FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM PROVISIONS: America's Affordable Health Choices Act & America's Healthy Future Act

The America's Affordable Health Choices Act of 2009 (the House bill) and America's Healthy Future Act of 2009 (the Senate Finance proposal) include an individual requirement to obtain health insurance, a Medicaid expansion and subsidies to help low-income individuals buy coverage through an Exchange. This analysis looks at the provisions related to Medicaid and the Children's Health Insurance Program (CHIP) compared to current law. Some of key differences between the two proposals are:

Medicaid Coverage. Both the House (in 2013) and Senate (in 2014) proposals would expand Medicaid to a national floor of 133% of poverty to help reduce state-by-state variation in eligibility for Medicaid and also include adults without dependent children who are currently not eligible for the program. There are key differences related to how income is calculated and where Medicaid enrollees get coverage – through Medicaid or through the exchange. States now use income disregards to exempt certain types of income or deduct certain expenses to cover work-related expenses (like child care, child support). The House bill does not change how income is calculated, but the Senate bill would use modified adjusted gross income (MAGI). Under the House bill, childless adults that qualify for Medicaid may enroll in coverage through the exchange if they were enrolled in qualified health coverage during the 6 months before becoming Medicaid eligible. The Senate would allow individuals between 100% and 133% of poverty to choose between Medicaid coverage and coverage through the exchange. Both the House and Senate proposals include provisions to coordinate enrollment in Medicaid and in the exchange.

Children's Health Insurance Program (CHIP) Coverage. The House bill would eliminate the CHIP program in 2013 and transition CHIP enrollees to the new health insurance exchange. The Senate proposal maintains the current CHIP structure and requires states to maintain income eligibility levels for Medicaid and CHIP through 2019. CHIP eligibility would be based on existing income eligibility rules (with income disregards).

Maintenance of Eligibility (MOE). Under the House bill, all individuals with Medicaid above 133% of poverty would continue to be eligible for Medicaid. The Senate proposal maintains Medicaid and CHIP coverage for children through 2019. The Senate also requires states to maintain Medicaid and CHIP eligibility levels for those with incomes above 133% FPL until 2013 (when the exchange is operational) and until 2014 for those with incomes at or below 133% FPL. A state is exempt from the maintenance of effort requirement for non-pregnant and non-disabled adults with incomes above 133% FPL from January 2011 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year.

Medicaid Financing. A provision in the House bill that would have fully financed the Medicaid expansions with federal funds was amended to replace full federal financing with 90% federal financing beginning in year 2015. Under the Senate proposal, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100% and a .15 percentage point increase in the Medicaid match rate beginning in 2013 to help pay for the MOE for children. States would also receive assistance in financing the costs of the Medicaid expansion through a percentage point increase in the FMAP. The percentage point increase in the FMAP would be 27.3 for "expansion" states that already cover adults with incomes above 100% FPL and 37.3 for other states. These percentage point increases will be adjusted over time so that by 2019, all states will receive an FMAP increase of 32.3 percentage points for the newly eligible (up to a cap of 95% in any year). Certain "high-need" states (those with total Medicaid enrollment that is below the national average for enrollment as a percentage of the state population on enactment and adjusted unemployment rates of 12% or higher for August 2009) could qualify for full federal financing for expansions for 5 years. States would be required to pay an amount equal to the state's average cost for Medicaid (by eligibility category) for those opting to enroll in the exchange.

Benefits and Access. In the House bill, those eligible for Medicaid would continue to receive the traditional Medicaid benefits package. Under the Senate proposal, all newly-eligible adults would receive a benchmark benefit package that meets minimum creditable coverage requirements. These packages are not likely to be as comprehensive as Medicaid. The House bill would increase Medicaid physician and other practitioners payment rates for primary care services to 100% of the Medicare rates by 2012 with 100% federal financing for the increase initially and 90% FMAP after 2015, no similar provisions are in the Senate proposal.

