# MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM PROVISIONS IN THE NEW HEALTH REFORM LAW

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act (P.L. 111-148), into law. The Health Care and Education Affordability Act of 2010 which included changes to the new law was signed on March 30, 2010. Overall, the new law includes an individual requirement to obtain health insurance, a significant Medicaid expansion and subsidies to help low-income individuals buy coverage through newly established Health Benefit Exchanges. The following summary examines the provisions related to Medicaid and the Children's Health Insurance Program (CHIP) included in the new health reform law.

## Medicaid Coverage and Financing.

The new law expands Medicaid to a national floor of 133% of poverty ($14,404 for an individual or about $29,326 for a family of four in 2009) to help reduce state-by-state variation in eligibility for Medicaid and also include non-Medicare eligible adults under age 65 without dependent children who are currently not eligible for the program. Children currently covered by CHIP between 100% and 133% of poverty would be transitioned to Medicaid coverage. These changes help to provide the base of seamless and affordable coverage nationwide through Medicaid for those with incomes up to 133% of poverty and then subsidies for coverage for individuals with incomes between 133% and 400% of poverty through state-based Health Benefit Exchanges. Individuals eligible for Medicaid would not be eligible for subsidies in the state exchange. For most Medicaid enrollees, income would be based on modified adjusted gross income without an assets test or resource test.[1]

The new law provides full federal financing for those newly eligible for Medicaid for 2014-2016; 95% FMAP for 2017; 94% FMAP for 2018; 93% FMAP for 2019 and 90% FMAP for 2020 and beyond. Those newly eligible include individuals with income above a states' eligibility level on the date of enactment (March 23, 2010) and 133% of poverty, those not eligible for full benefits, benchmark or benchmark equivalent coverage in Medicaid, individuals eligible for a capped program but not enrolled or on a waiting list and those covered in a non-Medicaid state funded program. States that have already expanded eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for currently Medicaid eligible non-pregnant childless adults so that by 2019 they receive the same federal financing as other states (93% in 2019 and 90% in 2020).[2] States are required to maintain eligibility in place on the date of enactment of the legislation (March 23, 2010) for children in Medicaid and CHIP through 2019 and for adults in Medicaid until 2014 (when coverage through new Health Benefit Exchanges is expected to be available).

## Children's Health Insurance Program (CHIP).

The legislation provides funding for CHIP through 2015 (an additional two years compared to current law), continues the authority for the program through 2019 and requires states to maintain eligibility standards for children in Medicaid and CHIP through 2019. 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.

[1] There is a special deduction to income equal to five percentage points of the poverty level raising the effective eligibility level to 138% of poverty. The legislation 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)).

[2] It appears that AZ, DE, DC, HI, ME, MA, MN, NY, PA, VT, WA and WI are expansion states. Expansion states that do not have new eligibles and are not using Disproportionate Share Hospital (DSH) payments for coverage under a waiver would receive a 2.2 percentage point increase in FMAP for individuals who are not newly eligible up to 133% of poverty. This provision appears to apply to Vermont.

## Benefits and Access.

The new law provides all newly-eligible adults with a benchmark benefit package or benchmark-equivalent that meets the minimum essential health benefits available in the Exchange. The new law increases Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014 with 100% federal financing for the increased payment rates. The new law also broadens the scope of the Medicaid and CHIP Payment and Access Commission (MACPAC) to include all eligible individuals (not just children), establishes 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.

## Duals and Long-Term Care.

The new law 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% of poverty who require an institutional level of care through a state plan amendment (SPA) and provides states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. The new law requires the Secretary to improve coordination of care for dual eligibles through a new office within the Centers for Medicare and Medicaid Services. The legislation also establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program).

## Cost Estimates.

The Congressional Budget Office (CBO) estimates that the legislation will increase Medicaid/CHIP coverage by 16 million from a baseline of 35 million by 2019 with a federal Medicaid/CHIP federal cost of $434 billion from 2010 to 2019 due to coverage related changes. CBO estimates that the coverage related changes in the legislation will increase state spending over baseline spending by $20 billion over the 2010 to 2019 period. Other significant federal Medicaid costs over the 2010 to 2019 period are related to: improving payments to primary care practitioners ($8.3 billion) and the Community First Choice Option ($6.09 billion). Significant federal Medicaid savings over the 2010 to 2019 period are related to: Medicaid prescription drug coverage (-$38.14 billion) and reductions in Medicaid disproportionate share hospital (-$14.0 billion).

A more detailed analysis of Medicaid and CHIP provisions in the new legislation follows. A comprehensive side-by-side of this legislation in addition to other health proposals can be found at http://www.kff.org/healthreform/sidebyside.cfm.

