordable Care Act. Benchmark coverage is equivalent to one of the following:

- The standard Blue Cross/Blue Shield preferred provider option for federal employees in the state;
- A health plan that is offered and generally available to state employees in the state;
- Coverage offered by the largest commercial, non-Medicaid HMO in the state; or
- Secretary-approved coverage.[56]

Upon enactment, the new law also expanded the required services included under benchmark coverage to include prescription drugs and mental health benefits.[57] Furthermore, the ACA requires that benchmark coverage offered by a provider that is not a Medicaid managed care organization must comply with the "mental health parity" requirements of section 2705(a) of the Public Health Service Act.[58] This means that entities providing both medical and surgical benefits and mental health or substance use disorder benefits must ensure that the mental health/substance use disorder benefits are subject to the same requirements and limitations as the medical/surgical benefits.

Beginning January 14, 2014, benchmark coverage **must include at least the "essential health benefits" available through the exchanges**.[59] According to Section 1302 of the ACA, essential health benefits must include at least the following:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;

- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Depending on further guidance from CMS, **these benefits could potentially leave out important services for people with disabilities** such as durable medical equipment, home health and personal care services. Moreover, while the statute ensures that these broad categories are covered, it is impossible to tell how substantial this package will actually be without further regulations or guidance from CMS. Without knowing the "amount, duration and scope" of these benefits, one cannot assess whether the benchmark benefits would meet the full range of services that people with disabilities require. For example, if HHS were to authorize significant restrictions on hospital visits or prescription drugs in defining essential health benefits, then the benchmark benefits package could be much more restrictive than traditional Medicaid and far too narrow for people with disabilities or other chronic health conditions.

Because the law merely sets a *floor* for benchmark benefits, Missouri can strengthen the program by **providing the expansion population with coverage equal to or better than full Medicaid benefits**. According to the definition of "Secretary-approved coverage" in the recently promulgated regulations governing benchmark benefits, the State can provide the "standard full Medicaid coverage package" through its benchmark benefit plan.[60] Additionally, the regulations require that *even if* the State adopts a "benchmark package," it must still assure access to emergency and non-emergency transportation, as well as access to rural health clinic services and FQHC services to individuals that receive benchmark coverage.[61] Moreover, the benchmark package must include "family planning" services regardless of other limitations the State seeks to impose.[62]

One reason to provide at least the traditional Medicaid benefits package to individuals in the new eligibility group is that the low-income childless adults covered in the new 133% group are generally in poorer health than their counterparts with children.[63] The Center on Budget and Policy Priorities notes that "many of these individuals may suffer from such undiagnosed or untreated conditions as clinical depression or anxiety disorder," thereby increasing their need for access to a broad range of services not typically covered by private insurance.[64]

Because of the significant health care needs of this population, **the State should implement a benefit package for this population that is at least as broad as the regular Medicaid package**. Given the extremely generous federal support for this group (including 100% federal match in the first three years), the State has a significant financial incentive to provide this broad coverage to the new eligibility group. This incentive could help reduce the State's interest in providing a benefits package that is below what is needed by this new group of Medicaid beneficiaries. Moreover, because the State must still ensure access to several traditional Medicaid services for the benchmark group (transportation, FQHC coverage, etc.), the savings from applying more limited benchmark packages may be much lower than perhaps is anticipated. And because the State will continue to be required to provide the full benefits package for

many of the traditional Medicaid groups (people with disabilities, the lowest-income parents, etc.), it would be far less burdensome, less complicated, and administratively more convenient to provide the full Medicaid package to the new 133% group as well.

If the State does *not* choose the administratively simpler approach of providing full Medicaid benefits to the new eligiblity group, then it will need to ensure that all "essential health benefits" are provided, that mental health parity and other requirements (e.g., family planning, transportation, FQHC coverage) are all met, and that the package meets the needs of the newly covered population, including persons with mental illness and/or substance abuse disorders, and persons with chronic health conditions for whom typical private health insurance coverage may not be sufficient. Also, as discussed further below, applying different benefits packages to different groups will require the State to screen people to make sure they do not qualify under a category for which it cannot require enrollment in benchmark coverage.[65]

It should be noted here that Missouri's *current* Medicaid benefits package still lacks important services such as medically necessary therapies and dental care. There is nothing about the Affordable Care Act that would prevent Missouri from adding these or other services to the current package and applying them to the new expansion group as well. Regardless of the State's ultimate decisions regarding the benefits package, these decisions should be made very carefully with input from all relevant stakeholders, including advocates for Medicaid beneficiaries.

B. Exemption for Individuals who are "Medically Frail"

The ACA provides an exemption from benchmark coverage for individuals who are "medically frail."[66] CMS has subsequently confirmed in regulations implementing the Deficit Reduction Act of 2005 that these exempted individuals "must receive medical assistance under the State's currently approved plan" (meaning they must receive the regular Medicaid benefits package).[67] The regulations implementing the Benchmark Benefits provisions define "medically frail" to include:

- Those individuals described in section 438.50 of this chapter;[68]
- Children with serious emotional disturbances;
- Individuals with disabling mental disorders;
- Individuals with serious and complex medical conditions; and
- Individuals with physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living.[69]

Thus, individuals who have *some* level of disability *but are not eligible for Medicaid on the basis of their disability* will still have access to full benefits if they meet the "medically frail" exemption. It will be critical for Missouri to establish a streamlined and administratively convenient process for establishing eligibility for this exemption for individuals with disabilities and/or chronic conditions who are approved under the new 133% income category, rather than the traditional aged, blind and disabled category. For example, a letter from a physician attesting to Medicaid recipient's condition ought to be

enough to exempt that person from "benchmark benefits" without having to go through the same disability determination process used to *establish eligibility* on the basis of disability since such individuals are already eligible for Medicaid under the new income eligibility group. A more streamlined process for the purpose of applying the "medically frail" exemption could be beneficial to the State and Medicaid beneficiaries by reducing administrative burdens and costs as well as unnecessary paperwork. Of course, this issue could be averted if the State chooses to provide at least the regular Medicaid benefits package for the new expansion population under the Affordable Care Act.

C. Implications of the Medicaid Eligibility Rules and Benefits Package for People with Disabilities

As noted earlier, the ACA eliminates the "asset test" for determining eligibility for children and families and individuals eligible under the new "133%" category, but does not do so for aged, blind and disabled individuals.[70] While Missouri already does not apply an asset test in determining eligibility for children and families, the State uses a restrictive asset test of $1,000 (and $2,000 for a married couple) for the aged, blind and disabled population.[71] **The absence of an asset test for the expansion group would allow people with disabilities who do not qualify for the Medicaid program now because of their assets to receive coverage** in this new eligibility category.

In addition, many individuals who do not qualify for Medicaid now (except on a spenddown basis) because Social Security Disability Benefits take them over the income limit for people with disabilities (85% of the federal poverty level in Missouri) will qualify for the new income eligibility group because Social Security Disability benefits will generally be disregarded from the income determination for this new category.[72] This also means that disabled individuals receiving Social Security Disability Benefits will receive health care coverage during the 24 month waiting period before which they can receive federal *Medicare* coverage. This ability to receive health coverage through Medicaid during the early years of a disability is a major benefit of health reform for people with disabilities.

The new income eligibility category will also be beneficial for people with chronic conditions whose disabilities are not yet severe enough to meet the SSI or Social Security disability standards that apply to Missouri's Medicaid program.

The expansion for childless adults will benefit Missourians with disabilities, particularly those **non-duals** who are only eligible now on a spenddown basis. Under the current system, individuals must go through a "medical review team" evaluation process which is supposed to apply Social Security/SSI standards often making the disability determination process long and complicated. This evaluation process also sometimes requires a referral to an in-person medical evaluation to determine the applicant's disability.

Ideally, the State would be able to enroll childless adults into the "133%" eligibility group without having to run them through this burdensome process and earn the State the

much more favorable federal match available for the new eligibility group. The State will obviously have the financial incentive to enroll people in the new eligibility category. However, because the law only requires a "benchmark benefit package" for this group, benefits could be less than the full Medicaid package that a disabled individual would receive if enrolled in the "aged, blind, and disabled" category of assistance. Thus, **the State will *still* need to ensure that individuals are properly evaluated for coverage based on disability so as to make sure they receive the proper benefits package**. This determination may also be important to ensure that people with disabilities receive services from the appropriate health care *delivery system*. For example, if the State continues to provide care for people with disabilities on a fee-for-service basis but provides HMO coverage for people in the new 133% eligibility group, it will be important to ensure that people with disabilities can receive coverage in the traditional disability-based category of coverage.

CMS will surely have something to say about states' ability to move individuals into the different categories of coverage and will likely expect states to ensure individuals eligible under current law receive coverage under the proper category rather than automatically being included in the new 133% eligibility group with a much higher federal match.

Moreover, when evaluating applicants for Medicaid, the State should ensure that individuals are properly placed in the **most favorable eligibility category for their** needs. Some of these issues can be simplified depending on how the State implements the "benchmark benefits" provision and the "Medically Frail" exemption to benchmark coverage, but the State must implement a system that ensures that these provisions are implemented in the "best interests" of Missouri Medicaid recipients.[73]

Another consideration is whether the State will be able to enroll people with disabilities in the new eligibility category immediately when they clearly meet the income guidelines for such coverage while they are awaiting the outcome of the State's determination as to disability. The State should develop the capability to enroll people in such coverage immediately using the simplified eligibility rules even if it is ultimately determined that the individual should be served under the traditional "aged, blind, and disabled" category of coverage.