A more detailed analysis of Medicaid and CHIP provisions in the House and Senate proposals 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, CHIP AND LOW-INCOME PROVISIONS TO HEALTH CARE REFORM PROPOSALS TO CURRENT LAW: HR 3200 America's Affordable Health Choices Act and America's Healthy Future Act

This side-by-side compares the Medicaid provisions in the House Tri-Committee, America's Affordable Health Choices Act (with key Committee amendments) and the Senate Finance America's Healthy Future Act (with key Committee amendments) to current law. This analysis focuses on Medicaid coverage and financing changes; how Medicaid and CHIP interface with a new health insurance exchange; how subsidies for low-income individuals work 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 Tri-Committee America's Affordable Health Choices Act	Senate Finance Committee America's Healthy Future Act
Date plan announced		July 14, 2009	Introduced September 16, 2009, modified on September 22, 2009, amended in Committee
Status		Bill passed out of Ways and Means, Education and Labor, and Energy and Commerce Committees.	Bill passed out of Finance Committee on October 13, 2009.
Overall approach to expanding access to coverage		Requires most individuals to have health insurance through a combination of public and private coverage expansions. Expands Medicaid to 133% 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.	Requires most individuals to have health insurance through a combination of public and private coverage expansions. Provides premium credits to individuals and families with incomes between 133-400% FPL in 2013, and includes individuals and families with incomes between 100-133% FPL in 2014, to purchase insurance through the Health Insurance Exchanges. Expands Medicaid to 133% of the poverty level in 2014 and maintains CHIP and Medicaid for children through 2019.
Medicaid and CHIP Coverage Changes			
Medicaid eligibility for children, pregnant women, parents and individuals with disabilities (traditional Medicaid eligibles)	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.	• Establishes a minimum Medicaid coverage threshold for all children, parents and individuals with disabilities under age 65 (Traditional Medicaid Eligible Individuals) up to 133% FPL (with no resource tests) in 2013. • States that currently cover children between 100% and 133% FPL under a separate CHIP program would be required to shift that coverage to Medicaid.	• Establishes a minimum Medicaid coverage threshold for children and parents with incomes up to 133% FPL starting January 1, 2014. • Maintains current eligibility for children through 2019. • Existing law does not change for pregnant women. • Effective January 1, 2014 eligibility would be based on modified adjusted gross income (MAGI) without income disregards except for the elderly and groups eligible through another program like foster care, low-income Medicare beneficiaries and Supplemental Security Income (SSI). MAGI would not apply to beneficiaries enrolled as of January 1, 2014, until March 31, 2014 or their next redetermination date.

	Current Law	House Tri-Committee America's Affordable Health Choices Act	Senate Finance Committee America's Healthy Future Act
Medicaid and CHIP Coverage Changes (continued)			
Medicaid eligibility for children, pregnant women, parents and individuals with disabilities (traditional Medicaid eligibles) (continued)	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: 7 states <200% FPL 29 states 200 – 250% FPL 14 states >250% FPL States must cover **pregnant women** with income below 133% FPL. 11 states at 133-184% FPL 18 states 185% FPL 22 states >185% FPL States must cover **parents** below states' July 1996 welfare levels. For Working Parents: 38 states <133% FPL 13 states > or = 133% FPL For Jobless Parents: 39 states <133% FPL 12 states > or = 133% FPL State must cover most **elderly and persons with disabilities** receiving Supplemental Security Income (SSI) and certain low-income Medicare beneficiaries.	• Extends Medicaid eligibility status to any newborn who does not have acceptable coverage for 60 days (until transition to Medicaid or other qualified coverage).	• Beginning in 2014, adults with incomes between 100 and 133% FPL would be able to choose between Medicaid and coverage through their state exchange. • Specifies that cost-sharing rules and out-of-pocket limit of 5% of family income continues to apply for children.
Eligibility for adults without dependent children (non-traditional Medicaid eligibles)	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. As of 2009, 5 states provide coverage to childless adults that is comparable to Medicaid, 14 states only provide coverage more limited than Medicaid, and an additional 5 states solely provide premium assistance with employment-related eligibility requirements.	• Establishes new Medicaid coverage for 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 133% FPL (with no resource tests) in 2013.	• Establishes a new eligibility category for all childless adults otherwise ineligible for Medicaid. Beginning in 2011, states would have the option to cover childless adults though a Medicaid State Plan Amendment. Mandatory minimum coverage at 133% FPL based on modified adjusted gross income (MAGI) would begin on January 1, 2014. • Beginning in 2014, adults with incomes between 100 and 133% FPL would be able to choose between Medicaid and coverage through their state exchange.

