



MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM PROVISIONS IN HEALTH REFORM BILLS: Affordable Health Care for America Act & The Patient Protection and Affordable Care Act

The Affordable Health Care for America Act (HR 3962) as passed by the House on November 7, 2009 and the Patient Protection and Affordable Care Act (HR 3590) as passed by the Senate on December 24, 2009 include an individual requirement to obtain health insurance, a significant Medicaid expansion and subsidies to help low-income individuals buy coverage through a newly established health insurance exchange. This analysis looks at the provisions related to Medicaid and the Children's Health Insurance Program (CHIP) compared to current law.

Medicaid Coverage and Financing. Both the House and Senate proposals would expand Medicaid to a national floor of poverty to help reduce state-by-state variation in eligibility for Medicaid and also include adults under age 65 without dependent children who are currently not eligible for the program. The House bill expands Medicaid to 150% of poverty in January 2013 with 100% federal financing for 2 years and 91% federal financing beginning in year 2015 for new eligibles and some current eligibles covered by a waiver. This additional federal financing applies to states that have expanded coverage for parents and childless adults through a Medicaid waiver. Under a maintenance of eligibility (MOE) requirement, all individuals eligible for Medicaid above 150% of poverty as of June 16, 2009 would continue to be eligible for Medicaid.

The Senate would expand Medicaid to 133% of poverty (based on modified adjusted gross income or MAGI) by January 2014 with 100% federal financing for 2014 through 2016, then differential increases in match rates for expansion states (those that had already expanded coverage for adults at or above 100% FPL) and other states that equalize so by 2019 all states would receive an increase of 32.3 percentage points (capped at 95% FMAP) for newly eligible populations.¹ This financing does not apply to states that have already expanded coverage for parents or childless adults through a waiver. The Senate bill includes a Medicaid MOE for children through 2019 and for adults until 2014.

Children's Health Insurance Program (CHIP). Under the House bill, the CHIP program would be eliminated at the end of 2013 and children in separate state CHIP programs with incomes below 150% of poverty would be transitioned to Medicaid and those with incomes above 150% of poverty would be transitioned into the new health insurance exchange. A CHIP MOE would be in place from June 16, 2009 through December 31, 2013; this MOE would continue to apply for children in Medicaid expansion CHIP programs (M-CHIP) beyond 2013. Children with incomes above 150% of poverty enrolled in M-CHIP programs would keep Medicaid coverage and states would receive the enhanced CHIP match rate for these children starting in 2014. The Senate bill continues CHIP through 2019, and includes funding for CHIP through 2015. CHIP-eligible children who cannot enroll in the program due to federal allotment caps must be screened to determine if they are eligible for Medicaid and if not would be eligible for tax credits in a plan that is certified by the Secretary by April 2015 to be comparable to CHIP in the exchange.

Benefits and Access. Both major reform bills include some important changes related to benefits and access. The House bill would increase Medicaid payment rates for primary care providers to 100% of Medicare rates by 2012 and would also require states to submit a state plan amendment specifying the payment rates to be paid under the state's Medicaid program. The House bill requires coverage for certain preventive services and vaccines with no cost sharing. Both the House and the Senate bills broaden the scope of the Medicaid and CHIP Payment and Access Commission (MACPAC) to include all eligible individuals (not just children), establish the Center for Medicare and Medicaid Innovation to test payment and service delivery models to improve quality and efficiency, and includes funding for pilot programs for medical homes and accountable care organizations.

¹ Nebraska, which will continue receiving 100% federal funding for new eligibles after 2017, and certain states not eligible for the enhanced federal funding because they had already expanded Medicaid to adults with incomes above 133% FPL, would receive a 2.2 percentage point increase in their FMAP for parents and childless adults who are not newly eligible for 2014 through 2019 or a .5 percentage point increase in the FMAP for all medical assistance for 2014 through 2016 for the State with the highest percentage of its population insured in 2008.

Duals and Long-Term Care. The House bill provides payment of Part B deductibles and cost sharing under Medicaid for Medicare beneficiaries under age 65 with incomes below 150% of poverty, subject to regular Medicaid matching rate. These individuals are not eligible for full Medicaid benefits. Both the House and the Senate bills establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Both bills also require the Secretary to improve coordination of care for dual eligibles through a new office within the Centers for Medicare and Medicaid Services. The Senate bill makes some improvements to Medicaid home and community based services.

Cost Estimates. The Congressional Budget Office (CBO) estimates that the House bill will increase Medicaid/CHIP coverage by 15 million from 35 million by 2019 with a federal Medicaid/CHIP cost of \$425 billion from 2010 to 2019 and an estimated increase in state spending of \$34 billion. Other significant federal Medicaid costs over the 2010 to 2019 period in the House bill are related to: payments to primary care practitioners (\$57 billion); extension of ARRA funds through June 30, 2011 (\$23.5 billion); Medicare cost sharing assistance (\$7.2 billion), and coverage of preventive services (\$10.7 billion). CBO estimates that the Senate bill will increase Medicaid/CHIP coverage by 15 million from 35 million by 2019 with a federal Medicaid/CHIP cost of \$395 billion from 2010 to 2019 and an estimated increase in state spending of \$26 billion. Both bills include significant federal Medicaid savings over the 2010 to 2019 period are related to changes in Medicaid prescription drugs and reductions in Medicaid disproportionate share hospital payments or DSH.

A more detailed analysis of Medicaid and CHIP provisions in the House and Senate bills follow. A comprehensive side-by-side of this proposal in addition to other leading health proposals can be found at www.kff.org/healthreform/sidebyside.cfm.