III. Cost-Sharing

The Affordable Care Act does *not* include new rules for Medicaid cost-sharing but the existing Medicaid rules for cost-sharing will come into play with regard to the new expansion group. For the lowest-income adults, only "nominal" cost-sharing is allowed and there are exemptions from cost-sharing for specific population groups and services.[74]

While "nominal" cost-sharing requirements apply to individuals with incomes at or below 100% of the federal poverty level, states have some additional flexibility to impose greater cost sharing for individuals with incomes *above* 100% of the federal poverty level, especially for individuals with incomes above 150% of poverty. For example, for individuals with incomes above 100% but at or below 150% of the federal poverty level,

the State has the ability charge up to 10% of the cost of a service and may charge up to twice the "nominal" amount for non-emergency use of emergency departments.[75] Thus, the State will have to decide what level of cost-sharing it will apply for individuals in the new ACA eligibility group (i.e., individuals with incomes up to 133% of the poverty level) who are above 100% of poverty.[76]

The ACA will not change cost-sharing rules for Missouri children. The Department of Social Services applies cost-sharing requirements based on family income levels for children enrolled in CHIP in accordance with federal and state law. While the State could choose to implement changes in cost-sharing requirements for children, such changes would not be based upon new requirements in the health care law. For example, the State legislature did not implement Governor Nixon's plan to streamline CHIP premium requirements in 2009. The State may well want to re-examine its premium requirements in light of the law's emphasis on expanding coverage and increasing enrollment. The extension of premiums to lower income CHIP children in 2005 previously led to deep reductions in Missouri's CHIP population and still presents a barrier to coverage for many families.[77]

IV. Enrollment, Coordination, Infrastructure

The new law includes a number of provisions intended to streamline the application process for "applicable state health subsidy programs," including Medicaid, CHIP and the new tax credits to pay premiums for "exchange" plans. A theme of these enrollment provisions is that there will be "no wrong door" for entry into the appropriate health insurance program. As discussed below, individuals seeking coverage through Medicaid, CHIP or the exchange "will be screened for eligibility for all programs and referred to the appropriate program for enrollment."[78] Individuals should "not have to submit duplicative materials or undergo multiple enrollment procedures."[79]

Streamlining Procedures Across Programs: The law provides that applicants will only have to use **one form**, developed by the Secretary of HHS, to apply for Medicaid, CHIP, state programs, or exchange health plans.[80] Applicants will be able to submit the form online, in person, by mail and by telephone to an exchange or with state officials operating another state subsidy program.[81] Applicants must then receive a notice of eligibility for various programs without providing additional documentation unless required by law.[82] This section also **mandates that individuals applying through an exchange be screened for Medicaid and CHIP and enrolled** if they qualify.[83] The single form must be developed with the needs of low-income individuals in mind to ensure their effective navigation of the application and enrollment process.[84]

The law also requires states to **develop a secure electronic interface for the exchange of data** to determine eligibility for all state health programs with this single form process.[85] Each individual program must, using data matching standards to be promulgated by the Secretary, establish, verify, and update eligibility for the program.[86] This section of the law allows contractual arrangements, under which **State Medicaid Agencies can determine eligibility for all health subsidy programs** (including

premium tax credits for the exchanges).[87] However, states must still abide by the Title XIX requirement that Medicaid eligibility be determined by a public agency.[88] The law also requires that the exchange, CHIP and Medicaid participate in data matching and whenever possible, using data available through existing federal data bases to establish, verify and update eligibility.[89]

Medicaid/CHIP Requirements: The ACA includes additional requirements as *conditions for receipt of federal financial assistance* for Medicaid, some of which overlap with the abovementioned provisions. States must:

- Enable individuals to apply for, enroll in, renew enrollment in or electronically consent to coverage through Medicaid using a website that is linked to the exchange website;
- Enroll those identified as eligible for Medicaid/CHIP through the state exchange without further determination;
- Ensure that children ineligible for Medicaid/CHIP be screened for eligibility in an exchange health plan, enrolled and given cost-sharing information;
- Ensure that Medicaid/CHIP agencies and exchanges use a secure system for data exchange;
- Coordinate services for individuals enrolled in Medicaid/CHIP and an exchange plan; and
- Conduct outreach to vulnerable and underserved populations.[90]

Discussion: Medicaid implementation decisions are very much related to state decisions regarding the new exchanges and premium tax credits. These provisions raise a host of questions regarding the implementation of the Medicaid expansion and the health insurance exchange in Missouri. One such question is **which agency will determine eligibility for the new premium tax credits** for purchasing coverage in the exchange? Given the Department of Social Services' existing infrastructure and experience in determining eligibility for public programs, it may be in a better position than other agencies to make these determinations. However, the agency must be sufficiently staffed in order for it to effectively evaluate eligibility for so many programs, and budget cuts have greatly reduced the staffing available to make additional eligibility determinations. Missouri's significant reductions in state employees and the possibility of closing county Family Support Division offices are not consistent with the Department of Social Services taking over eligibility for an entirely new population with new eligibility rules. Of course, it will be critical for Missouri to apply for all available "planning and establishment" grants for the new health insurance exchanges.[91] These grants, along with fees from enrollment premiums collected by the exchange, could help support the *exchange's* eligibility and enrollment responsibilities and thus could potentially help with the cost of contracting with the State Medicaid agency to perform these same functions.[92] The State also should apply for any available grants for "appropriate enrollment" technology, which could perhaps be used to update or replace current computer systems used for determining eligiblity.[93]

In addition, **current systems must be upgraded to meet the data matching requirements** which will likely require additional funding. Furthermore, the new eligibility rules and the interactions between Medicaid/CHIP and the exchange will require significant training and education of State agency staff as well as community organizations that interact with low- and moderate-income individuals.

It is possible the State will choose to contract with private companies to implement new technology and delivery systems. The MO HealthNet Division already "relies heavily on various contractors" for services from IT and call-center operations to program evaluation and service delivery.[94] However, the State's own consultants—the Lewin Group—found that "MO HealthNet's reliance on contractors necessitates stronger coordination and oversight than is currently provided."[95] Thus, to implement the above-cited provisions of ACA, the State must address its inadequate staffing and improve its ability to oversee any private contractors that are employed to implement these important functions.

Another question is the extent of the states' new obligation (mentioned above) to **conduct outreach to vulnerable and underserved populations** under the Affordable Care Act, which will likely require additional guidance from CMS. The legislation specifically requires outreach to children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.[96] The inclusion of this requirement certainly suggests a legal obligation beyond what the State is *already* doing (and what private agencies are doing) to enroll eligible individuals. Missouri needs to effectively implement this requirement to maximize the benefit of the new coverage expansions.[97]

As noted above, the law requires that the exchange, CHIP and Medicaid participate in "data matching," in which preexisting federal data is used to establish, verify and update eligibility.[98] These new requirements will be extremely important in Missouri—a state which still requires more verification than is needed under current federal law for continuing eligibility for Medicaid and CHIP.[99] In light of the new law's emphasis on more cost-effective eligibility determinations that place greater reliance on electronically available data, Missouri should take a closer look at the "administrative/ex parte renewal" options under CHIPRA (which enable the State to determine ongoing eligibility with minimal or no contact with the Medicaid beneficiary) and **de-emphasize or eliminate current state practices that rely on paper-based communications with beneficiaries and unnecessary forms and paperwork.**[100]

One such area is "citizenship documentation," where the State can take advantage of the new option under the Children's Health Insurance Program Reauthorization Act (CHIPRA) to obtain proof of citizenship through a data match with the Social Security Administration—an option that many states have found to be extremely cost-effective and which has reduced burdens for both states and families.[101] The ACA will *require* states to use similar data matching techniques to establish citizenship for the new exchanges.[102] Thus, Missouri should implement this option for Medicaid and CHIP so it

can better coordinate eligibility determinations and enrollment for these programs with the new health insurance exchanges established by the ACA.

It should be noted that a number of other provisions in the Affordable Care Act *not specific to Medicaid* also seek to move states in the direction of paperless verification and electronic enrollment. For example, eligibility for participation in the new exchanges, cost-sharing reductions, premium tax credits, and exemptions from the individual mandate generally must be done electronically or by checking information against federal records.[103] In addition, health information technology provisions of the Act authorize the Secretary of HHS to establish standards and protocols to facilitate electronic enrollment, and states' receipt of federal funds for health information technology investments may be made *contingent* on compliance with these requirements.[104] In light of these and other provisions of the Act, Missouri's Medicaid program would be "out of step" if it continues to rely on paper verification for enrollment and annual renewals.

Coordinating coverage between the exchange and public programs and ensuring proper transitions between the two systems will be challenging to say the least, and will create a need for advocacy to ensure that individuals are served in the proper categories. Having a single state agency addressing all of the eligibility issues (for both Medicaid and the premium credits) could help to ensure that such coordination occurs.

At least the following questions will need to be addressed with regard to transitions between Medicaid/CHIP and the exchange:

- How will the State address the different income eligibility methodologies employed by Medicaid and CHIP ("point in time" determinations) and the exchange (using the previous year's tax information)?
- Will there be health plans that participate in *both* Medicaid/CHIP and the exchange (and/or "Basic Health" if the state chooses that option)?
- Will individuals transferring from Medicaid to the exchange automatically be assigned to the same managed care plans if their Medicaid plan is also in the exchange?
- Will individuals terminated from Medicaid or CHIP be notified of their eligibility for tax credits/the exchange, and by what process will they be referred to the exchange?
- Will there be mechanisms for keeping families together in the *same plan* if the parent moves to the exchange but the child remains eligible for CHIP or Medicaid?
- How will CMS and the State ensure "interoperability" between State agencies and exchange?
- What rights will individuals transferred from Medicaid or CHIP to the exchanges have to change plans if they are automatically assigned to a plan?
- What kinds of procedures will the State adopt for families to report changes of circumstances at the time of enrollment, renewal and during the coverage year, and how difficult will it be for families to transfer coverage (among the different programs) when their eligiblity changes?[105]

There may well be lessons to be learned from states that, unlike Missouri, have separate CHIP and Medicaid programs administered by separate agencies, in terms of how best to ensure smooth transitions as individuals move back and forth between the exchanges and Medicaid/CHIP.[106]

The ACA also provides funding for new **health care "Navigators"** that could help to maximize the number of newly eligible individuals and families that ultimately enroll. Under this provision, community organizations, designated as navigators, can ensure vulnerable and underserved populations are educated about the wide array of options that will be available.[107] The exchanges will award such grants to organizations likely to have or be able to establish "relationships with employers, employees, consumers…or self-employed individuals likely to be qualified to enroll in a qualified health plan."[108] Once chosen, Navigators are to engage in public education activities, including outreach and information distribution, which are fair and impartial.[109] While further requirements are to be established by the Secretary, the new law prohibits navigators from being health insurers or receiving "consideration" from health insurers. Effective implementation of this provision could be instrumental to successful implementation of the coverage expansions of the health reform law. [110]

People with Disabilities: The increased emphasis on electronic enrollment and verification will create additional concerns for people with disabilities. The Americans with Disabilities Act and Section 504 of the Rehabilitation Act require state agencies to provide equal access to their programs for people with disabilities.[111] The Department of Justice has instructed States to ensure that state and local government agency websites are accessible to people with disabilities.[112] The State must address this issue as it designs new enrollment mechanisms to implement the ACA. In addition, the Department of Social Services must ensure that on-line applications are designed and tested to be accessible to people with disabilities.[113] While a full discussion of the issues involved in making newly modernized enrollment and eligibility systems accessible is beyond the scope of this paper, a recent publication from the Center on Law and Economic Justice and Maximus identifies many of the issues that state agencies must address to ensure that their modernization efforts are implemented in a may that complies with the ADA and Section 504.[114] Missouri should work with disability advocates to ensure that new application and enrollment systems for health reform comport with these anti-discrimination laws and meet the needs of persons with disabilities.[115]

Individuals with Limited English Proficiency: Similarly, the State must ensure that services are provided to meet the needs of individuals with limited English proficiency (LEP). The State should ensure that its computer systems for Medicaid, CHIP and the exchange generate notices and other vital documents to LEP individuals in their native languages. CHIPRA already increased the federal administrative matching rate for translation and interpretation services to children to 75% for Medicaid and about 80% for CHIP (the State's regular CHIP match rate plus 5%).[116] The State should take advantage of this additional federal financial assistance to provide meaningful access to LEP

individuals as part of its efforts to implement the Medicaid provisions of health care reform.

