

States Ramp Up Efforts in 2011 to Address Health Reform Implementation

By Caroline Jennette

Although the biggest health reform changes are not slated to become effective until 2014, several provisions going into effect this year will affect state Medicaid programs. The new political climate in Washington and courtroom battles may bring about significant changes to the Affordable Care Act (ACA), but states continue to move forward in implementation.

Changes to Medicaid in 2011

States continue to buckle under budgetary restraints, spending on average 16 percent of their general fund budgets on Medicaid. Several ACA provisions that become effective this year may help state Medicaid programs implement new service delivery systems, streamlining care and reducing future health care costs.

In January, states were given the op-

tion to create so-called health homes, an expansion of the medical home model already used in many state Medicaid programs. States that take up this option or that expand already existing managed care programs will qualify for 90 percent federal matching payments for the first two years the health home model is in effect. States also have the option, this year, to apply for grants supporting the development of state programs to ad-

dress chronic disease prevention.

In October, an ACA provision is slated to go into effect that expands access to Medicaid home- and community-based services (HCBS) programs. The State Balancing Incentive Program will provide enhanced federal matching to states increasing non-institutionally based long-term services. States can receive matching funds until 2015, and funds must be used to expand or enhance HCBS. A new program will also be established to help states provide statewide home- and community-based attendant supports and services to low-income individuals who need assistance with daily living activities and health related tasks.

Preparing for health exchanges

Health insurance exchanges (HIEs), among the most talked-about provisions of the ACA, are scheduled to go into effect January 2014. Each state will be responsible for creating and administering a virtual “marketplace” of qualified health plans for health care consumers to “shop” for health insurance plans. Eligibility is restricted to consumers who lack access to employer- or government-sponsored insurance and to small businesses with ≤100 employees. The HIEs will also provide enrollment guidance and filter eligible individuals into appropriate public plans. Other responsibilities of state HIEs include offering standardized information to help consumers choose between plans, creating a single enrollment form for all plans in the exchange, determining eligibility for subsidies and public programs, and providing navigators to help consumers review their plan choices and enroll.

States can opt out of creating their own HIEs and can have the federal government provide one instead, but they will risk losing federal tax credits and having less control over the state insurance market. Although states have until 2013 to notify the Secretary of Health and Human Services as to whether they intend to run an HIE, grants of up to \$1 million have already been awarded to 48 states and the District of Columbia to conduct research and begin planning the design of HIEs. The Department of Health and Human Services will also award Early Innovator grants this year. As many as five states could receive funding to develop information technology infrastructures necessary for operating state exchanges.

For more information on health reform implementation, see www.healthreformgps.org, <http://healthreform.kff.org>, and www.healthcare.gov

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