SIDE-BY-SIDE OF MEDICAID AND CHIP PROVISIONS: Current Law Compared to Health Reform Proposals

This side-by-side compares the Medicaid and CHIP provisions in the Affordable Health Care for America Act, passed by the House on November 7, 2009 and the Patient Protection and Affordable Care Act, passed by the Senate on December 24, 2009 to current law. This analysis focuses on Medicaid coverage and financing changes; how Medicaid and CHIP interface with a new health insurance exchange, and other Medicaid benefits and access changes. A more comprehensive side-by-side of health reform proposals can be found at: www.kff.org/healthreform/sidebyside.cfm.

	Current Law	House Bill Affordable Health Care for America Act (HR 3962)	Senate Bill Patient Protection and Affordable Care Act (HR 3590)
Date plan announced		Introduced October 29, 2009.	Introduced November 18, 2009.
Status		Passed by the House on November 7, 2009.	Passed by the Senate on December 24, 2009.
Overall approach to expanding access to coverage		<p>Requires most individuals to have health insurance through a combination of public and private coverage expansions.</p> <p>Expands Medicaid to 150% of the poverty level and provides premium and cost-sharing credits to individuals/families with incomes up to 400% of poverty and not eligible for coverage through Medicaid or employers to purchase health coverage in a new Health Insurance Exchange in 2013.</p>	<p>Requires most individuals to have health insurance through a combination of public and private coverage expansions.</p> <p>Expands Medicaid to 133% of the poverty level in 2014 and maintains CHIP and Medicaid for children through 2019.</p> <p>Creates state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals / families with income between 100-400% of poverty and creates separate exchanges through which small businesses can purchase coverage.</p>
Medicaid eligibility for children, pregnant women, parents and individuals with disabilities	<p>Individuals must meet categorical and income standards to be eligible for Medicaid. The federal government sets minimum eligibility standards and states have flexibility to expand coverage beyond these minimum levels for most groups. In general, states also have flexibility to determine income and resource methodologies for purposes of determining Medicaid eligibility.</p>	<ul style="list-style-type: none"> Establishes a minimum Medicaid coverage threshold for all children, parents and individuals with disabilities under age 65 (Traditional Medicaid Eligible Individuals) up to 150% FPL with no resource or asset test (Implementation: January 1, 2013). Requires states that currently cover children between 100% and 150% FPL under a separate CHIP program to transition coverage to Medicaid. 	<ul style="list-style-type: none"> Establishes a minimum Medicaid coverage threshold for children ages 6 to 19 and parents with incomes up to 133% FPL. (Implementation: January 1, 2014). Bases eligibility on modified adjusted gross income (MAGI) without income disregards, assets or resource test (maintains existing income counting rules for the elderly and groups eligible through another program like foster care, low-income Medicare beneficiaries and Supplemental Security Income (SSI)). (Implementation: January 1, 2014). MAGI would not apply to beneficiaries enrolled as of January 1, 2014, until March 31, 2014 or their next re-determination date.

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<p>Medicaid eligibility for children, pregnant women, parents and individuals with disabilities (continued)</p>	<p>States must cover children under age 6 with family income below 133% federal poverty level (FPL); children age 6 to 18 with family incomes below 100% FPL. Current eligibility for Medicaid and CHIP:</p> <ul style="list-style-type: none"> 4 states <200% FPL 23 states 200 – 250% FPL 24 states >250% FPL <p>States must cover pregnant women with income below 133% FPL.</p> <ul style="list-style-type: none"> 11 states at 133-184% FPL 16 states 185% FPL 24 states >185% FPL <p>States must cover parents below states' July 1996 welfare levels.</p> <p>For Parents:</p> <ul style="list-style-type: none"> 39 states <133% FPL 12 states > or = 133% FPL <p>State must cover most elderly and persons with disabilities receiving Supplemental Security Income (SSI) and certain low-income Medicare beneficiaries.</p>	<ul style="list-style-type: none"> • Extends Medicaid eligibility status to any newborn who does not have acceptable coverage for 60 days (until transition to Medicaid or other qualified coverage). If there is no determination for Medicaid or qualified coverage at the end of 60 days the child is deemed Medicaid eligible. • Preserves Medicaid eligibility for youths upon release from public institutions and requires states to ensure enrollment. 	
<p>Eligibility for adults without dependent children</p>	<p>Adults without dependent children are not included in the categories of people states can cover through Medicaid under current rules. States can only cover these adults if they obtain a waiver or create a fully state-funded program.</p> <p>As of 2009, 5 states provide coverage to childless adults that is comparable to Medicaid, 15 states only provide coverage more limited than Medicaid, and an additional 4 states solely provide premium assistance with employment-related eligibility requirements.</p>	<ul style="list-style-type: none"> • Establishes new Medicaid coverage for non-Medicare eligible childless adults under age 65 who are not eligible for Medicaid on the basis of disability or pregnancy ("Non-Traditional" Medicaid Eligible Individuals) up to 150% FPL with no resource or asset test (Implementation: January 1, 2013). 	<ul style="list-style-type: none"> • Establishes a new eligibility category for all non-pregnant, non-Medicare eligible childless adults under age 65 who are not otherwise Medicaid and requires minimum Medicaid coverage at 133% FPL based on modified adjusted gross income (MAGI) (Implementation: January 1, 2014). • Creates a state option to cover childless adults through a Medicaid State Plan Amendment (Implementation: April 1, 2010).

