



National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

Senate Finance Committee: Expanding Care Coverage Summary

Introduction

On May 11, 2009, Senator Baucus (D-MT) and Senator Grassley (R-IA) released a policy paper outlining policy options to provide affordable coverage to all Americans. These options outline a broad range of proposals for increasing the public and private health insurance coverage of uninsured individuals. The proposals deal with regulation reforms, Medicaid and Medicare expansions, and individual mandates. The document also outlines proposals to increase utilization of preventive care and wellness services.

Individual Market Reform

Non-Group, Micro-Group, and Small Group Market Reforms

The proposal imposes federal rating, guaranteed issue, and guaranteed renewal rules on all independently purchased coverage or group-coverage for 2-10 employees. The proposal would also prohibit excluding “pre-existing conditions” from coverage, and would restrict the ability to impose variable premiums. Premium adjustment would be limited to three factors: age, tobacco use, and family composition and could vary among rating areas to reflect geography. These rating rules would also apply to “small group” coverage (11-50 employees or as defined by states).

These changes would become effective on January 1, 2013, or sooner if possible, for non-group and micro-group markets which would allow for states to enact legislation by June 1, 2011. This would also allow for plans to develop offerings by June 2012 and begin marketing efforts. Federal rating rules for the small group market would be phased in over a three-to-ten year period as determined by the state and HHS Secretary. The proposal includes a federal fallback so that if states do not adopt federal rating rules (through licensing requirements or legislation), the Secretary could enforce the rules.

The proposal also requires the Secretary of HHS to implement a system for risk adjustment comparable to that used for Medicare payment adjustment for private plans. The Secretary could administer the risk adjustment or require states to do so. Additionally, the paper proposes to give states the option to merge pooling and rating rules for individual and small groups. This would allow a greater spread of risk to determine premiums in the individual and small group market.

Health Insurance Exchange

The policy paper proposes to create a national health insurance exchange that can be used to search for insurance options available in the state. All state-licensed private insurers in the non-group and small group markets, and the public health insurance option if applicable, would be required to participate in the exchange. The exchange would allow individuals to view and compare benefits, premiums and provider networks available based upon their zip code. The exchange would inform individuals of eligibility for public programs and would facilitate enrollment (either online, by mail, or in person at various locations) using a standardized application for plans participating in the exchange.

Micro-groups could purchase insurance through the exchange immediately while the remainder of small groups would be able to purchase insurance once the federal rating rules are fully phased in by that state. Individuals who currently have coverage, and small employers who currently provide coverage, would have the option of maintaining that coverage (grandfathered policies). Current tax exclusions for employer-provided health insurance would continue for small businesses that choose to purchase through the exchange.

State insurance commissioners would continue to provide oversight of plans with regard to consumer protections, rate reviews, solvency, reserve requirements and premium taxes. They would also provide oversight in regards to federal rating rules, additional state rating rules, and would facilitate risk-adjustment within services areas. Rating areas would be defined by State Insurance Commissioners and be reviewed by the Secretary.

The proposal includes an additional option to establish multiple, competing exchanges in addition to the national exchange established by the Secretary of HHS.

Making Coverage Affordable

Benefit Options

The proposal requires that individual and small group market health insurance plans provide, at a minimum, a broad range of medical benefits which meet the minimum standards set by federal and state laws. Plans could not include lifetime limits on coverage or annual limits on benefits and would not be allowed to charge cost-sharing for preventative care services. Another option proposed would be to allow nominal cost-sharing for prevention services.

All insurers would be required to offer coverage in each of four benefit categories: lowest, low, medium, and high. These categories vary by the percentage of actuarial value (the percentage of health care expenses paid by the plan). The proposal would require each plan design to apply parity for cost-sharing for the treatment of conditions within the benefit categories of inpatient hospital, outpatient hospital, physician services, and other items and services

including mental health services. Plans would also be required to meet Medicare part D class and category drug coverage requirements (generally plans must offer two drugs in each class or category). Lastly, the proposal requires that all insurers participating in the exchange to charge the same price for the same products in the entire state defined service area regardless of how the policy is purchased (from the exchange, from a broker, or directly from the insurance carrier).