V. Improving Access to Services

A. Improving Access to Primary Care

The legislation includes a vitally important change with regard to primary care reimbursement. From 2013 to 2014, **payments to primary care physicians must not be less than 100 percent of Medicare reimbursement rates** for those years.[117] Additionally, the law provides for an increased federal medical assistance percentage (FMAP) of 100 percent for states to cover the incremental costs of meeting this requirement.[118] The legislation does not indicate what will happen beyond 2014 but this provision should be extended to ensure that states continue to pay sufficient reimbursement for primary care. Like many other states, Missouri has had difficulty attracting sufficient numbers of providers to participate in Medicaid, and the Missouri General Assembly has previously sought to improve provider reimbursement rates to enhance access. For example, in 2007, the Missouri General Assembly enacted legislation requiring the MO HealthNet Division to develop a "*four-year plan to achieve parity with Medicare reimbursement rates*."[119] But in an era of tight budgets, the State has not come close to achieving such parity. The ACA's increases in rates for primary care are an important step in improving access to health care for Missourians, thereby helping the State implement a longstanding health policy objective.

Along these same lines, the ACA **improves access to preventive health services** for eligible adults in Medicaid by expanding the current Medicaid *state option* to provide "other diagnostic, screening, preventive and rehabilitation services" to include grade A or B preventive services (defined by the U.S. Preventive Services Task Force) and vaccines recommended by the Advisory Committee on Immunization Practices (ACIP).[120] Beginning January 1, 2013, states will receive a one percentage point increase in their FMAP payments for covering these services and vaccines provided they prohibit cost sharing for them.[121]

B. State Plan Option for Family Planning Services

Under current federal Medicaid law, states are required to cover family planning services to individuals who are eligible under the state Medicaid plan and are of childbearing age.[122] Missouri is one of 27 states that has also extended these services through a waiver to individuals *not* otherwise eligible for Medicaid.[123] Pursuant to state legislation enacted in 2007, uninsured Missouri women 18 to 55 years of age up to 185 percent of FPL are already eligible for family planning or "women's health services," and the State is reimbursed at a 90% federal matching rate for these services.[124] The ACA creates a state option to convert the program from a "waiver" to a "state plan" program.[125] The state plan option would eliminate some of the paperwork and additional burdens required for renewing the state's waiver, including documentation of "cost neutrality."

The law also allows states to provide "presumptive eligibility" for family planning services under this state plan option just as the state provides "presumptive eligibility" for pregnant women.[126] This "presumptive eligibility" option could well be a reason to convert Missouri's family planning waiver to a state plan program. The new state option also includes "medical diagnosis and treatment services" that are provided in a family planning setting as part of or as follow-up to a family planning visit, which could potentially be broader than what Missouri currently covers in its existing family planning waiver program.[127] CMS guidance includes several examples of such diagnosis and treatment services.[128]

CMS notes that some of the individuals that a State might cover under this new option (depending on their income) may well be eligible for a more comprehensive set of benefits as States implement Medicaid and other coverage expansions under the ACA in 2014 (or sooner if the state so chooses).[129] CMS makes it clear that taking up the new family planning eligibility group *does not preclude or in any way affect the state's ability to receive the increased federal matching rate* (based on the requirements in effect when the new expansion group becomes mandatory in 2014).[130] In other words, implementing the state plan option for family planning will not jeopardize the State's ability to receive the enhanced match rate for individuals covered in this group *before* 2014 under the family planning option.

The State should carefully review the ramifications of either maintaining its existing waiver or converting to a state plan benefit, in conjunction with CMS, family planning advocates, and providers.

C. Expanding Drug Coverage

Currently, Medicaid excludes coverage of over-the-counter smoking cessation drugs, barbiturates, and benzodiazepines.[131] The ACA eliminates these exclusions beginning January 1, 2014.[132] The Missouri General Assembly recently allocated over $8 million to cover smoking cessation services for "qualified participants" in fiscal year 2011 and the Department intends to implement this benefit for pregnant women only beginning October 1, 2010.[133] The federal health reform legislation will require coverage of smoking cession drugs for all Medicaid populations.[134]

D. New Opportunities to Coordinate Access to Health Care

Beginning January 1, 2011, states will have the option to coordinate care through "health homes." This means that the State can submit a state plan amendment to pay for care provided by a "designated provider," "a team of health professionals," or a "health team" for eligible individuals with chronic conditions.[135] The State will receive a **90 percent FMAP rate** for the first two years that the amendment is in effect to pay for health home services.[136] These types of programs show tremendous promise for coordinating care, particularly for Missouri Medicaid recipients with disabilities or chronic conditions. The additional federal matching funds provided by ACA make the option extremely attractive to our state.

One of the State's consultants—the Lewin group—has already recommended pursuing an "enhanced care management program" for the costliest participants in the non-dual eligible "elderly, blind and disabled" population.[137] The Lewin Group further suggested that patient-centered medical homes (also called "health homes")—which rely on coordinated primary care teams to address a patient's needs—"could meet the State's care management objectives" for this population.[138] A health home uses a team-based model of care "led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes."[139] The ACA's state option and enhanced funding for health homes would employ the patient-centered approach that Lewin has recommended for Missouri. This option would also provide an alternative to expanding risk-based managed care to additional populations or other geographic regions of the state. Missouri should take advantage of this new opportunity to coordinate care with substantial federal support.

It is worth noting that the ACA provides many other opportunities to coordinate care that the State should explore including but not limited to:

- Demonstration projects to integrate care for Medicaid beneficiaries around a hospitalization (under which payments are bundled for care that includes the hospitalization and concurrent physician services provided during the hospitalization);
- Medicaid global payment system demonstration projects for eligible safety net hospital systems or networks;
- "Accountable Care Organization" demonstration projects that allow pediatricians to form ACOs and receive payments under Medicaid and CHIP to share in cost-savings;
- Medicaid Psychiatric Demonstration Projects to address mental health needs of Medicaid beneficiaries; and
- Special Demonstration Projects that target dual eligibles.

The State should explore these options to improve care coordination and health quality.

V. Rebalancing Long-Term Care Services

The Affordable Care Act includes specific legislative findings regarding the importance of home and community based services (HCBS) and the need to decrease reliance on institutional care.[140] The law acknowledges the landmark *Olmstead* decision and recognizes that "Medicaid dollars can support nearly 3 elderly individuals and adults with physical disabilities" in the community "for every individual in a nursing home."[141] The Joint Medicaid Reform Commission of the Missouri General Assembly previously made similar findings.[142] In addition, recently enacted *Missouri legislation* requires that "prior to admission…into a long-term care facility, the prospective resident…shall be informed of the home and community based services available in the state and shall have on record that such home and community based services have been declined as an option."[143]

Missouri policymakers thus recognize the importance of "rebalancing" the state's long-term care services away from institutional care.

Long-term care represents a significant share of the State Medicaid budget and nursing home care represents a disproportionate share of those expenditures.[144] Yet states that spend a higher percentage of their long-term care budgets on HCBS are achieving greater savings in their long-term care programs. In fact, two recent studies document the cost-effectiveness of HCBS in comparison with institutionalized care.[145] Similarly, the Lewin Group recommended "right-sizing" Missouri's long-term care expenditures to eliminate the overemphasis on nursing home care.[146] Thus, Missouri could well save money by increasing its investment in programs promoting home and community based services, instead of limiting access to these services.