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<p>Other coverage</p>	<p>Medicaid provides a range of assistance for low-income Medicare beneficiaries. For individuals dually eligible for Medicare and Medicaid, Medicaid pays for all Medicare premiums and cost-sharing plus wrap around coverage; for Qualified Medicare Beneficiaries (QMBs) Medicare eligibles at or below 100% FPL Medicaid pays for all Medicare premiums and cost-sharing charges; for Specified Low-Income Medicare Beneficiaries (SLMBs) between 100% FPL and 120% FPL; Medicaid pays for Medicare Part B premiums, and for Qualifying Individuals 1(QI1s) between 120% FPL and 135% FPL Medicaid pays Medicare Part B premiums but the benefit is subject to an annual funding cap.</p> <p>States have many other optional coverage categories such as: medically needy (individuals spend-down to eligibility levels by deducting medical expenses); waiver coverage for home and community based services or family planning; and uninsured women with breast or cervical cancer screened by CDC. There is a 2 year waiting period for Medicare for individuals with disabilities.</p>	<ul style="list-style-type: none"> • Provides Medicare cost-sharing under Medicaid, subject to regular federal matching rate, for Medicare beneficiaries under age 65 whose income is less than 150% of poverty but who otherwise would meet the eligibility criteria for Qualified Medicare Beneficiaries (QMB) (Implementation: January 1, 2013). • Extends the QI1 program through December 2012 and removes the annual funding cap. • Provides optional Medicaid coverage with optional presumptive eligibility determinations for family planning services to non-pregnant individuals with incomes that do not exceed the highest income eligibility for Medicaid or CHIP for pregnant women (Implementation: Upon enactment). • Provides optional Medicaid coverage to low-income HIV-infected individuals (Implementation: Upon enactment through January 1, 2013 when exchange plans are operational). This coverage would be eligible for the CHIP level (enhanced match rate). • Requires the Secretary to issue guidance regarding standards and best practices for outreach for Medicaid and CHIP targeted to vulnerable populations (Implementation: Within 12 months of enactment). • Extends TMA through December 31, 2012. • Clarifies coverage and exemption from the 5 year ban for citizens of freely associated states residing in the US (Micronesia, Republic of Marshall Islands and the Republic of Palau). • Provides a state option to disregard income in providing continued Medicaid coverage to individuals with high prescription drug costs. 	<ul style="list-style-type: none"> • Establishes Medicaid coverage (with EPSDT benefits) for children under age 25 who were in foster care when they turned 18 (Implementation: January 1, 2014). • Provides optional Medicaid coverage for family planning services to certain low-income individuals up to the highest level of eligibility for pregnant women (Implementation: Upon enactment). • Requires states to report annually beginning January 2014 on changes in Medicaid enrollment by population, outreach and enrollment processes and other data to monitor enrollment and retention of Medicaid eligible individuals. Then HHS would report findings to Congress annually on a state-by-state basis.

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Maintenance of Eligibility (MOE)	While states generally have flexibility to change optional eligibility levels the American Recovery and Reinvestment Act (ARRA) that provided additional funding for states in the form of an enhanced FMAP requires states to maintain eligibility levels and enrollment procedures from July 1, 2008 to be eligible for enhanced funds.	<ul style="list-style-type: none"> • Requires a MOE for Medicaid to June 16, 2009. Eligibility standards, methodologies, or procedures (includes waivers) may not be more restrictive than what was in place as of June 16, 2009. • Requires a MOE for CHIP to June 16, 2009 through December 31, 2013; extends the MOE for children in Medicaid expansion CHIP programs (M-CHIP) with incomes above 150% FPL. • Provides an exception to the MOE for certain waivers that permit individuals to receive premium or cost-sharing subsidy for individual or group coverage provided in 2013. 	<ul style="list-style-type: none"> • Requires states to maintain current income eligibility levels for children in Medicaid and CHIP through September 30, 2019. • Requires states to maintain Medicaid eligibility levels until the Secretary determines that the state exchanges are fully operational (expected to be January 1, 2014). • Exempts states from the maintenance of effort requirement for non-disabled adults with incomes above 133% FPL starting in January 2011 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year. • Requires states to establish equivalent income thresholds to implement the MOE using MAGI that ensures that individuals eligible at the time of enactment do not lose coverage.
Role of CHIP	Enacted in 1997 to cover low-income uninsured children who were not eligible for Medicaid. Provides an entitlement to funding for states, not for beneficiaries. CHIP was reauthorized through 2013 in February 2009 with expanded funding, new coverage options, new tools to increase enrollment, fiscal incentives to cover more children, new benefit requirements and new quality initiatives.	<ul style="list-style-type: none"> • Requires 12-month continuous eligibility for children with incomes below 200% FPL (Implementation: January 1, 2010). • Prevents the application of a coverage waiting period for children under 2 years of age for whom health coverage is unaffordable (premiums, co-payments, deductibles and other cost sharing exceed 10% of family income) (Implementation: 90 days after enactment). • Requires an MOE for CHIP to June 16, 2009 through December 31, 2013. • Requires the Secretary to submit a CHIP transition report to Congress by December 31, 2011 that compares benefits under an average CHIP plan to the benefit standards in the NHI Exchange. The report must include recommendations to ensure that coverage in the Exchange is at least comparable to coverage provided under an average CHIP plan and that there are procedures in effect to transition CHIP enrollees (including pregnant women) from CHIP into the Exchange by December 31, 2013 without interruption of coverage or written plan of treatment. 	<ul style="list-style-type: none"> • Maintains the current CHIP structure and requires states to maintain income eligibility levels for Medicaid and CHIP through 2019. Beginning January 1, 2014, use MAGI to determine eligibility. • Requires that CHIP-eligible children who cannot enroll in CHIP due to federal allotment caps must be screened to determine if they are eligible for Medicaid and if not would be eligible for tax credits in a plan that is certified by the Secretary by April 2015 to be comparable to CHIP in the exchange. • Does not extend the CHIPRA enrollment bonuses beyond 2013. • Extends funding for CHIP through 2015. • Creates a new option for states to provide CHIP coverage to children of state employees eligible for health benefits if the state premium contribution for family coverage is less than 1997 levels (adjusted for inflation) or if the employee's premiums and cost sharing exceeds 5 percent of the family's income. • Extends and increases funding provided in CHIPRA for Medicaid and CHIP enrollment and renewal activities from \$100 million through 2013 to \$140 million through 2015.