Low-Income Tax Credits

Under the proposal, tax credits in the form of a “premium subsidy” would be provided for low income taxpayers (incomes under 400% of the federal poverty level) who purchase health insurance through the exchange. The tax credit would be effective for months of coverage beginning on or after January 1, 2013 and would be refundable and paid in advance to offset the cost of premiums. The level of coverage subsidized would be determined by an individual’s modified adjusted gross income and would fall under a high, medium, or low level benefit option. The subsidy would phase-out as an individual’s income increases.

The proposal included an alternative method of calculating the premium credit amount based on the enrollment-weighted average premium of the qualified low coverage option offered in the service area to be determined by the Secretary of HHS. Cost sharing assistance would be required with this method.

Small Business Tax Credits

The proposal would provide a tax credit to small businesses that provide health coverage for their employees based on the number of full-time employees and average employee earnings. The credit would phase-out for employers as the number of full-time employees and average employee earnings increased up to defined limits. The tax credit would not be paid in advance or refundable and would only be available to offset actual tax liability and employers would be required to claim the credit on their tax returns.

Public Health Insurance Option

Proposed Option A

The proposal includes three approaches for a public health insurance option for non-disabled individuals under 65 years of age. The first is a “Medicare-like” plan that would be established through the health insurance exchange. This plan would be administered by a new agency within HHS and eligibility rules, markets and income-related tax credits would mirror those for all plans offered through the exchange. Rating rules and risk adjustment would apply in the same way as rules to individual and small group market plans offered through the exchange. Medicare providers would be required to participate in the public option and would be paid Medicare rates plus 0-10%. The Medicare-like plan would not have solvency requirements and would start and accept enrollees on the same date the exchange begins.

The second approach would be similar to the first approach, but would be administered through multiple regional third-party administrators (TPAs) who report to the Secretary of HHS. TPAs would be required to establish networks of, and negotiate payments for, participating medical providers. This approach would have solvency requirements in that it requires reserve funds.

The third approach would be a state-run public option which could either be mandatory or optional for states but details of the administration of the plan would be left up to states. A possible option in the proposal was states allowing individuals to purchase coverage through state-employee plans.

Proposed Option B

The policy paper also presents the option of not including a public health insurance option and relies on reformed private options and a well regulated private market to expand coverage to this population.

The Role of Public Programs

Medicaid

Shortly after enactment of reform, States would be required to increase income eligibility for pregnant women, children and parents to a national “minimum” (ex: 150% of federal poverty level). States would also be required to maintain the income/eligibility for all of their other existing eligibility categories (such as spend-downs, Medicaid Buy-ins for Workers with Disabilities, etc). When the Health Insurance Exchange system is fully operational, all “obsolete eligibility categories” (as defined by the HHS Secretary) would be abolished. States would also not be allowed to allow income disregards for ANY Medicaid eligible population. All income would be measured based upon a “Modified Adjusted Gross Income” standard, which would also be used to determine eligibility for tax credits for purchasing private insurance.

The paper proposes 2 options to finance reform: either the Federal government would finance 100% of the costs for **newly eligible** Medicaid individuals due to the changes in this bill until 2015. Existing populations would continue to be funded at normal FMAP rates, and the Federal share of administrative costs would remain the same. Between 2016 and 2020, the state share would be gradually phased in (an additional 20% of the state share would be added each year). After that phase-in, regular FMAP would apply. As an alternate, the paper proposes paying an increased FMAP rate for all populations for an undefined time-period.

Additionally, the paper suggests that congress may impose a payment floor on Medicaid rates that is tied to a percentage of Medicare (e.g.: No Medicaid reimbursement can be less than 80% of what Medicare pays for the same or similar service).

Medicaid and the Health Insurance Exchange

The paper proposes 3 options for Medicaid to interact with the Health Insurance Exchange, which was proposed in section 1 (See page 2 of this summary).

Option 1: Medicaid Eligible individuals would not be eligible for tax credits to purchase insurance under the exchange. States would either be given the option to, or be required to, subsidize the premiums for people who are Medicaid eligible but who were receiving coverage through an employer.