The Affordable Care Act provides several new mechanisms for increasing access to HCBS and rebalancing Missouri's long-term care spending away from nursing homes and other such institutions. The law **makes it mandatory for states to apply Medicaid "spousal impoverishment" protections to HCBS** for five years beginning January 1, 2014.[147] Current law only mandates these protections for persons cared for in institutions such as nursing homes. This means that an individual in need of home and community-based long-term care services need not bankrupt his or her spouse in order to receive those services or move into a nursing home simply to ensure that the spouse can retain some of his or her assets.[148]

The ACA also provides several **new state options for** HCBS, all of which are either already in effect or become effective in 2011. Missouri should act to take full advantage of the following provisions to correct the current imbalance between institutional and community-based care and ensure that Missourians with disabilities are served in the least restrictive environment appropriate to their needs.[149]

A. State Balancing Incentive Payments Program

To help rebalance states' long-term care expenditures, the health reform law offers *enhanced federal reimbursement* to states that spend less than 50 percent of their total Medicaid long-term care funds on home and community based services.[150] States that spent less than 25 percent of their Medicaid Long-term care budgets for FY 2009 on HCBS are eligible to receive an increase of 5 percentage points towards their FMAP for the HCBS provided during the balancing incentive period (October 1, 2011 through September 30, 2015).[151] Other states, like Missouri, that spent less than 50 percent but more than 25 percent of their Medicaid long-term care budgets for FY 2009 on HCBS will be eligible to receive an increase of two percentage points towards their FMAP for HCBS provided during the incentive period.[152] States must apply for and be selected by HHS for participation and must aim to spend 25 and 50 percent respectively on HCBS by October 1, 2015.[153] The aggregate total that HHS can reimburse balancing incentive states is $3 billion.[154] States must meet the following conditions to receive the enhanced FMAP:

- Develop a "no wrong door-single entry point system" that will enable consumers to access all long-term care services through one outlet;
- Give consumers information on long-term care services including service availability, application for services, and referral services through the single entry point system;
- Use the additional FMAP funds to provide new or expanded HCBS;
- Collect data pertaining to services, quality and outcomes; and
- Ensure that their eligibility requirements for HCBS are no more restrictive than they are on December 31, 2010. [155]

Because this program goes into effect in October 2011, Missouri will have an early opportunity to expand HCBS while increasing federal reimbursement for these services.[156] Although HHS has not issued criteria for evaluation of state plans to meet their spending goals, the State should begin to identify the ways in which these services could be expanded to more effectively create a plan when the criteria are released.[157]

B. Community First Choice

The law creates a new "Community First Choice" option, which also goes into effect in October 2011. This provision gives states the option to provide home and community based attendant services under the State plan to those who are clinically eligible for medical assistance and whose income does not exceed 150 percent FPL ($1,354 a month).[158] This new option frees states from the expenditure caps associated with current HCBS waiver programs and increases the FMAP by 6 percentage points for the services provided.[159] Eligible individuals will receive coverage for attendant services to assist with activities necessary for daily living, health related tasks, and skill development.[160] This option is not available to those living in institutions or nursing facilities, however, such individuals can receive coverage for costs related to **transitioning back into the community including rent and utility deposits, first month's rent and utilities**, bedding, basic kitchen supplies, and other necessities that would facilitate transition.[161] The inclusion of these key transition costs alleviates a major barrier—obtaining housing—for individuals seeking to transition back into the community. This option thus provides a key mechanism not previously available to states to help transition people back into the community and also to keep people out of institutions to begin with.

Missouri must review this new option in relationship to its current personal care assistance program. Further CMS guidance may help the State determine how these two important benefits will interact. Nevertheless, the Community First Choice option provides another important tool for Missouri to achieve compliance with *Olmstead* and the Americans with Disabilities Act, and should be high on the State's list of priorities for ACA implementation.

C. State Plan HCBS Benefit

The ACA amends the Deficit Reduction Act of 2005 (DRA)'s HCBS "state plan" benefit. The DRA created a new opportunity for states to provide these services through a "state

plan amendment" (as opposed to a waiver) but there had been limited take-up of this option by the states.[162] The bill makes certain modifications that should make implementation of this new option easier, and create new opportunities to serve individuals in the community.[163]

For example, the law provides additional flexibility for states to offer services not listed in the state Medicaid plan, and allows states to **target services** to specific populations.[164] As noted in recent CMS guidance, the State could target HCB benefits to children with autism, persons with chronic mental illness (and/or substance use disorders), adults with HIV/AIDS, but specify different services to meet the needs for each targeted population group. [165] Or states could target services based on individual's functional need.[166] The State could "have multiple programs, each targeted at specific populations, e.g., one for persons with physical needs and another benefit package targeted at persons with chronic mental illnesses."[167]

States continue to have the option to offer "self-direction" to individuals receiving State Plan home and community based services, so that participants can plan and purchase their HCBS under their direction and control or through an authorized representative.[168] CMS "urges all States to afford participants the opportunity to direct some or all of their HCBS."[169]

The law eliminates states' authority to cap the number of individuals who receive coverage for this benefit or limit the benefit to certain geographic areas.[170] States can also create a **new Medicaid eligibility category** for individuals receiving this benefit so that individuals who meet these requirements are entitled to full Medicaid services, even if they do not meet the requirements of an existing Medicaid category. The law also allows states to expand eligiblity to certain Medicaid beneficiaries with incomes up to 300 percent of the Supplemental Security Income (SSI) benefit rate (instead of 150% of the federal poverty level) or the state can impose this limit for *all* HCBS state plan benefit recipients if it qualifies for the State Balancing Incentive Payments program.[171]

Most significantly, the HCBS state plan benefit option **would assist individuals who have *lower levels of need* than the state's nursing home requirements**. In other words, they do not need to meet an "*institutional* level of care" (which in Missouri means having at least 21 points on the State's level of care assessment) to receive the services they need to remain in the community. Under Missouri's current Medicaid program, individuals must meet a nursing home "level of care" in order to receive HCBS. This option, as modified by the ACA, allows the state to serve individuals in the community *before* their condition deteriorates to the point at which they *require* nursing home care. The new provisions became effective on April 1, 2010 giving the State an immediate opportunity to expand HCBS.[172] Missouri should certainly explore this opportunity to serve more individuals in the community rather than more expensive institutional settings.

D. Money Follows the Person

The Deficit Reduction Act of 2005 created the Money Follows the Person Rebalancing Demonstration grants for states to transition nursing home residents back into their homes or the community. Participating states receive an enhanced FMAP for services for the first twelve months after an individual's transition. The ACA extends this program for another five years.[173] Further, while under the DRA individuals were required to have lived in an institution from six months to two years, the ACA reduces the minimum residency requirement to 90 days.[174] This provision also gives the State an immediate opportunity to expand HCBS as it went into effect on April 22, 2010.[175] While Missouri has a limited MFP program, the health reform law provides an opportunity to continue and expand the program. In fact, the Lewin Group suggested that the State of Missouri "aggressively implement the MO Money Follows the Person Program."[176] These consultants estimated that **for every person who transitions out of nursing homes into the community, Missouri would save $10,000 per year**.[177] Lewin pointed out that "helping people move out of nursing facilities leads to immediate savings, facilitates *Olmstead* compliance and captures enhanced FFP[federal financial participation] for individuals who qualify for the Money Follows the Person demo."[178]

Of course, **keeping people out of nursing homes in the first place also saves money and facilitates compliance with *Olmstead***, as discussed above. It is far more difficult to transition people *out* of nursing homes than it is to serve them in the community when they are *already* in their own homes.[179] Hence, home and community based services are critical to preventing individuals from being admitted unnecessarily. The new health reform law offers significant opportunities for Missouri to do exactly that, thereby rebalancing its long-term care system and decreasing the emphasis on institutional care. Disability advocates should pay close attention to these new opportunities to help Missourians with disabilities integrate into the community.

VII. Creating a Public Process for Implementation

As shown by the discussion so far, many key issues will influence the effectiveness of Missouri's implementation of the Medicaid provisions of the ACA, not to mention the provisions regarding the exchanges, premium tax credits and other new requirements. Missouri's decisions in these key areas will significantly affect low-income individuals with serious and complex health needs, making it extremely important for the State to secure input from key stakeholders.

The State should establish advisory committees that include consumer representatives and advocates for low-income persons and consult these stakeholders on the issues that affect the health of vulnerable Missourians. The State should make transparent decisions and use the public rulemaking process for significant policy changes that affect large numbers of low-income Missourians. This would ensure an opportunity for public comment on key policy issues affecting vulnerable populations. State policymakers have significant expertise but do not have all the answers regarding the impact of the decisions they make to implement this sweeping legislation. **The Department of Social Services already recognized in another context the importance of public input** when it created an Advisory Board and multiple work groups to help implement the Health Information

Technology provisions of the American Recovery and Reinvestment Act. Similar stakeholder input is required in implementing health care reform which is an even more far-reaching endeavor than the Health IT Act. The Medicaid provisions discussed in this paper are just *one* component of the implementation process that requires public and stakeholder involvement. Similar public involvement is needed with regard to designing the new exchanges and premium tax credits established by the Affordable Care Act.

Conclusion

The health care reform law will dramatically expand health coverage as a result of the new premium tax credits and a robust Medicaid expansion. These changes will significantly reduce Missouri's uninsured, improving access to health care for hundreds of thousands of Missourians. These expansions will cost the State very little. In addition to expanding coverage, the Affordable Care Act gives states significant discretion over how they implement the new law. Within Medicaid, for example, states will have a number of choices to make when establishing the benefits package for the new eligibility expansion group, expanding access to home and community based services, and testing new options to improve access to care. While CMS guidance will likely clarify some of the eligiblity issues, the State will need to consider how to meld the ACA's eligibility rules with its current program rules and eligibility systems. The State also must make the Medicaid coverage expansion—particularly outreach and enrollment mechanisms—work in conjunction with the new health insurance exchanges and premium tax credits. Missouri will need to develop the infrastructure and technology most likely to get people enrolled and effectively coordinate enrollment between public programs and the exchanges. Thus, decisions affecting Medicaid cannot be made without considering their impact on and relationships with the exchange and premium tax credits.

There is a great deal of work to be done *before* 2014 when the ACA's major coverage expansions take effect. The State needs work on Medicaid implementation *now* and should do so with sufficient public and stakeholder input, including input from advocates for consumers and the low- and moderate-income Missourians affected by these provisions. The provisions discussed in this paper must be implemented in a way that maximizes enrollment and improves access to health care for these populations. Moving forward carefully but aggressively on implementation will provide the greatest benefit to our state, its health care system and most importantly, to those persons affected by the new law's coverage expansions and health access initiatives.

Endnotes

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[1] The term "Affordable Care Act" is used to refer to both the Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010), and the Health Care and Education Affordability Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029, both of which form the basis of health care reform, and were signed into law by President Obama in early 2010. *See* Dawn C. Horner & Sabrina Corlette, Georgetown Univ. Ctr. for Children & Families, *Health Insurance Exchanges: New Coverage Options for Children and Families, Center for Children and Families*, at 11 (Aug. 2010), *available at* http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf publications/health reform/health insurance exchanges.pdf.

[2] The other half will be enrolled largely as a result of new premium credits and other provisions of the Affordable Care Act. John Holahan & Irene Headen, Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, at 37 (May 2010), *available at* http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.

By 2019, 16 million are expected to obtain coverage through Medicaid and CHIP while 29 million will obtain coverage through the new Health Insurance Exchanges. Georgetown Univ. Ctr. for Children & Families, *Summary of Medicaid, CHIP and Low-Income Provisions in Health Care Reform*, at 1, 6 (Apr. 2010), *available at* http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf publications/health reform/health reform summary.pdf. CBO's 32 million estimate accounts for those gaining coverage through the Exchange and Medicaid/CHIP adjusted for a net change in those receiving employment-based and individual market coverage. *Id.* at 6.