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Role of CHIP (continued)		<ul style="list-style-type: none"> CHIP expires in 2014 and children in separate state CHIP programs with incomes above 150% FPL would obtain coverage through the exchange. CHIP enrollees with incomes between 100% and 150% FPL would be transitioned to Medicaid and states would receive the CHIP enhanced match rate for children above current levels and up to 150% FPL. Children in Medicaid expansion CHIP programs (M-CHIP) with incomes above 150% FPL would keep Medicaid coverage and states would receive the CHIP enhanced match rate for these children. 	
Medicaid/CHIP financing	<p>Medicaid financing is shared across state and federal governments. The federal matching percentage for each state (officially known as the Federal Medical Assistance Percentage, or FMAP) varies by state according to a formula set in statute that relies on states per capita income. On average the federal government pays for 57% of Medicaid costs, but this varies from a floor of 50 percent to a high of 76 percent in 2010; however, states are receiving an enhanced FMAP as a result of the American Recovery and Reinvestment Act (ARRA). ARRA provided states with an enhanced federal match (FMAP) to help states support Medicaid during an economic downturn when demand for Medicaid increases and states can least afford to support their programs.</p>	<ul style="list-style-type: none"> Extends the ARRA increase in the FMAP through June 30, 2011. Provides full federal funding (100% FMAP) for children and parents between states' eligibility levels as of June 16, 2009 and 150% FPL and for childless adults for 2 years until 2015 when FMAP becomes 91%. Enhanced FMAP applies to parents currently covered by Medicaid waivers or with state funds (just above 1931 minimums and up to 150% FPL) and to childless adults currently covered by state Medicaid waivers or with state funds. CHIP enhanced match level of financing available for children above Medicaid eligibility and up to 150% FPL. Enhanced match also applies to children in M-CHIP programs with incomes above 150% FPL starting in 2014. Requires current match rate to provide Part B deductibles and cost sharing for Medicare-eligible individuals under age 65 with incomes below 150% FPL. Provides 100% FMAP for newborns without acceptable coverage for 60 days (until transition to Medicaid or other qualified coverage) for 2 years until 2015 when FMAP becomes 91%. 	<ul style="list-style-type: none"> Provides full federal funding (100% FMAP) for newly eligible individuals (or those eligible for a capped program, but not enrolled or on a waiting list) for 2014-2016. Increase the FMAP for expansion states by 30.3 percentage points in 2017 and 31.3 in 2018 and for other states by 34.3 in 2017 and 33.3 percentage points in 2018 for new eligibles. (Expansion states are those with coverage of parents and childless adults at or above 100% FPL (through Medicaid or state only health programs) that may be less comprehensive than Medicaid, but must be more than premium assistance, hospital-only benefits, or health savings accounts.) Increases the FMAP for all states by 32.3 percentage points (up to a cap of 95%) for newly eligible in 2019 and thereafter, except Nebraska, which will continue receiving 100% federal funding for new eligibles after 2017. Provides certain states not eligible for the enhanced federal funding because they had already expanded Medicaid to adults with incomes above 133% FPL with a 2.2 percentage point increase in their FMAP for parents and childless adults who are not newly eligible for 2014 through 2019 or .5 percentage point increase in the FMAP for all medical assistance for 2014 through 2016 for the state with the highest percentage of its populations insured in 2008.

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<p>Medicaid/CHIP financing (continued)</p>		<ul style="list-style-type: none"> • Provides states with enhanced (CHIP level) match rate for optional Medicaid coverage for low-income HIV-infected individuals (Implementation: Upon enactment and before January 1, 2013). • Provides additional federal financing increases in provider payment rates for primary care services for the amount that these rates exceed the rates applicable under the state plan as of June 16, 2009. The cost of the rate increases would be 100% federally financed until 2015 and then 91% FMAP [Implementation: January 1, 2010]. • Requires GAO reports on the FMAP (effect of removing floors and ceilings and revising the formula) and on administrative costs no later than February 15, 2011. • Delays the elimination of certain managed care provider taxes by 1 year until October 1, 2010. 	<ul style="list-style-type: none"> • Limits state’s ability to increase the share of Medicaid expenditures from political sub-divisions (like counties) beyond what was in place as of December 31, 2009 to be eligible for an increase in the FMAP. • Provides a special adjustment to the FMAP for certain states recovering from a major disaster (Implementation: January 1, 2011). • Beginning in October 1, 2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%. • Clarifies that states must maintain Medicaid and CHIP eligibility to continue to receive Medicaid funding.
<p>CBO scoring for Medicaid</p>		<ul style="list-style-type: none"> • Increases Medicaid/CHIP coverage by 15 million from 35 million by 2019. • Estimates Medicaid/CHIP costs for coverage to increase by \$425 billion from 2010 to 2019. • Estimates state spending on Medicaid and CHIP would increase by about \$34 billion over the 2010 to 2019 period as a result of the coverage provisions in the Act. • Other significant federal Medicaid costs over the 2010 to 2019 period are related to: Payments to primary care practitioners (\$57 billion); Extension of ARRA funds (\$23.5 billion); Medicare cost sharing assistance (\$7.2 billion); coverage of preventive services (\$10.7 billion); and payments for GME (\$6 billion). • Significant federal Medicaid savings over the 2010 to 2019 period are related to: Medicaid pharmacy reimbursement and prescription drug rebate provisions (-\$24.6 billion) and reductions in Medicaid disproportionate share hospital payments or DSH (-\$10 billion). 	<ul style="list-style-type: none"> • Increases Medicaid/CHIP coverage by 15 million from 35 million by 2019. • Estimates Medicaid/CHIP costs for coverage to increase by \$395 billion from 2010 to 2019. • Estimates state spending on Medicaid and CHIP would increase by about \$26 billion over the 2010 to 2019 period as a result of the coverage provisions. • Other significant federal Medicaid costs over the 2010 to 2019 period are related to: Community First Choice Option (\$6.9 billion). • Significant federal Medicaid savings over the 2010 to 2019 period are related to: Medicaid prescription drug coverage (-\$38.4 billion) and reductions in Medicaid disproportionate share hospital (-\$18.5 billion).