	Current Law	House Tri-Committee America's Affordable Health Choices Act	Senate Finance Committee America's Healthy Future Act
Medicaid and CHIP Coverage Changes (continued)			
Other coverage	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.	• Provides optional Medicaid coverage to low-income HIV-infected individuals until exchange plans are operational. • Provides optional Medicaid coverage for family planning services to certain low-income individuals. • Extends TMA through 12/31/2012 and makes QI program permanent. • *E&C Committee amendment: QI program is extended through 12/31/2012.*	• Provides optional Medicaid coverage for family planning services to certain low-income individuals (up to the highest level of eligibility for pregnant women). • Permits hospitals to make presumptive eligibility determinations and allows hospitals and other providers to make presumptive eligibility determinations for all Medicaid eligible populations. • Allows states to provide Medicaid coverage to individuals with MAGI >133% FPL through traditional Medicaid or in the form of supplemental wrap benefits. Individuals with only a benefit wrap are eligible for tax credits in the state exchange. • Requires states to report on changes in Medicaid enrollment for parents, childless adults and other individuals and outreach and enrollment processes. Then HHS would report findings to Congress annually on a state-by-state basis. • Requires HHS to issue guidance to states regarding standards and best practices to improve enrollment for vulnerable populations in Medicaid and CHIP.
Maintenance of effort	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.	• MOE for Medicaid to June 16, 2009. Eligibility standards, methodologies, or procedures (includes waivers) may not be more restrictive that what was in place as of June 16, 2009. • *E&C Committee amendment: Provides an exception to the MOE for certain waivers that permit individuals to receive a premium or cost-sharing subsidy for individual or group health insurance coverage.* • *E&C Committee amendment: Chanes MOE to refer to "maintenance of eligibility."*	• Requires states to maintain current income eligibility levels for children in Medicaid and CHIP through 2019. • Requires states to maintain Medicaid eligibility levels until 2013 for those with incomes above 133% FPL (when the exchange is operational) and until 2014 for those with incomes at or below 133% FPL. • A state is exempt from the maintenance of effort requirement for non-disabled adults with incomes above 133% FPL from January 2011 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year.
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,	• In 2010, requires 12-month continuous eligibility for children with incomes below 200% FPL. • CHIP expires in 2013.	• Maintains the current CHIP structure and requires states to maintain income eligibility levels for Medicaid and CHIP through 2019. CHIP eligibility would be based on existing income eligibility rules, including the use of income disregards.

	Current Law	House Tri-Committee America's Affordable Health Choices Act	Senate Finance Committee America's Healthy Future Act
Medicaid and CHIP Coverage Changes (continued)			
Role of CHIP (continued)	new tools to increase enrollment, fiscal incentives to cover more children, new benefit requirements and new quality initiatives.	• In 2013, CHIP enrollees would obtain coverage through the exchange; however, CHIP enrollees in separate CHIP programs (about 21 states) with incomes between 100% and 133% FPL would be transitioned to Medicaid. • There is a CHIP MOE that would remain in place until CHIP enrollees are transitioned into the exchange. This transition would take place when the Health Choices Commissioner determines that the Exchange has the capacity to support participation of CHIP enrollees and that there are procedures in place to ensure that the transition would not interrupt coverage. • *E&L Committee amendment: Requires early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21 be included in the essential benefits package in the Exchange.* • *E&C Committee amendment: Requires that CHIP enrollees not be enrolled in an Exchange plan until the Secretary certifies that coverage is at least comparable to coverage under an average CHIP plan in effect in 2011. The Secretary must also determine that there are procedures to transfer CHIP enrollees into the exchange without interrupting coverage or a written plan of treatment.* • *E&C Committee amendment: 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).*	• CHIP eligible children who cannot enroll in CHIP due to federal allotment caps would be eligible for tax credits in the exchange. • Does not extend the CHIPRA enrollment bonuses beyond 2013. • CHIP benefit package and cost-sharing rules will continue as under current law.