Option 2: Individuals with disabilities, Medicare/Medicaid dual eligible participants, and other “special needs populations” would continue to be covered under existing state Medicaid structure. Children, parents, pregnant women, and childless adults would be covered through private insurance plans participating in the Exchange. The state would also have the option to provide premium assistance for employer-sponsored care. Under these private insurance plans, state Medicaid programs would be required to provide wrap-around coverage when the plans do not provide services that traditional Medicaid is required to provide (Such as EPSDT and Medical Transportation).

Existing requirements placed on Medicaid managed care organizations would apply to plans participating in Medicaid through the exchange. The paper also suggests some alternate variations under this option, including:

- Increasing FMAP reimbursement;
- Providing Medicaid eligible individuals with a choice of “high-option plans”;
- Allowing states to choose between enrolling beneficiaries in private plans through the Exchange or providing them with benefits through the current Medicaid structure;
- Allowing States to limit the populations that would be required to participate in private plans through the Exchange;
- Allowing States to create an Exchange plan, or to act as an Exchange plan; or
- Allowing state Medicaid programs to participate in the Exchange.

Option 3: Medicaid eligibility for children, pregnant women and parents would be expanded and these populations would continue to receive Medicaid under the current program structure. Childless adults under 115% FPL would not be covered under Medicaid, and instead would be eligible for Federal tax credits to purchase coverage, either privately through the Exchange, or as a voucher to “buy-in” to Medicaid (States would be required to accept these vouchers). Individuals who meet this criteria (and either enroll in private coverage or Medicaid) would receive the protections on cost-sharing and access to safety-net providers that are available to parents in Medicaid. The paper proposes some alternatives under this option, including:

- Having some of the childless adults (ex: up to 50% FPL) become fully Medicaid eligible, and the rest participate as described above;
- Giving states the option to accept the vouchers to buy-in to Medicaid, rather than making it a requirement; and

- Making Medicaid available to the “mandatory” populations through the Exchange, rather than automatically enrolling them into Medicaid;

Treatment of Territories

Under this proposal, US Territories would receive FMAP, calculated through the standard formula, and would not have a capped annual allotment. Territories would be required to adopt all of the Mandatory eligibility categories as State Medicaid programs.

Children’s Health Insurance Program

The CHIP program would remain as it is currently structured until the later of either: the end of the current program authorization, September 30, 2013, or the Exchange is fully operational. States would not be able to lower income eligibility levels for existing child categories during this period. After the later of the two dates, the Federal eligibility limit would increase to 275% FPL with no disregards and the Medicaid EPSDT benefit requirements would be extended to CHIP. As with the proposal for Medicaid, income counted for eligibility would be based on the family’s Modified Adjusted Gross Income.

Once the Exchange is fully operational, individuals in CHIP would obtain coverage through an Exchange plan. The plans would be subject to limitations on cost-sharing. States would contract with the Exchange plans and subsidize any premiums. States would also be required to provide wrap-around services for benefits in CHIP but not the Exchange plan. Other options suggested include:

- Allowing states to create or act as a Health Insurance Exchange Plan;
- Allowing states to create a Medicaid-only plan Exchange; and
- Limiting premium reimbursements to services covered in Medicaid but not in the Exchange Plan.

Quality of Care in Medicaid and CHIP

The proposal would apply similar quality measures to Medicaid as to CHIP. The quality measures are based on the CHIPRA law which directed the Secretary of HHS to develop health quality measures, a standardized format for reporting and procedures to encourage states to voluntarily report on the quality of care in Medicaid and CHIP.

The proposal would also appropriate \$10 Million for the Medicaid and CHIP Payment and Access Commission, which is intended to investigate and report a variety of issues surrounding Medicaid and CHIP payment rates and their effect on program outcomes.