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Medicaid interface with the exchange		<ul style="list-style-type: none"> States must enter into a Memorandum of Understanding with the NHI Exchange to coordinate and ensure enrollment Medicaid eligible individuals in acceptable coverage. Includes a “Medicaid screen and enroll obligation” that would require states to auto-enroll childless adults who apply for coverage in the exchange and are found to be Medicaid eligible. States can opt to use the same auto-enrollment process for children and parents or do re-determinations of eligibility. States may be authorized to determine eligibility for affordability credits through the NHI Exchange. The Commissioner will reimburse Medicaid agencies for the costs of the determinations. 	<ul style="list-style-type: none"> Requires states to: enable individuals to apply or renew Medicaid coverage through a website with electronic signature; establish procedures to enable individuals to apply for Medicaid, CHIP or the Exchange through a State-run website that must be in operation by January 1, 2014, conduct outreach to enroll vulnerable and underserved populations in Medicaid and CHIP. Allows the state Medicaid and CHIP agency to enter into an agreement with the Exchange to determine eligibility for premium subsidies to purchase coverage through the Exchange. Permits hospitals to make presumptive eligibility determinations and allows hospitals and other providers to make presumptive eligibility determinations for all Medicaid eligible populations.
Medicaid benefits and delivery system	<p>Medicaid covers a broad range of acute and long-term care services. States must cover certain mandatory services but are permitted to cover important services that are “optional”. Medicaid benefits have been designed to serve low-income and high-need populations.</p> <p>Medicaid provides comprehensive coverage for children through the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit.</p> <p>Some services covered that are typically not included in private plans are transportation, durable medical equipment, case management, personal care and institutional long-term care.</p> <p>Medicaid is required to cover and pay for services provided by Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC). Medicaid also contracts with other providers not typically in private insurance networks (like school health clinics).</p> <p>States have the option under current law to provide services for Medicaid beneficiaries through managed care arrangement or through fee-for-service. On average, 64.1% of Medicaid enrollees are in managed care.</p>	<ul style="list-style-type: none"> Prohibits enrollment of childless adults in managed care plans unless that state can demonstrate that the plan has capacity to meet the health, mental health and substance abuse needs of these individuals (Implementation: January 1, 2013). Requires any Medicaid benchmark benefit packages to meet the minimum benefits and cost-sharing standards of a basic plan offered through the NHI Exchange (Implementation: January 1, 2013). Requires coverage for certain preventive services recommended by the Task Force for Clinical Preventive Services and vaccines with no cost sharing (Implementation: July 1, 2010). Eliminates smoking cessation coverage from excluded drug list (Implementation: January 1, 2010). Provides optional coverage for free-standing birth centers (Implementation: On or after enactment). Provides optional coverage of nurse home visitation services for first-time pregnant women or children under 2 (Implementation: January 1, 2010). 	<ul style="list-style-type: none"> Provides all newly-eligible adults with a benchmark benefit package or benchmark-equivalent that meets minimum essential health benefits in the Exchange (including prescription drugs and mental health parity at actuarial equivalence). Populations exempt from mandatory enrollment in these benchmark plans would remain exempt. Provides states with a 1% increase in the FMAP for preventive services recommended by the US Preventive Services Task Force with a grade of A or B and recommended immunization for adults if offered with no cost sharing (Implementation: January 1, 2013). Eliminates smoking cessation drugs, barbiturates, and benzodiazepines from excluded drug list (Implementation: January 1, 2014). Requires coverage for free standing birth center services (Implementation: upon enactment except if state legislation is required). Allows Medicaid eligible children to receive hospice services concurrent with other treatment.