	Current Law	House Tri-Committee America's Affordable Health Choices Act	Senate Finance Committee America's Healthy Future Act
Financing Changes			
Medicaid financing for new coverage	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.	• Full federal funding (100% FMAP) for new traditional eligibles between states' eligibility levels as of June 16, 2009 and 133% FPL and traditional eligibles currently covered by waivers (just above 1931 minimums and up to 133% FPL). • 100% FMAP for non-traditional Medicaid eligibles (includes non-traditional newborns) and non-traditional eligibles currently covered by waivers. • *E&C Committee amendment: Replaces full federal financing for Medicaid coverage expansions with 100% federal financing through 2014 and 90% federal financing beginning in year 2015.*	• Beginning in 2014, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100% and a .15 percentage point increase in the Medicaid match rate. • Financing of the coverage for the newly eligible (those who were not previously eligible for a full benchmark benefit package or who were eligible for a capped program but were not enrolled) will be shared between the federal government and the states through an increase in the federal medical assistance percentage (FMAP) for each state. • Initially, the percentage point increase in the FMAP will be 27.3 for "expansion" states that already cover adults with incomes above 100% FPL and 37.3 for other states. These percentage point increases will be adjusted over time so that by 2019, all states will receive an FMAP increase of 32.3 percentage points for the newly eligible. The FMAP could not exceed 95% in any year. • 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. • Provides full federal financing for newly eligible beneficiaries for 5 years (2014 – 2018) for "high-need" states (those that have total Medicaid enrollment that is below the national average for enrollment as a percentage of the state population on enactment and had adjusted unemployment rates of 12% or higher for August 2009). • For adults between 100 and 133% FPL who choose to enroll in the state exchange instead of Medicaid, states would be required to pay an amount equal to the state's average cost of coverage for individuals in that same Medicaid eligibility category.

	Current Law	House Tri-Committee America's Affordable Health Choices Act	Senate Finance Committee America's Healthy Future Act
Financing Changes (continued)			
CBO scoring for Medicaid		• Increases Medicaid/CHIP coverage by 11 million from 35 million. • Estimates Medicaid/CHIP costs for coverage to increase by $438 billion from 2010 to 2019. • Estimates state spending on Medicaid and CHIP would be reduced by about $10 billion over the 2010 to 2019 period.	• Increases Medicaid/CHIP coverage by 14 million from 35 million. • Estimates Medicaid/CHIP costs for coverage to increase by $345 billion from 2010 to 2019. • Estimates that state spending on Medicaid/CHIP will increase by $33 billion due to coverage specifications over the 2010-2019 period.
Medicaid Benefits and Access Changes			
Medicaid interface with the exchange		• Non-traditional (childless adults) Medicaid beneficiaries may enroll in coverage through the exchange if they were enrolled in qualified health coverage during the 6 months before becoming Medicaid eligible. • States must enter into a Memorandum of Understanding with the Health Insurance Exchange to coordinate enrollment of individuals in Exchange-participating health plans and under the state's Medicaid program. • There is a "Medicaid screen and enroll obligation" that would require states to auto-enroll non-traditional Medicaid-eligible individuals in Medicaid if they apply for coverage in the exchange and are found to be Medicaid eligible. For traditional eligibles, states can opt to use the same auto-enrollment process or use presumptive eligibility and follow Medicaid enrollment procedures. • States may be authorized to determine eligibility for affordability credits through the Health Insurance Exchange.	• Beginning in 2014, adults with incomes between 100 and 133% FPL would be able to choose between Medicaid and coverage through their state exchange. • Allows for a single form to apply for Medicaid, CHIP and tax credits (except additional forms may apply for Medicaid eligibility not based on MAGI). The form can be filed on-line, in person, by mail, telephone and can be filed with the Exchange, Medicaid or CHIP. • Requires exchanges, Medicaid and CHIP to operate systems to ensure electronic interface to determine eligibility using third party data to establish, verify and update eligibility. • Allows the Secretary to promulgate model agreements for data-sharing and allows state exchanges to contract with state Medicaid agencies to determine eligibility for Medicaid, CHIP, and tax credits for state residents if the contract lowers overall administrative costs and reduces the likelihood of eligibility errors and disruptions in coverage.
Medicaid benefits and delivery system	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.	• Requires coverage for certain preventive services and vaccines with no cost sharing. • Eliminates smoking cessation coverage from excluded drug list. • Provides optional coverage of nurse home visitation services.	• All newly-eligible adults would receive a benchmark benefit package or benchmark-equivalent that meets minimum creditable coverage requirements (including prescription drugs) as established by the DRA. Populations exempt from mandatory enrollment in these benchmark plans would remain exempt.