Other Improvements to Medicaid

The paper outlines a number of options for changing Medicaid programs as part of the broader health care reform initiative. These include:

Enrollment and Retention: The proposal would eliminate the state-option to require face-to-face interviews for Medicaid applicants, and the state-option to apply an assets test when determining eligibility for acute care services. States would also be required to:

- Establish 12-month eligibility periods upon application/renewal;
- Establish a website to facilitate enrollment in Medicaid;
- Allow states to enroll beneficiaries at DSH Hospitals, FQHCs and DMV offices; and
- Extend the “Express Lane Agency” eligibility process, as defined in the CHIPRA legislation, to all Medicaid eligible individuals.

The proposal would also require the HHS Secretary to develop a process to coordinate ongoing eligibility and enrollment for individuals who frequently move between states.

Family Planning Services: the proposal creates a new optional eligibility group to provide family planning services and supplies to non-pregnant women. The financial eligibility would be set, at the state’s option, to either the highest level for pregnant women under Medicaid/CHIP or to individuals who are eligible under 1115 family planning waivers.

Selected Optional Benefits: The proposal would allow podiatrists, optometrists, and birth centers to be Medicaid providers.

Interstate Coordination: The proposal would also require coordination between states to ensure that a Medicaid program will cover an eligible child’s medical costs when he/she is out of the state.

Prescription Drugs: The proposal would make prescription drugs a mandatory covered benefit for both categorically and medically needy populations. The proposal would also allow Medicaid to cover smoking cessation drugs, barbiturates and benzodiazepines.

Additionally, the proposal would revise the way that Medicaid pays for prescription drugs. The Federal Upper Limit would be increased from 250% to 300% of the Average Manufacturer Price (as defined and calculated by CMS). The proposal would also define and clarify additional aspects of the Average Manufacturer Price Calculation, and would add a new prior-authorization requirement to increase the utilization of less-expensive generic drugs.

Section 1115 Waivers: the proposal would impose statutory requirements regarding transparency when states develop, implement and evaluate section 1115 waivers under Medicaid and CHIP. These requirements might include:

- Providing notice of the intent to develop/renew an 1115 waiver, and holding at least one meeting of the state’s medical advisory board;
- Soliciting written comments on the proposal;

- Making the waiver available on the state website; and/or
- Convening open meetings during the proposal development.

The proposal would also apply statutory requirements on the HHS Secretary regarding transparency of 1115 waiver proposals. These requirements could include:

- Publishing information regarding waiver proposals, approvals and denials in the Federal Register;
- Publishing a copy of the proposed waiver on the CMS website;
- Publishing the proposal and soliciting comment from the public, and publishing the comments received; and/or
- Publishing waiver terms and conditions, data and evaluations on the website.

State Plan Amendments: The proposal would also add similar transparency provisions with the State Plan Amendment process. States may be required to:

- Provide notice of intent to develop a SPA and hold at least one meeting of the state's medical advisory board to discuss the proposed changes;
- Publish notice of the proposal and solicit comments;
- Post the SPA proposal on the state website; and/or
- Convene at least one public meeting on the proposed SPA.

The HHS Secretary would also be subject to new transparency requirements that could include:

- Publishing a copy of the proposed SPA on the CMS website;
- Publishing the proposal and soliciting comment from the public, and publishing the comments received; and/or
- Publish a notice in the Federal Register identifying SPA approvals, denials and returns to the state.

Changes to the FMAP Formula: The proposal would revise the FMAP formula to account for both the state's average per-capita income as well as the percentage of the state population that is below the federal poverty line. The calculation would be done based on a 2-year period, rather than the 3 year period in current statute.

Please note: Several of the trial calculations have indicated that there may be an error in this section's formula. Further clarification is needed.

The proposal would also add an automatic FMAP increase during times of economic downturn. During periods where at least 23 states show a 10% increase in average unemployment rate during a quarter, as compared to the same quarter 2 years prior, states with increased unemployment rates would receive additional FMAP. The increase in FMAP would be based on the increased medical costs attributable to the economic downturn. The increase in FMAP would be gradually phased out as the economy recovers.

DSH Hospital Payments: The definitions and calculations for DHS allotments would remain the same. The HHS Secretary would automatically disperse DHS payments directly to qualifying hospitals.