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<p>Medicaid benefits and delivery system (continued)</p>		<ul style="list-style-type: none"> • Enhanced match for translation services in Medicaid extended to adults (Implementation: January 1, 2010). • Requires coverage of podiatrist services (Implementation: January 1, 2010). • Requires coverage of optometrist services (Implementation: 90 days after enactment). • Clarifies coverage for therapeutic foster care for eligible children in out-of-home placements. • Codifies the regulatory requirement for provision of non-emergency transportation to medically necessary services. • Requires that Medicaid programs reimburse certain school-based health clinics (those receiving grant funding under Section 2511 of the bill) using the methodology for FQHCs. 	<ul style="list-style-type: none"> • Allows states to provide coordinated care through a health home for individuals with chronic conditions. Provides 90% match for 2 years and \$25 million for the Secretary to award for planning grants (Implementation: January 1, 2011).
<p>Provider payment rates</p>	<p>State Medicaid programs have broad flexibility to set provider payment rates and rates vary across states. On average, hospital fees are estimated to be 5% below Medicare rates, physician fees 40% below and managed care rates about 15% below Medicare rates. On average across the country, Medicaid fees for primary care physicians are at 66% of Medicare fees.</p> <p>CHIPRA established the Medicaid and CHIP Payment and Access Commission (MACPAC) to examine payment policies and access for children and report to Congress.</p>	<ul style="list-style-type: none"> • Phases in increases in payments for primary care services in fee-for-service and managed care to adjusted Medicare payment rates (80% of Medicare in 2010, 90% in 2011, and 100% in 2012 and after). • Provides additional federal financing for the amount that these rates exceed the rates applicable under the state plan as of June 16, 2009. The cost of the rate increases would be 100% federally financed until 2015 and then 91% FMAP (Implementation: January 1, 2010). • Broadens the scope of the Medicaid and CHIP Payment and Access Commission (MACPAC) to include all eligible individuals and requires MACPAC to report to Congress on nursing facility payment policies by January 1, 2012 and pediatric sub-specialist payment policies by January 1, 2011. Requires reports related to the implementation of health reform that relate to Medicaid or CHIP including the effect of implementation on access. Provides appropriations of \$11.8 million beginning on January 1, 2010. 	<ul style="list-style-type: none"> • No similar provisions related to increase in provider payments or reporting on payment rates. • Broadens the scope of the Medicaid and CHIP Payment and Access Commission (MACPAC) to include adult services (including duals) and clarifies the topics for review including eligibility policies, enrollment and retention processes, coverage policies, quality of care, and interactions with Medicare and Medicaid. (Provides appropriations of \$11 for FY 2010). • Establishes the CMS Innovation Center designed to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to foster patient-centered care, improve quality, and slow Medicare costs growth. Payment reform models that improve quality and reduce the rate of costs could be expanded throughout the Medicare, Medicaid, and CHIP programs (Implementation: January 1, 2010).

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<p>Provider payment rates (continued)</p>		<ul style="list-style-type: none"> Establishes the Center for Medicare and Medicaid Innovation to test payment and service delivery models to improve quality and efficiency. Evaluate all models and expand those models that improve quality without increasing spending or reduce spending without reducing quality, or both (Implementation: January 1, 2011). Requires states to submit a state plan amendment specifying the payment rates to be paid under the state's Medicaid program that must be approved/disapproved by the Secretary within 90 days (Implementation: Upon enactment). Requires an annual report on Medicaid payment rates and methodologies and an explanation of the process used to allow providers and the public opportunity to review and comments on rates. Requires hospitals to report and states to provide access to information (at a minimum on a website) on information including charges for the most common inpatient and outpatient services (Implementation: States have 2 years to come into compliance). Includes graduate medical education (GME) in the definition of medical assistance and requires states to submit information regarding GME to the Secretary for review and then reporting through rules (by December 31, 2011) on goals and requirements for use of Medicaid GME (Implementation: Upon enactment). 	
<p>Demonstrations and pilots</p>		<ul style="list-style-type: none"> Establishes an accountable care organization pilot program in Medicaid to test payment incentive models and to assess the feasibility of reimbursing qualified patient-centered Medicaid homes. Increases the match rates for administration to 90% for 2 years and then 75% for the next 3 years (Implementation: January 1, 2012). 	<ul style="list-style-type: none"> Establishes demonstration projects in Medicaid and CHIP to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (Implementation: January 1, 2012 – December 31, 2016). Authorizes a demonstration for stabilization of emergency medical conditions by Institutions for Mental Disease for individuals 21 to 65 who require stabilization in these settings as required by the Emergency Medical Treatment and Active Labor Act (EMTALA). Today, these hospitals are denied

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Demonstrations and pilots (continued)		<ul style="list-style-type: none"> • Authorizes a demonstration for stabilization of emergency medical conditions by Institutions for Mental Disease for individuals 21 to 65 who require stabilization in these settings as required by the Emergency Medical Treatment and Active Labor Act (EMTALA). Today, these hospitals are denied payment for care that is required under the EMTALA rules (Appropriations of \$75 million for FY 2010 available through December 31, 2012). • Establishes a 5-yr. medical home pilot program for Medicaid eligibles (including medically fragile children and high-risk pregnant women). The pilot can waive state-wideness and comparability and would increase the FMAP to 90% for 2 years and then 75% for the next 3 years for administrative costs. (Federal funding limited to \$1.235 billion over 5 years). 	<ul style="list-style-type: none"> • payment for care that is required under the EMTALA rules (Implementation: (Appropriations of \$75 million for fiscal year 2011 through 2015). • Establishes a global payments demonstration project for up to 5 states from 2010 to 2012 for large safety-net hospital systems (Implementation: Fiscal year 2010 through 2012). • Establishes a bundled payment demonstration project for up to 8 states for acute and post-acute care (Implementation: January 1, 2012 to December 31, 2016). • Authorizes \$100 million in funding for grants for healthy lifestyle demonstration programs in Medicaid (Implementation: January 1, 2011). • Requires the Secretary of HHS to issue regulations to establish a process for public notice and comment for section 1115 waivers in Medicaid and CHIP.
Long-term care	<p>Medicaid is the primary provider of long-term care services. Medicaid provides care for 1 million nursing home residents and 2.8 community-based residents and pays for over 40% of all long-term care services in the U.S.</p>	<ul style="list-style-type: none"> • Establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). The program will provide individuals with functional limitations a cash benefit to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. (Implementation: January 1, 2011). • Requires coordinate to assure adequate infrastructure to implement CLASS including a requirement for states to assess the extent to which there is capacity for personal care services to serve Medicaid and those receiving benefits under CLASS (Implementation: 2 years after enactment). • Requires information regarding CLASS to be available through the National Clearinghouse for long-term care information and appropriates \$7 million in FY 2011, 2012 and 2013. 	<ul style="list-style-type: none"> • Establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of \$50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out (Implementation: January 1, 2011). • Establishes the Community First Choice Option in Medicaid to allow states to provide community-based attendant supports and services to individuals with incomes up to 150% FPL with disabilities who require an institutional level of care through a state plan amendment (SPA). Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program (Implementation: October 1, 2010).