## SUMMARY OF MEDICAID AND CHIP PROVISIONS IN THE NEW HEALTH REFORM LAW

This summary compares the Medicaid and CHIP provisions in the Patient Protection and Affordable Care Act (P.L. 111-148) along with changes made to the law by The Health Care and Education Reconciliation Act of 2010. 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 the new health reform law can be found at: http://www.kff.org/healthreform/sidebyside.cfm.

| | Pre-Reform Law | Patient Protection and Affordable Care Act (P.L. 111-148) |
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| **Status** | | The Patient Protection and Affordable Care Act was signed by President Obama on March 23, 2010. The Health Care and Education Reconciliation Act of 2010, which made changes to the Patient Protection and Affordable Care Act was signed by President Obama on March 30, 2010. |
| **Overall approach to expanding access to coverage** | | Requires most individuals to have health insurance through a combination of public and private coverage expansions.<br>Expands Medicaid to 133% of the poverty level in 2014 and maintains CHIP and Medicaid for children through 2019.<br>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 133–400% of poverty and creates separate exchanges through which small businesses can purchase coverage. |
| **Medicaid eligibility for children, pregnant women, parents and individuals with disabilities** | 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.<br>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:<br>4 states <200% FPL<br>23 states 200 – 250% FPL<br>24 states >250% FPL<br>States must cover **pregnant women** with income below 133% FPL.<br>11 states at 133-184% FPL<br>16 states 185% FPL<br>24 states >185% FPL | • Establishes a minimum Medicaid coverage threshold for children ages 6 to 19 and parents with incomes up to 133% FPL based on modified adjusted gross income with special adjustment of 5 percentage points to bring effective income eligibility to 138% FPL. Eligibility is determined without an assets or resource test (Implementation: January 1, 2014).<br>• Maintains eligibility levels in place on the date of enactment (March 23, 2010) for parents through 2014 and for children through 2019 and allows states the option to provide Medicaid coverage to individuals with incomes above 133% of poverty at regular state matching rates. |

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| **Medicaid eligibility for children, pregnant women, parents and individuals with disabilities** (continued) | States must cover **parents** below states' July 1996 welfare levels.<br>For Parents:<br>39 states <133% FPL<br>12 states > or = 133% FPL<br>State must cover most **elderly and persons with disabilities** receiving Supplemental Security Income (SSI) and certain low-income Medicare beneficiaries. | |
| **Eligibility for adults without dependent children** | 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.<br>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. | • Establishes a new eligibility category for all non-pregnant, non-Medicare eligible childless adults under age 65 who are not otherwise eligible for Medicaid and requires minimum Medicaid coverage at 133% FPL based on modified adjusted gross income (MAGI) with special adjustment of 5 percentage points to bring effective income eligibility to 138% FPL. Eligibility is determined without an assets or resource test (Implementation: January 1, 2014).<br>• Creates a state option to cover childless adults though a Medicaid State Plan Amendment (Implementation: April 1, 2010).<br>• Maintains coverage levels in place on the date of enactment (March 23, 2010) until 2014 and allows states the option to provide Medicaid coverage to individuals with incomes above 133% of poverty at regular state matching rates.<br>• Permits states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees. States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges. |
| **Determination of Income** | In general, states also have flexibility to determine income and resource methodologies for purposes of determining Medicaid eligibility. | • Bases eligibility on modified adjusted gross income (MAGI) with no asset or resource test. MAGI includes total income plus tax exempt interest and foreign earned income. Applies a special adjustment of 5 percentage points to bring effective income eligibility to 138% FPL. |

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| **Determination of Income** (continued) | | • 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)). Does not affect eligibility determinations made though Express Lane Eligibility. Requires states to establish equivalent income thresholds to implement the MOE requirements for children using MAGI that ensures that individuals eligible on January 1, 2014 do not lose coverage. MAGI would not apply to beneficiaries enrolled as of January 1, 2014, until March 31, 2014 or their next re-determination date. (Implementation: January 1, 2014) |
| **Other coverage** | 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.<br><br>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. | • Establishes Medicaid coverage (with EPSDT benefits) for children under age 26 who were in foster care when they turned 18 (Implementation: January 1, 2014).<br>• Creates a state option to provide Medicaid coverage for family planning services through a State Plan Amendment to certain low-income individuals up to the highest level of eligibility for pregnant women (Implementation: Upon enactment).<br>• Requires states to report annually beginning January 2015 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 beginning in April 2015 annually on a state-by-state basis.<br>• Permits all hospitals participating in Medicaid (with state verification of capability) to make presumptive eligibility determinations and allows hospitals and other providers to make presumptive eligibility determinations for all Medicaid eligible populations (Implementation: January 2014). |
| **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. | • Requires states to maintain current income eligibility levels in place on the date of enactment (March 23, 2010) for children in Medicaid and CHIP through September 30, 2019.<br>• Requires states to maintain Medicaid eligibility levels for adults in place on the date of enactment (March 23, 2010) until the Secretary determines that the state exchanges are fully operational (expected to be January 1, 2014).<br>• 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.<br>• Conditions Medicaid payments on compliance with the maintenance of eligibility requirements. |