[3] ACA § 2001. The ACA left intact prohibitions on Medicaid and CHIP coverage for undocumented immigrants as well as current restrictions on coverage for *legal* immigrants. *See* discussion *infra* section I.B. These restrictions apply to *both* traditional Medicaid populations and the new income eligiblity group covered under the Affordable Care Act.

[4] ACA § 2001; AARP Pub. Pol'y Inst., *Health Reform Provides New Federal Money to Help States Expand Medicaid*, at 1 (May 2010), *available at* http://assets.aarp.org/rgcenter/ppi/health-care/fs185-health-reform.pdf.

[5] ACA, § 2001(e).

[6] Holahan & Headen, *supra* note 2, at 41. This figure is a conservative estimate based on a "standard participation" scenario that assumes "moderate levels of participation similar to current experience among those made newly eligible for coverage and little additional participation among those currently eligible." *Id.* at 1, 41. The researchers project higher participation under an "enhanced outreach scenario" that assumes a "more aggressive outreach and enrollment campaign by federal and state governments as well as key stakeholders including community based organizations and providers." *Id.* at 1, 25. The Missouri Department of Social Services has estimated that the expansion will cover 255,000 Missouri adults. Mo. Dep't of Social Servs., *Informational Memo: Impact of Health Care Reform Bill on Missouri Medicaid Program (MO HealthNet)* (Mar. 2010).

[7] Specifically, the State will earn an enhanced FMAP for new eligibles that are 19 or older and, as of December 2009, either: (1) were not eligible for full benefits under a state plan or waiver, or benchmark or equivalent coverage; or (2) were eligible for benefits through a capped state waiver, but not enrolled because it reached its limit. Holahan & Headen, *supra* note 2, at 42.

[8] Missouri's original FMAP for 2010 is 64.10%, while the FMAP after the American Recovery and Reinvestment Act (ARRA) enhancement is 74.43% through December 31, 2010. Kaiser Family Found., Missouri: Temporary Federal Medicaid Relief, http://www.statehealthfacts.org/profileind.jsp?sub=154&rgn=27&cat=4 (last visited July 1, 2010).

[9] Holahan & Headen, *supra* note 2, at 41.

[10] Holahan & Headen, *supra* note 2, at 42.

[11] The Affordable Care Act will also **gradually reduce Disproportionate Share Hospital (DSH) payments** made to states because the number of uninsured (and hence, the level of "uncompensated care") will be reduced. ACA § 2551, as amended by § 10201 and HCERA § 1203. This reduction in DSH makes it all the more important that as many people as possible are covered so that the *need* for uncompensated care funding is diminished as these payments are reduced. For further discussion of the ACA's DSH revisions, s*ee* Nat'l Health L. Program, 2 *Analysis of the Health Care Reform Law: PPACA and the Reconciliation Act*, at 32-33 (2010) *available at* http://www.healthlaw.org/images/stories/PPACA_Part_II.pdf [hereinafter "NHeLP"].

[12] Kaiser Family Found., *Financing New Medicaid Coverage Under Health Reform: The role of the Federal Government and States*, at 3 (May 2010), *available at* http://www.kff.org/healthreform/upload/8072.pdf.

[13] *Id.* It should be noted that while the individual mandate may cause a welcome mat effect among current eligibles, most people eligible for Medicaid—current and new—will not actually be subject to penalties as a result of the mandate, due to their low incomes.

[14]ACA § 2001(e).

[15] Holahan & Headen, *supra* note 2, at 42.

[16] ACA § 2001(a)(4)(A), as amended by § 10201(b).

[17] Unfortunately, because the enhanced federal medical assistance percentage is not effective until 2014, early expansion states will receive reimbursement under the current FMAP structure. *See* ACA § 2001(a)(3), as amended by HCERA § 1201(1)(B).

[18] *See* McKenna, Long & Aldridge, L.L.P., Weekly Health Care Wrap Up 4.23.2010, http://www.mckennalong.com/news-advisories-2297.html (last visited Sept. 8, 2010); U.S. Dep't of Health & Human Servs., News Release: Connecticut First in Nation to Expand Medicaid Coverage to New Groups Under the Affordable Care Act (June 18, 2010), *available at* http://www.hhs.gov/news/press/2010pres/06/20100618h.html.

[19] The Medical Assistance for Workers with Disabilities (MAWD) Program was eliminated in 2005 by Senate Bill 539. In 2007, the Missouri General Assembly passed a more limited "Ticket to Work Health Assurance" program for workers with disabilities as part of Senate Bill 577. *See* Mo. Rev. Stat. § 208.146.1. Individuals with disabilities enrolled in this program can receive Medicaid coverage without having to "spend down" to the income eligiblity limits of the program.

[20] ACA § 2001; Mo. Family Support Div., Mo. Income Maintenance Manual: Family Healthcare, at § 0920.010.35 (2010), *available at* http://www.dss.mo.gov/fsd/iman/fhc/fhctoc.html [select "0920.010.35" hyperlink].

[21] Mo. Rev. Stat. § 208.151.1(26).

[22] ACA § 10203. The children of state employees can be covered by CHIP in either of two situations. First, a child can be enrolled in CHIP if the state agency employing the child's parent can show that, in the most recent fiscal year, the average expenditures paid by the agency for an employee with dependent coverage was greater than or equal to such amounts paid in the 1997 fiscal year, adjusted for inflation (in other words, so long as it has not gotten cheaper since 1997 for the state agency to provide family health coverage). *Id.* Second, a particular child can be enrolled in CHIP if the State finds that the annual, aggregate amount of premiums and cost-sharing imposed on the child's family would exceed 5% of the family's income for that year. *Id.*

[23] *See Summary of Medicaid, CHIP, and Low-Income Provisions in Health Care Reform*, *supra* note 2, at 3. It should be noted that this additional funding hinges on reauthorization of the CHIP program, and the money to pay for this increased matching rate has not yet been appropriated. Funding for the program is provided through September 30, 2015, two years beyond the current expiration date. *Id.* If a state runs out

of federal CHIP funding, children can be enrolled in exchange plans with comparable coverage. *Id.*

[24] *Id.*

[25] The CHIPRA options for earning states performance bonuses include: (1) joint application and renewal forms and same verification process for Medicaid and CHIP; (2) no face-to-face interview requirements; (3) no asset test (or simplified asset verification) for Medicaid and CHIP; (4) presumptive eligibility; (5) administrative verification of income or ex parte renewal; (6) 12-month continuous eligibility; (7) express lane eligibility; and (8) premium assistance. *See, e.g.*, Kaiser Comm'n on Medicaid & the Uninsured & Georgetown Univ. Ctr. for Children & Families, *CHIP Tips: Medicaid Performance Bonus "5 of 8" Requirements* (Apr. 2009), *available at* http://www.kff.org/medicaid/upload/7885.pdf. Missouri applied for but was denied CHIPRA performance bonuses, as CMS found that Missouri satisfies only the first three out of the eight options, not the five necessary to earn the bonuses. Letter from Cindy Mann, Director, Dep't of Health & Human Servs., to Ian McCaslin, Director, MO HealthNet (Dec. 18, 2009). Missouri was specifically found not to meet the automatic renewal, presumptive eligibility, and premium assistance options. *Id.* Presumptive eligibility was not satisfied because Missouri does not allow this option for CHIP children in families with incomes above 150% of poverty. Thus, expanding presumptive eligibility to the entire CHIP population would help Missouri meet the "5 of 8" measures needed to earn a performance bonus.

[26] U.S. Dep't of Health & Human Servs., CHIPRA Performance Bonuses, http://www.insurekidsnow.gov/professionals/CHIPRA/chipra_awards.html (last visited Sept. 8, 2010).

[27] David A. Lieb, *Kids' Health Care Plans on Hold in State: Expansion is High on Nixon's Wish List,* Columbia Daily Tribune, Dec. 9, 2009, *available at* http://www.columbiatribune.com/news/2009/dec/07/kids-health-care-plans-on-hold-in-state/ .

[28] *See* Donna Cohen Ross, Ctr. on Budget & Pol'y Priorities, *It Happened One Night* (Apr. 2010), *available at* http://theccfblog.org/2010/04/it-happened-one-night.html; Kaiser Comm'n on Medicaid & the Uninsured, *Louisiana Express Lane Eligibility*, at 1-2 (Aug. 2010) *available at* http://www.kff.org/medicaid/upload/8088.pdf.

[29] In addition, the Missouri legislature recently passed SB 583 which increases CHIP outreach through collaboration with child-care providers, school districts and the free/reduced lunch program. More specifically, the bill requires the State to give child-care providers receiving state or federal funding, as well as all school districts, information on the CHIP program to be distributed to parents at enrollment. Mo. S.B. 583 § 376.1450(1)(1). The State must also attach a form to the free/reduced lunch application allowing parents to indicate whether their children have health insurance. §

376.1450(1)(2). The school will then notify the parent or guardian that their child may qualify for CHIP. *Id.* Aggressive implementation of these provisions could help improve children's participation in Medicaid and CHIP.

[30] *Summary of Medicaid, CHIP and Low-Income Provisions in Health Care Reform*, *supra* note 2, at 2. Advocates have taken the position that Missouri law in fact requires the State to cover legal immigrant children and pregnant women without a five-year waiting period. Letter from Joel Ferber, Dir. of Advocacy, Legal Servs. of Eastern Mo., to Ronald J. Levy, Dir., Mo. Dep't of Social Servs. (Mar. 3, 2009) (and citations therein).

[31] *Id.*

[32] *Id.*

[33] ACA § 2001(a)(4)(B).

[34] ACA § 2202(a)(3).

[35] *See, e.g.*, Donna Cohen Ross, Ctr. on Budget & Pol'y Priorities, *How Health Care Providers Can Help Link Children to Free and Low Cost Health Insurance Programs* (Sept. 1999), http://www.cbpp.org/cms/?fa=view&id=399 (describing outstations at hospitals on the border between Missouri and Kansas). Missouri currently allows hospitals and federally-funded health clinics to serve as "qualified entities" for determining presumptive eligibility.

[36] ACA § 2201(b).

[37] ACA § 2001.