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Long-term care (continued)		<ul style="list-style-type: none"> Appropriates \$6 billion from 2010 through 2013 for the Nursing Facility Supplemental Payment Program to reimburse facilities for quality care for Medicaid-eligible individuals. 	<ul style="list-style-type: none"> Provides states with new options for offering home and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and a higher level of need and permit states to extend full Medicaid benefits to individual receiving home and community-based services under a state plan (Implementation: October 1, 2010) Creates the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally-based long-term services and supports (Implementation: October 1, 2011 through September 30, 2015). Extends the Medicaid Money Follows the Person Rebalancing Demonstration program through 2016 and requires that individuals reside in a nursing home for not less than 90 consecutive days (Implementation: 30 days after enactment). Allocate \$10 million per year for 2010 through 2014 to continue the Aging and Disability Resource Center initiatives. Includes protections against spousal impoverishment in Medicaid HCBS (Implementation: January 1, 2014 for five years). Includes a Sense of the Senate that Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals care they need and that care should be available in the community in addition to institutions.
Duals	<p>Medicaid provides assistance to 8.8 million low-income aged and disabled who are dually eligible for Medicare (18% of Medicare beneficiaries). Medicaid provides assistance with Medicare premiums and cost-sharing and covers</p>	<ul style="list-style-type: none"> Requires the Secretary to improve coordination of care for dual eligibles through a new office or program within the Centers for Medicare and Medicaid Services. 	<ul style="list-style-type: none"> Establishes the Federal Coordinated Health Care Office (CHCO) within CMS to align Medicare and Medicaid financing, benefits, administration, oversight rules, and policies for dual eligibles (Implementation: March 1, 2010).

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Duals (continued)	services not covered by Medicare. In 2005 duals represented 18% of all Medicaid enrollees but 46% of all Medicaid costs.	<ul style="list-style-type: none"> Increases the asset test threshold for Medicare Savings Program and Part D Low-Income Subsidies to \$17,000 per individual and \$34,000 per couple (Implementation: 2012). 	<ul style="list-style-type: none"> Clarifies Medicaid demonstration authority for coordinating care for the duals for up to 5 years.
Quality and program integrity	<p>Most states use managed care to implement quality initiatives. Most states have pay-for-performance programs and report quality data through HEDIS and CAHPS.</p> <p>States have the primary responsibility for Medicaid program integrity through efficient administration of the program and through Medicaid fraud and abuse control units (MFUCs). The Deficit Reduction Act (DRA) of 2005 created the Medicaid Integrity Program (MIP) which increased federal resources and required CMS to devise a national strategy to combat Medicaid fraud, waste, and abuse. Appropriations for the MIP are now at \$75 million per year.</p>	<ul style="list-style-type: none"> Requires development and reporting format for maternity under Medicaid by January 1, 2012 and sets up a process to develop and report other adult health quality measures under Medicaid. Appropriates \$40 million for 5 years starting in FY 2010. Prohibits Medicaid payment for certain health care-acquired conditions (Implementation: January 1, 2010). Extends the 60 days that states have to repay the federal share of a Medicaid overpayment to one year or 30 days after a an amount is determined through the judicial processes (Implementation: Upon enactment). Authorizes the Secretary to withhold matching payments when states do not report enrollee encounter data through MMIS in a timely way. Terminates provider participation in Medicaid and CHIP if a provider is terminated under Medicare or other state or child health plan. Excludes certain providers from Medicaid and CHIP due to ownership control or management affiliations with individuals or entities that have been excluded from participation or have unpaid overpayments. Requires additional data reporting to MMIS to detect waste, fraud and abuse (Implementation: January 1, 2010). Requires billing agents, clearinghouses and alternative payees to register under Medicaid. Mandates state use of national correct coding initiative (Implementation: October 1, 2010). Requires annual reporting on effectiveness of activities carried out by entities authorized under the Medicaid Integrity Program. 	<ul style="list-style-type: none"> Establishes the Medicaid Quality Measurement Program to establish priority for the development and advancement of quality measures for adults in Medicaid. Sets deadlines for development of measures January 2011 – initial and January 2012 (core measures), standardized reporting format (January 2013) and report to Congress (January 2014). Prohibits federal payments to states for Medicaid services related to healthcare acquired conditions (Implementation: Through regulations effective July 1, 2011). Extends the 60 days that states have to repay the federal share of a Medicaid overpayment to one year or 30 days after a an amount is determined through the judicial processes (Implementation: Upon enactment). Authorizes the Secretary to withhold matching payments when states do not report enrollee encounter data through MMIS in a timely way. Terminates provider participation in Medicaid and CHIP if a provider is terminated under Medicare or other state or child health plan. Excludes certain providers from Medicaid and CHIP due to ownership control or management affiliations with individuals or entities that have been excluded from participation or have unpaid overpayments. Requires additional data reporting to MMIS to detect waste, fraud and abuse (Implementation: January 1, 2010). Requires billing agents, clearinghouses and alternative payees to register under Medicaid. Mandates state use of national correct coding initiative (Implementation: October 1, 2010).