Dual Eligible Individuals: The proposal includes a number of provisions to improve coordination of care for individuals who are Medicare and Medicaid eligible. The provisions include:

- Creating a new Medicaid Demonstration authority to explore new ways for care coordination of Dual Eligible beneficiaries. The authority would last for five years;
- Modifying 1915(b) waiver authority to allow states to use federal Medicare cost savings in the budget neutrality section; and
- Creating an Office within CMS that is responsible for coordinating care, funding and policies across Medicaid and Medicare.

Medicare Waiting Period: The white paper proposes reducing or eliminating the 24-month waiting period between when an individual becomes eligible for Social Security Disability Insurance and when they become eligible for Medicare. Four options are provided for addressing this situation:

- Option 1: Reduce the period from 24 months to 12 months;
- Option 2: Gradually reduce the waiting period from the current 24 months to zero months over a period from 2009 – 2015;
- Option 3: Phase out the waiting period based upon the date of disability determination, as follows:
 - 24 month waiting period for persons who acquired their disability before October 1, 2009;
 - 18 month waiting period for persons who acquired their disability between October 1, 2009 and March 31, 2010;
 - 12 month waiting period for persons who acquired their disability between April 1, 2010 and September 30, 2010;
 - 6 month waiting period for persons who acquired their disability between October 1, 2010 and March 31, 2011; and
 - No waiting period for individuals who acquired their disability after April 1, 2011.
- Option 4: The 24 month period would remain for individuals who had access to private health insurance (other than COBRA). For all other individuals, one of the 3 phase-out options would be enacted.

Temporary Medicare Buy-in: the paper outlines one option for providing Medicare to uninsured, older individuals who do not yet qualify for Medicare. Under this option, between January 1, 2011 and the enactment of the Health Insurance Exchange, individuals who are 55-64 and who do not have access to employer sponsored insurance would be able to buy-in to Medicare. These individuals would pay a premium of expected average cost of benefits for Medicare participants plus an administrative fee of 5%. If the actual cost of benefits exceeds the premium, the individuals would be required to continue paying an

additional Medicare premium until age 85. If the actual cost of benefits is less than the premium, the individuals would receive a rebate on Medicare premiums once they reach normal Medicare age.

In addition to the option outlines, the paper notes that the committee is seeking input for an alternative way to provide coverage to uninsured older Americans who do not yet qualify for Medicare.

Long Term Care Services and Supports

Medicaid Home and Community Based Services (HCBS) Waivers and the Medicaid HCBS State Option

Under the proposal, individuals would be able to enroll in more than one Medicaid waiver simultaneously. The institutional level-of-care eligibility requirement for section 1915(c) waivers would be eliminated and states would be required to replace it with less stringent criteria.

States would be allowed to offer additional services under the Medicaid HCBS State Plan Option as approved by the Secretary of HHS. The proposal would eliminate 1915(i) service provision restrictions to individuals with incomes over 150% FPL. States would have the option to confer eligibility for section 1915(i) HCBS services as well as full Medicaid benefits to individuals who meet needs-based criteria with income up to a state specified level, not to exceed 300% of the maximum SSI payment. Individuals with Miller Trusts would also be able to qualify through this income rule eligibility pathway.

The proposal includes three approaches to increase access to Medicaid HCBS services: 1) increase the number of individuals under the cap that states have to enroll in either sections 1915(c) or 1915(i) or both; 2) to prohibit states from utilizing waiting lists for HCBS services; and 3) provide the committee with input on ways to ensure that individuals are able to access HCBS. The proposal would also provide a 1% increase the federal match for Medicaid HCBS.

The proposed option would amend Medicaid law to require that states apply spousal impoverishment rules to individuals applying for HCBS under sections 1915(c), (d), (e), (i), (k), section 1115 of the Social Security Act, and HCBS services for the medically needy. Regarding resources, states would be authorized to allow individuals applying for HCBS to retain higher levels of assets. States could continue to use section 1902(r)(2) to disregard assets for this population and the look-back period for asset transfers would be reset to 36 months under the proposal. The penalty period would remain unchanged.

Grants would be made available under this proposal for the Secretary of HHS to award to eligible states. This discretionary funding could be used for activities to facilitate the delivery of HCBS. ADRCs would also continue to be funded through this proposal.