[38] *See Olmstead v. L.C.*, 527 U.S. 581, 597 (1999). The ADA's integration mandate requires public entities to "administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." *Id.* at 592; 28 C.F.R. § 35.130(d).

[39] *See* discussion *infra* section VI.

[40] *See generally* Joel Ferber & James Frost, *Expanding Medicaid Managed Care to People With Disabilities and Seniors Would Be Risky and Unwise* (Aug. 2010), *available at* http://www.paraquad.org/Policy/documents/ManagedCareReportAugust2010.pdf (paper prepared for the Disability Coalition on Healthcare Reform and The Federation of Missouri Advocates for Mental Health and Substance Abuse Services).

[41] ACA § 2002(a), as amended by HCERA §§ 1004(b)(1)(A) and 1004(e).

[42] ACA §§ 2202(a) and 1411(b).

[43] ACA § 1411(b)(3)(A) (determinations will be made using the information "for the taxable year ending with or within the second calendar year preceding the calendar year in which the plan year begins").

[44] ACA § 2002(a), as amended by HCERA §§ 1004(b)(1)(A), 1004(e). *See also* NHeLP, *supra* note 11, at 8 (stating the same).

[45] ACA § 2002(a), as amended by HCERA §§ 1004(b)(1)(A) and 1004(e).

[46] *Id.*

[47] *Id.*

[48] *Id.* The ACA requires that, between now and 2014, states must work with the Secretary of HHS to "establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, *do not lose coverage under the State plan or under a waiver of the plan*." *Id.* This means that Missouri must carefully look at its current income eligibility methodologies and determine what needs to be done to ensure that current beneficiaries do not lose health care coverage when the new income eligibility methodologies are implemented.

[49] ACA § 1401(a).

[50] NHeLP, *supra* note 11, at 10-11 (and citations therein). *See generally* Internal Revenue Service, *Publication 54 - Tax Guide for U.S. Citizens and Resident Aliens Abroad* (2009), *available at* http://www.irs.gov/pub/irs-pdf/p54.pdf; Internal Revenue Service, *Publication 17 - Your Federal Income Tax for Individuals* (Nov. 2009), *available at* http://www.irs.gov/pub/irs-pdf/p17.pdf.

[51] ACA § 2002. States using "express lane" eligiblity may also continue to rely on express lane agencies' findings relating to express lane eligibility, rather than have to use the new "MAGI" income test. *Id.*

[52] ACA § 1331.

[53] ACA § 1331(a)(2)(B).

[54] In addition to all of the new provisions and options discussed above, the ACA extends the state option to provide "premium assistance" for employer-sponsored insurance to all Medicaid recipients and their families—an option that was previously available only to children on Medicaid. *See* ACA §§ 2003, 10203.

[55] ACA § 2001(a)(2)(A).

[56] Medicaid Act, 42 U.S.C. § 1396u-7(b).

[57] ACA § 2001(c).

[58] ACA § 2001(c)(6).

[59] ACA § 2001(c).

[60] 75 Fed. Reg. 83, 23102, 23103 (Apr. 30, 2010).

[61] 75 Fed. Reg. 83, 23103, 23104 (Apr. 30, 2010).

[62] ACA § 2303(c); 75 Fed. Reg. 23068 (Apr. 30, 2010).

[63] Matthew Broaddus, Ctr. on Budget & Pol'y Priorities, *Childless Adults Who Become Eligible for Medicaid in 2014 Should Receive Standard Benefits Package*, at 2 (July 2010), *available at* http://www.cbpp.org/files/7-6-10health.pdf.

[64] *Id.* at 4.

[65] States will likely have to conduct such screening to some extent anyway for financing purposes (i.e., to determine which federal matching rate applies) but the "medically frail" determination would seem unnecessary if the state provides a traditional Medicaid package to the new eligiblity group.

[66] ACA § 2001(a)(2)(A).

[67] Letter from Cindy Mann, Director, Centers for Medicaid and Medicare Services, to State Medicaid Directors (Apr. 9, 2010).

[68] This section includes children under 19 years of age who are eligible for SSI under title XVI, eligible under section 1902(e)(3) of the Act, in foster care or adoption assistance, or receiving services through a family-center, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the State in terms of either program participation or special health care needs. 42 C.F.R. § 438.50(d)(3).

[69] 75 Fed. Reg. 83, 23101, 23102 (Apr. 30, 2010).

[70] ACA § 2202.

[71] *See* Mo. Rev. Stat. § 208.010.2.(4). Missouri is one of small group of states that has elected to apply more restrictive resource limits than the federal Supplemental Security Income (SSI) program, often referred to as "section 209(b) states" (based on the section of the Social Security Act that afforded them this option to obtain standards that are more

restrictive than SSI). Federal law requires states to provide Medicaid coverage to all persons receiving Supplemental Security Income (SSI) disability benefits except where a state exercises the "§ 209(b) option." *See* 42 U.S.C. § 1396a(f); 42 C.F.R. § 435.121.

[72] Judith Solomon, Ctr. for Budget and Pol'y Priorities, *Health Reform Expands Medicaid Coverage for People with Disabilities*, at 2 (July 2010), *available at* http://www.cbpp.org/files/7-29-10health.pdf.

[73] 42 U.S.C. § 1396a(a)(19) ("A State plan for medical assistance must…provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the **best interests of the recipients**") (emphasis added).

[74] 42 C.F.R. § 447.53 (2009) (excluding children, pregnant women, institutionalized individuals, emergency services, and family planning services and supplies). The maximum allowable cost-sharing depends upon the type of cost-sharing involved: deductibles cannot exceed $2.30 per month per family member; coinsurance cannot exceed 5% of what the Medicaid program pays for the service; and copayments cannot exceed $.60 for a service costing $10 or less, $1.15 for a service costing $10.01 to $25, $2.30 for a service costing $25.01 to $50, or $3.40 for a service costing $50.01 or more. 42 C.F.R. § 447.54. These nominal amounts became effective Dec. 31, 2009, *id.*, and are required to be adjusted annually, 42 U.S.C. § 1916(h) ("the Secretary shall increase such 'nominal' amounts for each year (beginning with 2006) by the annual percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) as rounded up in an appropriate manner").

[75] 42 C.F.R. 447.72(b).

[76] If the state were to expand Medicaid eligiblity beyond 133%, it would have to decide what cost sharing to apply to those individuals as well.

[77] For a discussion of this decline in Missouri CHIP after the extension of premiums to additional income groups as well as similar results in other states, *see generally* Joel Ferber, *Measuring the Decline in Children's Participation in the Missouri Medicaid Program: An Update* (Sept. 2006).

[78] Georgetown Univ. Ctr. for Children & Families, *supra* note 2, at 5.

[79] *Id.*

[80] ACA § 1413(b)(1)(A). A state may also create its own form to use, provided it is consistent with the standards established by the Secretary of HHS. ACA § 1413(b)(1)(B).

[81] ACA § 1413(b)(1).

[82] ACA § 1413(b)(2).

[83] ACA § 1413(a).

[84] ACA § 1413(b)(1)(A)(iv).

[85] ACA § 1413(c)(1).

[86] ACA §§ 1413(c)(2)-(3).

[87] ACA § 1413(d)(2)(A).

[88] ACA § 1413(d)(2)(B).

[89] ACA § 1413(c).

[90] ACA § 2201.

[91] Grants are already available—and will be through 2014—to help states plan and establish their exchanges. *See* U.S. Dep't of Health & Human Servs., Exchange State Planning & Establishment Grants Frequently Asked Questions, http://www.hhs.gov/ociio/initiative/exchange_grants_faq.html (last visited Sept. 2, 2010) [hereinafter "Frequently Asked Questions"] (the deadline for states to submit applications for the first round of funding (up to $1 million) was September 1, 2010). The State of Missouri has applied for an initial planning grant to assess whether to establish a state-based exchange. Email from John Huff, Director, Missouri Department of Insurance, Financial Institutions and Professional Registration, to Joel Ferber, Director of Advocacy, Legal Services of Eastern Missouri (Sept. 8, 2010). Almost all other states have applied for the initial round of exchange planning grants, but there will be additional rounds of grants for which the State may be eligible and which could help the State address the eligibility determination responsibilities of the exchanges. Future funding will support the states in activities related to development and implementation of the exchanges. HealthCare.gov, *Establishing Health Insurance Exchanges and a New Competitive* Marketplace, *available at* http://www.healthcare.gov/news/factsheets/esthealthinsurexch.html (last visited Sept. 9, 2010). After these federal grants are exhausted, the exchanges are expected to be self-sustaining with premiums being the most likely source of funding for operation and administration of the exchanges, including any eligiblity and enrollment functions they would perform.

[92] HHS has made it clear that "any information and technology costs related to planning and establishment of the exchanges, *including costs incurred to enable necessary systems changes to accommodate Exchange eligiblity and enrollment functions*, may be funded using the Exchange planning and establishment grants." Frequently Asked Questions, *supra* note 91, at 5 (emphasis added).

[93] *See* ACA § 1561 and *infra* note 103. Funding has yet to be appropriated for these HIT grants. *See* Frequently Asked Questions *supra* note 91, at 5.

[94] The Lewin Group, *MO HealthNet Comprehensive Review Final Report*, at 12 (Feb. 28, 2010), *available at* http://www.dss.mo.gov/mhd/oversight/pdf/final-report2010apr30.pdf [hereinafter "Lewin Comprehensive Report"].

[95] Lewin found that the State's oversight of these contractors "appears limited" and "may be the result of staffing levels, skill sets, or historical lack of institutional emphasis." *Id.*

[96] ACA § 2201.

[97] As noted earlier, it is even more critical to maximize the benefit of the ACA's coverage expansions in light of the decrease in DSH payments under the ACA, which is based on an assumption that the need for "uncompensated care" will decrease. *See* discussion *supra* note 11.

[98] ACA § 1413(c).

[99] For example, current Missouri law requires the Family Support Division to send verification request letters to all Medicaid beneficiaries requesting updated information *and* specific documentation regarding their income as part of the annual review process. Mo. Rev. Stat. § 208.147. This *may* include but is not limited to current wage stubs, W-2s, statements from the recipient's employer, wage matches from the division of employment security, and bank statements. If the recipient does not respond and/or provide the requested documentation within the 10 days, then the individual has another 10 days to request a hearing or have his/her benefits terminated. This kind of paper-based system does not comport with the new framework of electronic data matching and improved technology. These kinds of rules and practices must be eliminated or revised substantially to comport with the provisions of ACA.