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| 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. | • Extends authorization and funding for CHIP through 2015 (2 years beyond the current authorization) and requires states to maintain income eligibility levels in place on the date of enactment (March 23, 2010) for Medicaid and CHIP through 2019.<br>• 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.<br>• Provides for a 23 percentage point increase in the CHIP match rate up to a cap of 100% beginning in October 1, 2015.<br>• Does not extend the CHIPRA enrollment bonuses beyond 2013.<br>• 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 (Implementation: Upon Enactment).<br>• 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. |
| Medicaid/CHIP financing | 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. | • Provides full federal funding (100% FMAP) for individuals newly eligible for Medicaid (includes those not eligible for full benefits, benchmark or benchmark equivalent coverage in Medicaid, those eligible for a capped program but not enrolled or on a waiting list and those covered in a non-Medicaid state funded program) for 2014-2016; 95% FMAP for 2017; 94% FMAP for 2018; 93% FMAP for 2019 and 90% FMAP for 2020 and beyond.<br>• Phases in increase in the FMAP for expansion states for current Medicaid coverage of non-pregnant childless adults so that by 2019 they receive the same federal financing as other states (93% in 2019 and 90% in 2020). Expansion states are those that currently cover adults (parents and childless adults) at or above 100% FPL (through Medicaid or state-funded health programs) that is not dependent on access to employer coverage or employment and not limited to premium assistance, hospital-only benefits, a high-deductible plan or alternative benefits under Section 1938. It appears that AZ, DE, DC, HI, ME, MA, MN, NY, PA, VT, WA and WI are expansion states. |

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| **Medicaid/CHIP financing** (continued) | | • Provides for a 2.2 percentage point increase in FMAP for individuals who are not newly eligible up to 133% of poverty for expansion states that do not have new eligibles and are not using Disproportionate Share Hospital (DSH) payments for coverage under a waiver would receive a 2.2 percentage point increase in FMAP. This provision appears to apply to Vermont.<br>• 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.<br>• Provides a special adjustment to the FMAP for certain states recovering from a major disaster (Implementation: January 1, 2011).<br>• Clarifies that states must maintain Medicaid and CHIP eligibility to continue to receive Medicaid funding. |
| **CBO scoring for Medicaid** | | • Increases Medicaid/CHIP coverage by 16 million from 35 million by 2019.<br>• Estimates Medicaid/CHIP costs for coverage to increase by $434 billion from 2010 to 2019.<br>• Estimates state spending on Medicaid and CHIP would increase by about $20 billion over the 2010 to 2019 period as a result of the coverage provisions.<br>• Other significant federal Medicaid costs over the 2010 to 2019 period are related to: Improving payments to primary care practitioners ($8.3 billion) and the Community First Choice Option ($6.0 billion).<br>• Significant federal Medicaid savings over the 2010 to 2019 period are related to: Medicaid prescription drug coverage (-$38.1 billion) and reductions in Medicaid disproportionate share hospital (-$14.0 billion). |
| **Medicaid interface with the exchange** | | • 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. (Enrollment website must be operational by January 1, 2014)<br>• 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. |
| **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.<br>Medicaid provides comprehensive coverage for children through the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit. | • Provides all newly-eligible adults with a benchmark benefit package or benchmark-equivalent that meets minimum essential health benefits available in the Exchange (including prescription drugs and mental health parity at actuarial equivalence to the benchmark). Populations exempt from mandatory enrollment in these benchmark plans (including the elderly, persons with disabilities and pregnant women) would remain exempt. |