CMS was directed through the Deficit Reduction Act of 2005 (DRA) to develop a Continuity Assessment Record and Evaluation (CARE) tool to measure several factors and outcomes for post acute care (PAC) Medicare beneficiaries. The proposal would provide a timeframe for CMS to implement this tool. The proposal would also extend the Money Follows the Person Demonstration that was established through the DRA from September 30, 2011 to September 30, 2016.

Shared Responsibility

Personal Responsibility Coverage Requirement

The policy paper proposes the option of a personal responsibility requirement for individuals to obtain health insurance. There would be a three month initial open-enrollment period for eligible individuals in the non-group market with special enrollment periods allowed for qualifying events and annual open-enrollment periods where an individual can change plans.

Another option proposed is an initial 45-day open enrollment period where all coverage is guaranteed issue with no limits on pre-existing conditions. If an individual does not enroll during this period, insurance carriers would be allowed to exclude pre-existing conditions for up to 9 months and charge higher premiums. Current enrollees could only change plans annually excepting special changes allowed under COBRA.

The proposal requires that all individuals purchase coverage through the individual market, a grandfathered plan, or in the group market. Coverage requirement exemptions would be allowed for religious objections (consistent with those allowed under Medicare) and undocumented aliens. Compliance would be ensured by requiring taxpayers to report the months they had the required minimum coverage on their tax returns and requiring insurers to report months of coverage to individuals and the IRS. A phased-in excise tax would be applied to those not insured though individuals could apply for an exemption from this penalty.

The individual requirement would be effective beginning January 1, 2013 or sooner if possible.

Employer Requirement

The proposal outlines two options for the employer requirement. The first option requires that all employers with more than \$500,000 in payroll for a taxable year offer their full-time employees health insurance coverage or pay an assessment. The employer would be required to provide for at least 50 percent of the premium for the employer-sponsored insurance. If the employee accepts the coverage, the employee will receive the tax exclusion for employer provided health insurance, but will not receive the income-based tax credit. If the employee opts out of employer coverage, the employee may be eligible for the income-based tax credit. Employers who do not demonstrate that they offered the required

level of coverage to their employees, would have to pay an assessment based on total annual payroll amounts.

Under this option, states would be required to offer current-law Medicaid premium assistance to eligible individuals who are offered employer-sponsored coverage.

The second option would have a coverage requirement for individuals. Medicaid eligible individuals who are offered employer-sponsored coverage could enroll in an individual policy using the combination of premium and cost sharing assistance through Medicaid and low-income tax credits offered under this proposal.

Options to Improve Access to Preventative Service and Encourage Healthy Lifestyles

Promotions of Prevention and Wellness in Medicare

The proposal authorizes a free comprehensive health risk assessment (HRA) either through an interactive telephonic or web-based program or during a visit with a health care professional as determined by the Secretary. The assessment would be designed by the Secretary in consultation with relevant groups and entities. Within six months of the HRA, Medicare would pay for a visit to a qualified health professional to complete a personalized prevention plan at no cost to the beneficiary. The plan would include various medical elements, a schedule and referral for recommended preventative services and immunizations, strategies to address conditions and risk factors, identification of all medications and providers involved in an individual's care, and health advice and referrals to Medicare-covered health education and preventative counseling or referral to community based interventions to address modifiable risk factors. Other optional elements can also be included.

The proposal includes the option to remove limit beneficiary cost-sharing for preventative services covered under Medicare that are rated "A" and "B" by the United States Preventative Services Task Force (USPSTF). The Secretary would be encouraged to establish a mechanism to provide refunds or other incentives to beneficiaries who successfully comprehensive, evidence-based behavior-modification programs. Programs must be widely available and easily accessible to beneficiaries. The option would seek to improve provider education and patient awareness of covered preventative services.

The Secretary of HHS would have the authority under this option to withdraw Medicare coverage for certain preventative services unless deemed medically necessary by a physician.