[100] The term "administrative renewals" generally refers to a process by which states attempt to renew eligibility based on information available to them, for example, through other program records or data bases. *CHIP Tips*, *supra* note 25, at 3. CHIPRA describes a process whereby the state can send a pre-printed form with the most current information available to the state and require the parent or caretaker to report any changes. If there are no changes, eligibility is renewed and coverage continues. *Id.* *Ex parte* renewals similarly refer to a process whereby the state uses information available to it through other databases, such as wage and labor records, to verify ongoing eligibility, rather than require the *family* to produce such information. *See id.*

[101] *See generally* Donna Cohen Ross, Ctr. on Budget & Pol'y Priorities, *New Citizenship Documentation Option for Medicaid and CHIP is Up and Running: Data Matches With Social Security Administration are Easing Burdens on Families and States* (Apr. 20, 2010), *available at* http://www.cbpp.org/files/4-20-10health.pdf. State cost-savings have been significant, with California estimating savings of $26 million annually in state and

federal costs associated with administering the citizenship documentation requirement without the new SSA data matching option. *Id.* at 2-3. States adopting this date matching technique have also found it to be an extremely accurate method of documenting citizenship. *Id.* As noted above, implementation of this option for Medicaid and CHIP will prepare the State for what it will be *required* to do for citizenship documentation in the new health insurance exchanges.

[102] The ACA requires the exchange of information between states and federal agencies to verify the information contained in applications. For example, a state exchange must submit the information provided by an applicant to the Secretary of HHS. ACA § 1411(c)(1). The Secretary of HHS then submits the applicant's name, date of birth, social security number, and attestation of citizenship to the Commissioner of Social Security for verification, and also submits an alien applicant's attestation of lawful residence (or the information of those found by the Commissioner of Social Security not to be citizens) to the Secretary of Homeland Security for verification. ACA § 1413(c)(2). This streamlined method of verifying citizenship obviates the need for applicants to provide original documentation, such as birth certificates or passports, and is already in use by almost half of all Medicaid programs. Kaiser Family Found., Kaiser Comm'n on Medicaid & the Uninsured, *Optimizing Medicaid Enrollment: Perspectives on Strengthening Medicaid's Reach Under Health Care Reform*, at 6 (Apr. 2010), *available at* http://www.kff.org/healthreform/upload/8068.pdf.

[103] ACA § 1411(c); Kaiser Family Found., *Explaining Health Reform: Eligibility and Enrollment Process for Medicaid, CHIP, and Subsidies in the Exchanges*, at 4 (Aug. 2010), *available at* http://www.kff.org/healthreform/upload/8090.pdf [hereinafter "Kaiser Enrollment Paper"].

[104] Section 1561 of the ACA provides that the Secretary shall establish standards and protocols for electronic enrollment that allow for the following:

> (1) Electronic matching against existing Federal and State data, including vital records, employment history, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation;
>
> (2) Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility;
>
> (3) Reuse of stored eligibility information to assist with retention;
>
> (4) Capability for individuals to apply, recertify and manage their eligibility information online;
>
> (5) Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate;
>
> (6) "Other functionalities" necessary to streamline the process for applicants.

ACA § 1561. The law also provides for grants to states and localities to develop or adapt existing systems to meet the new standards and protocols. The Secretary **may require the State to incorporate such standards as a condition of receiving federal health information technology funds**. *Id.*

[105] *See* Horner and Corlette, *supra* note 1, at 9.

[106] The State of Wisconsin has developed a flow chart that provides an overview of the eligiblity determination process that will be conducted by the health insurance exchange. Wisc. Office of Health Care Reform, *White Paper: Health Insurance Exchanges*, at 48 (Aug. 2010) (draft). The flow chart attempts to show how the exchanges will address eligibility determinations across programs, including Medicaid. It may be useful for Missouri to develop a similar flow chart to begin to grapple with how the State can coordinate eligiblity for the different types of subsidies authorized by the ACA.

[107] ACA § 1311(i).

[108] ACA § 1311(i)(2)(B), as amended by § 10104(h).

[109] ACA § 1311(i).

[110] In addition, grants are available now to help states establish consumer assistance ombudsmen programs, to help educate consumers about their choices and guide them through the enrollment process. Dep't of Health & Human Servs., Office of Consumer Info. & Ins. Oversight, CFDA 93.519: Consumer Assistance Program Grants, at 3-4 (July 22, 2010), *available at* https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=11720. [select "View File" hyperlink at bottom of page]. These grants are also designed to help individuals with problems in the private insurance market such as denials of coverage and appeals of those denials. Missouri should take advantage of this critical opportunity to help individuals in need of assistance with their private insurance coverage.

[111] *See Medicaid and Health care reform in New Mexico: Opportunities and Recommendations*, Report for New Mexico's Health Care Reform Working Group, at 13 (July 2010).

[112] *Id.* (and citations therein). Civil Rights Division, Dep't of Justice, *Accessibility of State and Government Websites to People With Disabilities*, at 1-2 (June 2003), *available at* http://www.ada.gov/websites2_scrn.pdf [hereinafter "DOJ Guidance"]. As the DOJ notes:

> Many people with disabilities use "assistive technology" to enable them to use computers and access the Internet. Blind people who cannot see computer monitors may use screen readers—devices that speak the text that would normally appear on a monitor. People who have difficulty

> using a computer mouse can use voice recognition software to control their computers with verbal commands. People with other types of disabilities may use still other kinds of assistive technology. New and innovative assistive technologies are being introduced every day. Poorly designed websites can create unnecessary barriers for people with disabilities, just as poorly designed buildings prevent some from entering. Designers may not realize how simple features built into a web page will assist someone who, for instance, cannot see a computer monitor or use a mouse.

Id. at 2. For additional examples of the access issues that may arise with regard to people with disabilities, see Nat'l Center for Law & Economic Justice and Maximus, *Modernizing Public Benefits Programs: What the Law Says State Agencies Must Do to Serve People with Disabilities* (2010), *available at* http://nclej.org/documents/ModernizingPublicBenefits_20Jul10.pdf [hereinafter *Modernizing Public Benefits Programs*].

[113] *Id.*

[114] *See id.* Another recent study by the National Center for Law and Economic Justice found that state public benefits agency websites have accessibility and disability problems. *See* Cary LaCheen, *The Closed Digital Door: State Public Benefits Agencies' Failure to Make Websites Accessible to People with Disabilities and Usable for Everyone* (July 22, 2010), *available at* http://nclej.org/documents/TheClosedDigitalDoor.pdf. Although Missouri was not one of the states included in the study, the State must take steps to ensure that the problems found in the study are not barriers in Missouri as it implements the new health care law.

[115] For example, the DOJ points out that one way to increase accessibility is to periodically enlist disability groups to test web pages for ease of use. DOJ Guidance, *supra* note 112, at 3.

[116] CHIPRA § 201(b). *See also* Ctrs. for Medicare & Medicaid Servs., State Medicaid Director Letter (July 1, 2010), *available at* http://www.nasuad.org/documentation/policy_priorities/SHOs/IncreasedFedMatchingFundsforTranslation.pdf.

[117] ACA § 2303, as amended by HCERA § 1202(a).

[118] ACA § 2303, as amended by HCERA § 1202(b).

[119] Mo Rev. Stat. § 208.152(23).

[120] ACA § 4106.

[121] *Id.*

[122] 42 U.S.C. § 1396(a)(4)(C).

[123] *See* Mo. Dep't of Social Servs., *Physician Bulletin Women's Health Coverage*, at 1 (Feb. 9, 2009), *available at* http://www.dss.mo.gov/mhd/*providers*/pdf/bulletin31-44_2009feb09.pdf.

[124] Missouri Senate Bill 577, enacted in 2007, also requires a participant to have total assets of no more than $250,000. Mo. Rev. Stat. § 208.659. So long as a woman meets these eligibility requirements and requires family planning services, she can remain indefinitely covered by the program. *See* Mo. Dep't of Social Servs., *supra* note 123, at 1 ("women are not limited to one year of coverage"). Covered services include contraception, testing and treatment of sexually transmitted diseases, counseling and education on birth control methods, and other prescribed women's health services. *Id.* at 2.

[125] ACA § 2303(a)(2).

[126] ACA § 2303(b)(1).

[127] ACA § 2303(a)(3).

[128] Ctrs. for Medicare & Medicaid Servs., Dear State Health Official Letter, at 3 (July 2, 2010), *available at* https://www.cms.gov/smdl/downloads/SMD10013.pdf. CMS guidance includes several examples of family planning-related services covered under the new state plan amendment option, including:

- **Drugs for the treatment of sexually-transmitted diseases (STD) or sexually-transmitted infections (STI)**, except for HIV/AIDS and hepatitis, when the STD/STI is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may be covered. In addition, subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.

- **Annual visits for men:** some states and family planning programs encourage men to have an annual visit at the office/clinic. Such an annual family planning visit may include a comprehensive patient history, physical, laboratory tests, and contraceptive counseling.

- **Drugs for the treatment of lower genital tract and genital skin infections/disorders**, and urinary tract infections, when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may be covered.

- **Other medical diagnosis, treatment, and preventive services** that are routinely provided pursuant to a family planning service in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.

- **Treatment of Major Complications** The following are examples of treatment of major complications that States may cover: Treatment of a perforated uterus due to an intrauterine device insertion; Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or, Treatment of surgical or anesthesia-related complications during a sterilization procedure.

- CMS states that for persons who have had a sterilization, states must cover family planning-related services that were provided as part of, or as follow-up to, the family planning visit in which the sterilization procedure took place.

Id. at 3-4.

[129] *Id*. at 2.

[130] *Id.*

[131] NHeLP, *supra* note 11, at 30.

[132] ACA § 2502.

[133] Mo. H.B. 2011 § 11.430 (2010); Email from Ian McCaslin, Director, MO HealthNet, to Joel Ferber, Dir. of Advocacy, Legal Services of Eastern Missouri (July 29, 2010). The smoking cessation services must be evidence-based, and enrollees must obtain prior-authorization for these services. Mo. H.B. 2011 § 11.430.