	Current Law	House Tri-Committee America's Affordable Health Choices Act	Senate Finance Committee America's Healthy Future Act
Medicaid Benefits and Access Changes (continued)			
Medicaid benefits and delivery system (continued)	Medicaid provides comprehensive coverage for children through the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit. 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. 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). 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.	• Requires payment for items and services provided by school-based health clinics. • Establishes a 5-yr. medical home pilot program for high need Medicaid beneficiaries. • Other: enhanced match for translation services in Medicaid extended to adults; provides optional coverage for free-standing birth centers; includes public health clinics in VFC program; establishes a minimum medical loss ratio for Medicaid MCOs of 85%. • *E&C Committee amendment: Requires Medicaid coverage for optometrists and podiatrists as well as codifies the regulatory requirement for provision of non-emergency transportation to medically necessary services.* • *E&C Committee amendment: 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 and Medicare and Medicaid reimbursement.*	• Requires states to offer premium assistance and wrap-around benefits to Medicaid beneficiaries who are offered ESI if it cost-effective to do so starting July 1, 2013. • Allows Medicaid eligible children to receive hospice services. • Eliminates smoking cessation drugs, barbiturates, and benzodiazepines from coverage from excluded drug list on January 1, 2014. • Requires Medicaid coverage for tobacco cessation services for pregnant women and for states that provide Medicaid coverage and remove cost sharing for preventive services recommended by the US Preventive Services Task Force and recommended immunization provide a one percentage point increase in the FMAP for these services and for the tobacco cessation services. • Authorizes $100 million in funding for grants for healthy lifestyle demonstration programs. • Creates a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions or one condition and risk of developing another (or enrollees with at least one serious mental health condition) to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years. • Authorizes $25 million for a childhood obesity demonstration project and requires HHS to issue guidance to states regarding Medicaid coverage of obesity-related services. • Establishes a three-year, $75 million demonstration project that would allow Medicaid funding for non-publicly owned and operated psychiatric hospitals for Medicaid beneficiaries between the ages of 21-64 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. • Establishes a grant program to fund operating costs for school-based health centers ($200 million).

	Current Law	House Tri-Committee America's Affordable Health Choices Act	Senate Finance Committee America's Healthy Future Act
Medicaid Benefits and Access Changes (continued)			
Provider payment rates	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. CHIPRA established the Medicaid and CHIP Payment and Access Commission (MACPAC) to examine payment policies and access for children and report to Congress.	• Phases in increases in payments for primary care services in fee-for-service and managed care to Medicare payment rates (80% of Medicare in 2010, 90% in 2011, and 100% in 2012 and after). • The cost of the rate increases would be 100% federally financed over a 2009 base. • *E&C Committee amendment: 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. Reduces the 100% federal financing to 90% FMAP beginning in 2015. 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.* • *E&C Committee amendment: Delays the elimination of certain managed care provider taxes from by 1 year until October 1, 2010.*	• Authorizes $11 million for MACPAC for FY 2010 and expands mission to include assessment of adult services (including duals). • Establishes a bundled payment demonstration project for up to 8 states for acute and post-acute care. • Establishes a Global Payments demonstration project for up to 5 states from 2010 to 2012 for large safety-net hospital systems. • 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. • Establishes demonstration projects in Medicaid and CHIP to allow pediatric medical providers organized as accountable care organizations to share in cost-savings.
Long-term care	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 US.	• *E&C Committee amendment: 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. Provision is subject to Ways and Means Committee's amending the tax code.*	• Extends the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016 and allocate $10 million per year for five years to continue the Aging and Disability Resource Center initiatives. • Provides states that undertake reforms to increase nursing home diversions and access to home and community-based services in their Medicaid programs with a targeted increase in the federal matching rate for five years. • Establishes the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. Sunset the option after five years.