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| **Medicaid benefits and delivery system** (continued) | 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.<br><br>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).<br><br>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. | • 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).<br>• Requires coverage for smoking cessation for pregnant women without cost sharing (Implementation: October 1, 2010)<br>• Eliminates smoking cessation drugs, barbiturates, and benzodiazepines from excluded drug list (Implementation: January 1, 2014).<br>• Requires coverage for free standing birth center services (Implementation: upon enactment except if state legislation is required).<br>• Allows Medicaid eligible children to receive hospice services concurrent with other treatment.<br>• Allows states to provide coordinated care through a health home for individuals with chronic conditions. Provides 90% match for 2 years for health home services including care management, care coordination and health promotion, transitional care, patient and family support and referral to community and social support services and use of HIT where feasible and appropriate Provides $25 million for the Secretary to award for planning grants (Implementation: January 1, 2011). |
| **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.<br><br>CHIPRA established the Medicaid and CHIP Payment and Access Commission (MACPAC) to examine payment policies and access for children and report to Congress. | • Increases payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014 and provides 100% federal financing for the difference in rates based on rates applicable on July 1, 2009. Primary care services are defined as evaluation and management services service codes and services related to immunizations.<br>• 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 million for FY 2010 with $9 million from Medicaid and $2 million from CHIP)<br>• 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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| Demonstrations and pilots | | • Authorizes $100 million in grant funding for states to establish programs for Medicaid beneficiaries to cease tobacco use, control weight, lower cholesterol, lower blood pressure and/or avoid or improve management of diabetes. (Implementation: January 1, 2011)<br>• 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).<br>• 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).<br>• 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).<br>• 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 (Implementation: (Appropriations of $75 million for fiscal year 2011 through 2015).<br>• 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 (Implementation: Issue regulations 180 days post enactment). |
| 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 U.S. | • 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, 2011).<br>• Provides states with new options for offering home and community-based services through a Medicaid State Plan Amendment rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and a higher level of need and permits states to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan (Implementation: October 1, 2010).<br>• 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 stated will be eligible for FMAP increases for medical assistance expenditures for non-institutionally-based long-term services and supports with $3 billion in federal matching funds (Implementation: October 1, 2011 through September 30, 2015). |

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| **Long-term care** (continued) | | • 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).<br>• Allocate $10 million per year for 2010 through 2014 to continue the Aging and Disability Resource Center initiatives.<br>• Includes protections against spousal impoverishment in Medicaid HCBS (Implementation: January 1, 2014 for five years).<br>• 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.<br>• 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). |
| **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 | • 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).<br>• Clarifies Medicaid demonstration authority for coordinating care for the duals for up to 5 years. |
| **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.<br>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. | • 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, standardization of reporting formats, and requires a report to Congress (January 2014 and then every 3 years).<br>• Prohibits federal payments to states for Medicaid services related to healthcare acquired conditions (Implementation: Through regulations effective July 1, 2011).<br>• 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). |

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| **Quality and program integrity** (continued) | | • Requires CMS to include Medicare, Medicaid, CHIP, VA, DOD SSA and IHS 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.<br>• Extends the 60 days that states have to repay the federal share of a Medicaid overpayment to one year or 30 days after an amount is determined through the judicial processes (Implementation: Upon enactment).<br>• Authorizes the Secretary to withhold matching payments when states do not report enrollee encounter data through MMIS in a timely way.<br>• Terminates provider participation in Medicaid and CHIP if a provider is terminated under Medicare or other state or child health plan.<br>• 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.<br>• Requires additional data reporting to MMIS to detect waste, fraud and abuse (Implementation: January 1, 2010).<br>• Requires billing agents, clearinghouses and alternative payees to register under Medicaid.<br>• Mandates state use of national correct coding initiative (Implementation: October 1, 2010).<br>• 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.<br>• 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.<br>• Increases funding for health care fraud and abuse control funding by $10 million per year (Implementation: Fiscal year 2011 through 2020).<br>• Requires states to implement fraud, waste, and abuse programs by January 1, 2011. |
| **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 aggregate DSH allotments by $.5 billion in 2014; $.6 billion in 2015; $.6 billion in 2016; $1.8 billion in 2017; $5 billion in 2018; $5.6 billion in 2019 and $4 billion 2020. Requires the Secretary to develop a methodology to distribute the DSH reductions that imposes the largest reduction in DSH for states with the lowest percentage of uninsured, imposes smaller reductions for low-DSH states and accounts for DSH allotments used for 1115 waivers. Provides DSH allotments for TN and HI. |

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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. | • Increases the Medicaid drug rebate percentage for brand name drugs from 15.1% 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. For purposes of applying the additional rebates, a new formulation of a drug is a line extension of a single source or innovator multiples source drug that is an oral solid dosage form of the drug (Implementation: January 1, 2010 except for rebates for managed care plans which is effective upon enactment).<br>• 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. | • Increases spending caps for the territories by $7.3 billion from 2014 through 2019 and allows each territory to establish a Health Benefits Exchange.<br>• Requires the territories to cover childless adults up to the eligibility standards in place for parents and exempts the costs of new coverage in counting toward the spending caps. |
| Sources of information | | www.democraticleader.house.gov/ |

This publication (#7952-03) is available on the Kaiser Family Foundation's website at www.kff.org.

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