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<p>Quality and program integrity (continued)</p>		<ul style="list-style-type: none"> • Requires providers and suppliers to adopt programs to reduce waste, fraud and abuse. • Establishes a minimum medical loss ratio for Medicaid MCOs of 85% (Implementation: For contract years beginning on or after January 1, 2010). • Prohibits payments for litigation-related misconduct for managed care organizations (Implementation: January 1, 2010). 	<ul style="list-style-type: none"> • Establishes procedures for screening, oversight, and reporting requirements for providers and suppliers that participate in Medicaid, Medicare, and CHIP. Imposes a fee on providers and suppliers for screening purposes (Implementation: varies based on whether an existing provider/supplier or a new provider/supplier; fee begins in 2010). • Permits states to impose a moratorium on enrollment of providers or suppliers under Medicaid and CHIP that are identified as being at high-risk for fraud, waste, and abuse. • Requires CMS to include Medicare, Medicaid, CHIP, VA, DOD, SSA and IHS in the integrated Data Repository (IDR) and requires the Secretary to enter into data-sharing agreements with these agencies to identify waste, fraud and abuse. Allows DOJ to access the IDR to conduct law enforcement activities. • Expands the use of Civil Monetary Penalties (CMP) to individuals who order a medical service when they are not enrolled as a provider in a Federal health care program, to individuals who make false statements on applications or contracts to participate in a Federal health care program, and to individuals who are aware of an overpayment and do not return it. Each violation is subject to up to a \$50,000 penalty. • Increases funding for health care fraud and abuse control funding by \$10 million per year (Implementation: Fiscal year 2011 through 2020). • Requires states to implement fraud, waste, and abuse programs by January 1, 2011.
<p>DSH</p>	<p>Medicaid disproportionate hospital share (DSH) payments are supplemental payments that states can use for reimburse hospitals that serve high levels of Medicaid and uninsured patients. Federal DSH funds are capped and represent about 5% of all Medicaid spending.</p>	<ul style="list-style-type: none"> • Reduces federal DSH allotments by \$1.5 billion in FY 2017; \$2.5 billion in FY 2018 and \$6 billion in FY 2019 using a formula that imposes the largest percentage reductions on states that have the lowest percentages of uninsured. • Requires a report on the continued role of DSH by January 1, 2016. The report would also include recommendations about targeting DSH within states and distributing DSH across states. 	<ul style="list-style-type: none"> • Reduce a state’s Medicaid DSH allotment by 50% (or 25% for low DSH states (and by lesser percentages for states meeting certain criteria) once the state’s uninsured rate decreases by at least 45%. DSH allotments will be further reduced, not to fall below 35% of the total allotment in 2012 if states’ uninsured rates continue to decrease. Exempt any portion of the DSH allotment used to expand Medicaid eligibility through a section 1115 waiver (Implementation: October 1, 2011).

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Prescription drugs	Manufacturers must provide rebates to state Medicaid programs, but drugs purchased through managed care organizations are not subject to the rebate program. Medicaid payments to pharmacists include acquisition costs and dispensing fees. The DRA made changes to the way Medicaid pays pharmacists and CMS issued a rule (known as the AMP Rule) in July 2007. A U.S. District Court issued a preliminary injunction against this change.	<ul style="list-style-type: none"> • Changes payments to pharmacists based on a federal upper limit of 130% weighted average of AMP (Implementation: January 1, 2011). • Imposes additional rebates for new formulations of existing drugs; increases minimum rebate for single source drugs (Implementation: December 31, 2009). • Increases the minimum rebate for single source drugs to 23.1% (Implementation: December 31, 2009). • Extends prescription drug rebates to Medicaid managed care plans (Implementation: January 1, 2010). 	<ul style="list-style-type: none"> • Increases the Medicaid drug rebate percentage for brand name drugs to 23.1% (except for clotting factor and drugs for pediatric indications increase to 17.1%), increases the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price, extends the drug rebate to Medicaid managed care plans (excludes 340B programs), and limits the total rebate liability to 100% AMP with revenue due to the federal government (Implementation: January 1, 2010). • Calculates the Federal Upper Limit as no less than 175% weighted average AMP for therapeutically equivalent multiple source drugs (Implementation: 180 days after enactment).
Territories	Medicaid programs in the territories are subject to spending caps. The FMAP is statutorily set at 50% for the territories.	<ul style="list-style-type: none"> • Increases caps for the territories for FY 2010 through 2019 totaling \$9.3 billion. (Optional Medicaid coverage to low-income HIV-infected individuals exempt from caps). • Requires a report on achieving Medicaid parity payments beginning with fiscal year 2020. Requires the Secretary to submit a plan to congress by October 1, 2013. 	<ul style="list-style-type: none"> • Increases spending caps for the territories by 30% and the applicable FMAP by 5 percentage points (from 50% to 55%) (Implementation: January 1, 2011). • The cost of covering newly eligibles would not count toward these spending caps.
Sources of information		http://rules.house.gov/	www.democrats.senate.gov/

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