Promotions of Prevention and Wellness in Medicaid

The proposed option would define "screening and preventative" services covered at the states' option for adults as those services rated "A" and "B" by the

USPSTF and immunizations recommended by the Advisory Committee on Immunization Practices. States who provide Medicaid coverage for all approved preventative services and immunizations would receive a 1% increase in the federal share of its FMAP for those services. States would be required to provide Medicaid coverage for comprehensive tobacco cessation services for pregnant women with no cost-sharing requirements.

As in the Medicare option, the option would remove or limit cost-sharing for clinical preventative services rated “A” and “B” by the USPSTF. States would be permitted to design a proposal and apply for funding to explore a mechanism to provide refunds or other incentives to beneficiaries who successfully complete comprehensive, evidence-based behavior-modification programs. Programs must be widely available and easily accessible to individuals. The state’s plan must include plans to improve provider education and patient awareness of covered preventative services. Funding for states will be capped.

Options to Prevent Chronic Disease and Encourage Healthy Lifestyles

The proposal mentions the option to promote prevention and wellness in the short-term until the exchange is operational through annual “RightChoices” grants to states. These capped grants would provide access to certain evidence-based primary preventative services.

Another proposed option would establish a competitive grant program to promote health and human services program integration, improve care coordination, improve access to preventative services, and better integrate health care service delivery to improve outcomes. Three approaches for states are identified, but the option includes flexibility to encourage other innovations.

In one approach, states would submit an application to the Secretary to create locally integrated delivery systems including the establishment multidisciplinary care teams. Community health teams would be required to provide comprehensive care coordination and support, referral to and coordination with community based programs, and comprehensive transitional assistance from inpatient care settings. They will also be required to assure appropriate follow up.

Another approach would allow states to integrate services and to develop an individualized plan to address the needs of low-income beneficiaries. The last approach would allow states to submit an innovative proposal that meets the goals and objectives of this grant. An evaluation component must be included in the proposal that assesses the impact of the proposed innovation on the health status of individuals.

This option would also require HHS to review and improve the administration of its low income programs. HHS would be required to conduct a study of best practices at the end of the grant period to improve wellness outcomes for low-income families. Best practices would then be issued to states who would be

required to submit a plan to better integrate services for low-income families to HHS within two years of the issuance.

Employer Wellness Credits

Under the option, if an employer offers a “qualified wellness program” during a taxable year, the employer would receive a non-refundable tax credit for 50 percent of the program’s cost (not including food or health insurance). The employer would have to obtain a certification from the Secretary that the program meets the definition of a qualified wellness program to be eligible for the credit. This credit would not be paid in advance and has a five year maximum. Another option provides employers with 50 or fewer employees a credit that has no sunset requirement.

Options to Address Health Disparities

To address health disparities, this proposal would require the Social Security Administration (SSA) to collect race, ethnicity, and language data on Medicare enrollees and would provide funding to upgrade and integrate SSA databases. Additionally, federally funded population surveys would be required to collect sufficient data to generate statistically reliable estimates in health disparities studies. Quality reporting requirements would include proposals to collect data on individuals by race, ethnicity and primary language. Provisions to collect data on individuals with disabilities by disability type would be included in quality reporting requirements. The proposal would also extend the MIPAA provisions pertaining to health disparities data collection to the Medicaid and CHIP populations.

The proposal would seek to establish uniform categories for collecting data on race and ethnicity requiring the use of OMB standards. Funding for technology upgrades would be provided to states to allow for the adoption of OMB categories as OMB standards would apply to Medicaid. Primary language data on CHIP enrollees and their parents would be collected by CMS. Access and treatment data collection for individuals with disabilities would also be required of CMS. Additionally, health care quality data would have to be published by race, ethnicity, and gender.

The federal matching rate of 75% for translation services would be extended to all Medicaid beneficiaries for whom English is not the primary language. Private insurers in the Health Insurance Exchange would be held to national standards for the delivery of culturally and linguistically appropriate health care services (CLAS). Grants for outreach and enrollment efforts would also be established under the proposal. States would have the option of extending coverage to non-pregnant, legal immigrants during their first five years in the United States. States, tribes, and territories would also receive grant funding through Title V – Maternal and Child Health Services Block Grants to develop and implement targeted approaches to reduce infant mortality.