[134] The law also makes changes to prescription drug rebates. The Centers for Medicare and Medicaid Services has issued guidance to States to implement a provision of the Affordable Care Act that increases the Medicaid drug rebates that Manufacturers must give to the States, but also increases the amount of money from these rebates that States must remit to the Federal government. Cindy Mann, Ctrs. for Medicare and Medicaid Servs., State Medicaid Director Letter, at 1-2 (Apr. 22, 2010), *available at* https://www.cms.gov/smdl/downloads/SMD10006.pdf. This provision also requires drug manufacturers to extend rebates to Medicaid MCOs which previously were not able to receive them. *Id*. at 2. For a discussion of Medicaid managed care as it relates to the pharmacy benefit, *see* Ferber & Frost, *supra* note 40, at 4, 17-18.

[135] ACA § 2703.

[136] NHeLP, *supra* note 11, at 38-39.

[137] Lewin Comprehensive Report, *supra* note 94, at 66.

[138] *Id*. at 68.

[139]Am. Coll. of Physicians, *Understanding the Patient-Centered Medical Home*, http://www.acponline.org/running_practice/pcmh/understanding/index.html (last visited Sept. 9, 2010).

[140] ACA § 2406.

[141] ACA § 2046.

[142] The Missouri General Assembly's Medicaid Reform Commission previously found that in-home care is often much less costly than institutional-based care, in many cases as little as 1/6th the cost of nursing home care. Medicaid Reform Comm'n, *Report*, at 40 (Dec. 2005), *available at* http://www.senate.mo.gov/medicaidreform/MedicaidReformCommFinal-122205.pdf.

[143] Mo. Gen. Assembly, S.B. 1007 §A (2010) (creating Mo Rev. Stat. § 198.016).

[144] According to CMS data, 68.9% of Missouri's long term care spending for the elderly and disabled population is allocated towards institutionalized care while only 31.1% is allocated towards home and community based services. Ctr. for Medicaid and State Operations, Div. of Fin. Operations, Ctrs. for Medicare & Medicaid Servs., *Distribution of Long Term Care Expenditure: Institutional vs. Community Based Services, FY 2007* (2008). *See also* Steve Gold, *FY 2009 Institution vs Community-Based Medicaid Services for Older and Younger Americans With Disabilities: Information Bulletin # 321* (Aug. 31, 2010), *available at* http://www.stevegoldada.com/stevegoldada/archive.php?mode=A&id=321;&sort=D (showing in each state the percentage of expenditures spent on institutional care compared to community-based care in fiscal year 2009); Steve Gold, *A Comparison of Medicaid Institutional Versus Community Expenditures: FY 2008: Information Bulletin # 298* (Jan. 11, 2010), *available at* http://www.stevegoldada.com/stevegoldada/archive.php?mode=A&id=298;&sort=D (same for 2008); Steve Gold, 2007 *Institution vs Community-Based Medicaid Services: Information Bulletin # 26* (Oct. 1, 2008), ava*ilable at* http://www.stevegoldada.com/stevegoldada/archive.php?mode=A&id=263;&sort=D (same for 2007).

[145] An analysis of state spending data for two distinct population groups receiving long-term care services has shown that spending growth was greater for states offering limited non-institutional services than for states with large, well established, non-institutional programs. H.S. Kaye et al., *Do Institutional Long-Term Care Services Reduce Medicaid Spending?*, 28 Health Affairs 262, 262 (Jan./Feb. 2009). Over time, states that invest in HCBS programs experience slower Medicaid spending than states with low HCBS spending. R. Mollica et al., AARP Pub. Pol'y Institute, *Taking the Long View:*

Investing in Medicaid Home and Community-Based Services is Cost-Effective, at 3 (Mar. 2009) *available at* http://assets.aarp.org/rgcenter/il/i26_hcbs.pdf. For example, a Lewin Group study found that HCBS programs produced savings in 1994 of $43 million in Colorado, $49 million in Oregon and $75 million in Washington. *Id.*

[146] Lewin Group, *MO HealthNet Long Term Care Review* (Nov. 2009) (revised Jan. 2010), *available at* http://www.dss.mo.gov/mhd/oversight/pdf/longterm-care2010jan07.pdf [hereinafter "Lewin Long Term Care Report"]. The report specifically recommends a "Right-Sizing Initiative" to move rates closer to the national average while reducing an excess supply of beds. *Id*. at 24.

[147] ACA § 2404.

[148] Missouri currently applies "spousal impoverishment" protections to home and community based care services (HCBS) to a limited extent. *See* Mo. Family Support Div., Mo. Income Maintenance Manual: Medical Assistance for the Aged, Blind and Disabled: Eligibility Based on Receipt of HCB Waiver Services, at § 0820.030.00 (2010), *available at* http://www.dss.mo.gov/fsd/iman/medasst/matoc.html [select "0820.020.00" hyperlink]; Mo. Family Support Div., Mo. Income Maintenance Manual: December 1973 Eligibility Requirements: Available Resources (OAA and PTD), at § 1030.035.00 (2010), *available at* http://www.dss.mo.gov/fsd/iman/dec1973/ertoc.html [select "1030.035.00" hyperlink]. The Affordable Care Act would apply "spousal impoverishment" protections far more broadly to *all* home and community based services, including "state plan" services rather than limiting the protections to the waiver programs to which Missouri current applies these protections. ACA § 2404. The ACA provision would also provide spousal impoverishment protections to aged, blind and disabled Missourians who are eligible only on a spenddown basis. *Id.* In addition, states will be required to consider only the income of applicants for HCBS waiver programs, and *not* the income of their community spouse, when they make eligiblity determinations. *See* 42 U.S.C. 1396r-5(b)(1).

[149] In addition to all of the provisions discussed herein, the new health care law provides $10 million for each of fiscal years 2010 through 2014 to expand Aging and Disability Resource Centers. ACA § 2405. These centers "assist seniors and people with disabilities in understanding and choosing among long-term care options including home and community based services as well as understanding preventive care and prescription drug coverage under Medicare." NHeLP, *supra* note 11, at 27.

[150] Nat'l Senior Citizens L. Ctr., *The Medicaid Long-Term Services and Supports Provisions in the Health Care Reform Law*, at 2 (Apr. 2010) *available at* http://www.nsclc.org/areas/medicaid/health-reform-ltss/at_download/attachment.

[151] ACA §§ 10202(c)(2)(A), 10202(d)(1).

[152] ACA §§ 102029c)(2)(B), 10202(d)(2). The Kaiser Foundation reports that Missouri spent 43.3% of its Medicaid long-term care funds on HCBS in FY 2008. Kaiser Family Found., State Health Facts: Missouri Distribution of Medicaid Spending on Long Term Care, FY 2008, http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=4&rgn=27&ind=180&sub=47 (last visited June 28, 2010).

[153] ACA § 10202(b),(c).

[154] ACA § 10202(e)(2).

[155] ACA §§ 10202(c)(1)-(6).

[156] ACA § 10202(f)(2). The program runs until September 30, 2015. *Id.*

[157] HHS has not specified its plans for oversight of these programs but the ACA does not include any penalties for states that fail to meet their targets.

[158] ACA § 2401, as amended by HCERA § 1205.

[159] ACA § 2401, as amended by HCERA § 1205.

[160] ACA § 2401, as amended by HCERA § 1205.

[161] ACA § 2401, as amended by HCERA § 1205. The ACA sets the income limit at the greater of 150% of the FPL or the state's income limit for nursing facility services. *Id.* However, while the income limit for nursing facility services in 38 states is set at 300% of the eligibility threshold for SSI, Missouri is not among them. *See* Kaiser Comm'n on Key Facts, *Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities*, at 3 (Feb. 2010), *available at* http://www.kff.org/medicaid/upload/8048.pdf.

[162] *See* Gene Coffey, Nat'l Senior Citizens L. Ctr., *The Medicaid Long-Term Services and Supports Provisions in the Senate's Patient Protection and Affordable Care Act*, at 5-7 (Jan. 2010), *available at* http://www.nsclc.org/areas/medicaid/the-medicaid-long-term-services-and-supports-provisions-in-the-senate2019s-patient-protection-and-affordable-care-act/at_download/attachment.

[163] ACA § 2402.

[164] Ctrs. for Medicare & Medicaid Servs., State Medicaid Director Letter, at 1-2 (Aug. 6, 2010), *available at* https://www.cms.gov/smdl/downloads/SMD10015.pdf [hereinafter "State Medicaid Director Letter Aug. 6, 2010"].

[165] *Id. See also* Steve Gold, Improving Access to Home and Community-Based Services-Informational Bulletin # 319 (Aug. 12, 2010), *available at* http://www.stevegoldada.com/stevegoldada/archive.php?mode=A&id=319;&sort=D

[166] *Id.*

[167] *Id.*

[168] State Medicaid Director Letter Aug. 6, 2010, *supra* note 164, at 3.

[169] *Id.*

[170] The ACA allows states to offer HCBS that differ in amount, duration, or scope as long as the services are within the scope of services described in Section 1915(c)(4)(B) of the Social Security Act. ACA, § 2402(b). However, while the State can offer these services to targeted populations, it can no longer waive the requirement that the services be provided statewide or place caps on enrollment for these services. ACA § 2402(e),(f). The program can be authorized for five years with the opportunity for a five-year renewal if the Secretary determines that the State has complied with the pertinent requirements. ACA § 2402(b).

[171] ACA §§ 2402(b), 10202(c)(1)(B).

[172] ACA § 2402(g).

[173] ACA § 2403(a)(1).

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[174] ACA § 2403(b)(1)(A).

[175] ACA § 2403(b)(2).

[176] *See* Lewin Long Term Care Report, *supra* note 146, at 18.

[177] *Id.* at 18-19, 33.

[178] *Id.* at 18-19.

[179] A lack of available housing has often been identified as a barrier for individuals who would otherwise benefit from the Money Follows the Person Program. *See*, *e.g.*, Mo. HealthNet Div., Mo. Dep't of Social Servs., *MFP Data Report* (Sept. 10, 2009) (identifying 14 individuals who could not be placed into the MFP Program because of a lack of affordable, appropriate, qualified housing). Lewin notes that a person admitted to a nursing home is roughly twice as likely to stay in the nursing home beyond 90 days in Missouri than in Oregon. Lewin Long Term Care Report, *supra* note 146, at 19.