	Current Law	House Tri-Committee America's Affordable Health Choices Act	Senate Finance Committee America's Healthy Future Act
Medicaid Benefits and Access Changes (continued)			
Long-term care (continued)		• *E&C Committee amendment: Requires the director of food services of a Medicaid nursing facility to be a qualified dietitian or a certified dietary manager and also requires new quality indicators for care of people with Alzheimer's by physicians, hospitals, other medical, residential and home care agencies and providers.*	• Includes protections against spousal impoverishment in Medicaid HCBS. • Allows states to offer HCBS through a SPA and include individuals with incomes up to 300% of the maximum SSI payment. • 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	Medicaid provides assistance to 8.8 million low-income aged and disable who are dually eligible for Medicare (18% of Medicare beneficiaries). Medicaid provides assistance with Medicare premiums and cost-sharing and covers services not covered by Medicare. In 2005 duals represented 18% of all Medicaid enrollees but 46% of all Medicaid costs.	• Creates a new office or program within CMS to improve coordination between Medicare and Medicaid for dual eligibles. • *E&C Committee amendment: Requires the new office to work with States to establish quality and reporting measures for Medicare and Medicaid that include integrations and consolidate current reporting. Also requires an evaluation of certain Medicare Advantage dual eligible special needs plans with regard to cost, quality and patient satisfaction.* • Increases the asset test for the Medicare Savings Program.	• Clarifies Medicaid demonstration authority for coordinating care for the duals for up to 5 years. • 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.
Quality and program integrity	Most states use managed care to implement quality initiatives. Most states have pay-for-performance programs and report quality data through HEDIS and CAHPS. 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.	• Medicaid non-payment for certain health care acquired conditions; reports and evaluations required under the Medicaid Integrity Program. Require providers and suppliers to adopt programs to reduce waste, fraud and abuse. • *E&C Committee amendment: Requires development and reporting format for maternity and adult health services under Medicaid and appropriates $40 million for 5 years starting in FY 2010.* • *E&C Committee amendment: Conduct accountable care organization pilot programs in Medicaid.*	• Establishes the Medicaid Quality Measurement Program to establish priority for the development and advancement of quality measures for adults in Medicaid. • Prohibits federal payments to states for Medicaid services related to health care acquired conditions. • Imposes statutory requirements regarding transparency related to 1115 demonstration programs and state plan amendments to limit benefits or states and the Secretary of HHS. • Uses funds from the Medicaid Improvement Fund (MIF) established in the 2008 Supplemental Appropriations Act for improvements in Medicaid ($700 million).

	Current Law	House Tri-Committee America's Affordable Health Choices Act	Senate Finance Committee America's Healthy Future Act
Medicaid Benefits and Access Changes (continued)			
Quality and program integrity (continued)		• *E&C Committee amendment: Establishes the Center for Medicare and Medicaid Payment Innovation Center to test payment models that address populations experiencing poor clinical outcomes or avoidable expenditures. Evaluate all models and expand those models that improve quality without increasing spending or reduce spending without reducing quality, or both.*	• 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.
DSH	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.	• Reduces federal DSH payments 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.	• Reduces a state's Medicaid DSH allotment by 50% (25% for low DSH states) once the uninsured rate decreases by at least 50%. 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.
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 US District Court issued a preliminary injunction against this change.	• Changes payments to pharmacists; additional rebate for new formulations of existing drugs; increases minimum rebate for single source drugs; extends prescription drug rebates to Medicaid managed care plans.	• Increases the Medicaid drug rebate percentage for brand name drugs to 23.1, increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price, and extend the drug rebate to Medicaid managed care plans (excludes 340B programs). • Requires the Comptroller General to review state laws that have a negative impact on generic drug utilization in federal programs.
Medicaid provisions for American Indians and Alaska natives	ARRA prohibits premiums and cost-sharing for Indians who are provided services by Indian Health providers (including Urban Indian organizations) or through referral by contract health services.	No provision.	• Prohibits cost-sharing for all AI/AN with incomes below 300% FPL for state exchange plans and public programs. • Adds Indian tribes, tribal organizations and urban Indian organizations to the definition of an Express Lane Agency. • Ensures that Indian tribes, tribal organization and urban Indian organizations are the payers of last resort.

	Current Law	House Tri-Committee America's Affordable Health Choices Act	Senate Finance Committee America's Healthy Future Act
Medicaid Benefits and Access Changes (continued)			
Territories	Medicaid programs in the territories are subject to spending caps. The FMAP is statutorily set at 50% for the territories.	• Includes $10.350 billion for 2011-2019 available to increase the caps for the territories. (Optional Medicaid coverage to low-income HIV-infected individuals exempt from caps). • *E&C Committee amendment: Specifies the caps for each jurisdiction for each year and raises the FMAP from 50% to the highest of any state (76%).*	• Increases spending caps for the territories by 30% and the applicable FMAP by 5 percentage points (from 50% to 55%) beginning January 1, 2011. • The cost of covering newly eligibles would not count toward these spending caps.
Sources of information		Ways and Means Committee: http://waysandmeans.house.gov/MoreInfo.asp?section=52 Energy and Commerce Committee: http://energycommerce.house.gov/index.php?option=com_content&view=article&id=1687&catid=156&Itemid=55 Education and Labor Committee: http://edlabor.house.gov/newsroom/2009/07/ed-labor-approves-historic-hea.shtml	http://www.finance.senate.gov/

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