KEY QUESTIONS ABOUT CHANGES FOR MEDICAID AND LOW-INCOME INDIVIDUALS

This brief highlights some key questions about provisions related to Medicaid, the Children's Health Insurance Program (CHIP), and provisions that affect low-income individuals included in HR 3200, the America's Affordable Health Choices Act of 2009 (the House Tri-Committee Bill) released on July 14, 2009. Medicaid is the nation's primary health insurance program for low-income and high-need Americans providing affordable and comprehensive coverage to 60 million Americans. States administer the Medicaid program within broad federal guidelines and financing is shared between states and the federal government. Key elements of the bill that affect Medicaid and low-income individuals include:

- Requirement that individuals have health insurance through a combination of public and private coverage expansions;
- Expansion of Medicaid to a national floor of 133% of poverty which would reduce state-by-state variation in eligibility for Medicaid and also include adults without dependent children who are currently not eligible for the program; expansions would be fully federally financed. Individuals with Medicaid above 133% of poverty would continue to be eligible;
- Increases in Medicaid provider payment rates for primary care services to 100% of the Medicare rates by 2012 with 100% federal financing for the increase;
- Elimination of the CHIP program in 2013 and the transition of CHIP enrollees to the new health insurance exchange; and
- Subsidies for eligible low-income individuals not eligible for Medicaid or employer-sponsored coverage to purchase health insurance in a new health insurance exchange.

A more detailed analysis of these provisions compared to current law is found at the end of this brief. 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.

Medicaid Coverage and Financing Changes

- **Who is eligible for Medicaid under current law?**

  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 which has resulted in significant program variation across states. States also have flexibility to determine income and resource methodologies for purposes of determining Medicaid eligibility. Almost all states currently cover children in Medicaid or CHIP with family incomes at or above 200% of poverty; however, eligibility levels for parents are more limited and federal law prohibits states from covering adults without dependent children under Medicaid without a waiver. Forty states cover working parents and 39 states cover jobless parents with incomes at or below 133% of poverty. Six states have waivers to cover childless adults with benefits comparable to Medicaid and 11 states have waivers to cover this population with more limited benefits or limited enrollment. States must cover most elderly and persons with disabilities receiving Supplemental Security Income (SSI) and certain low-income Medicare beneficiaries.

- **Who would be newly eligible for Medicaid under America's Affordable Health Choices Act?**

  The Act would establish a minimum coverage threshold for Medicaid for individuals with family income up to 133% of poverty ($14,400 for an individual in 2009) which would increase eligibility for parents in many states and newly include adults without dependent children in the program. States that currently cover children between 100% and 133% FPL under a separate CHIP program would be required to shift that coverage to Medicaid. In addition, newborns without acceptable coverage will be auto-enrolled in Medicaid for 60 days. States would have new eligibility options for family planning and for low-income HIV-infected individuals (coverage for HIV-infected individuals would end when exchange plans are operational).

- **What happens to those currently eligible for Medicaid?**
  America's Affordable Health Choices Act includes a maintenance of effort that would require states to hold eligibility standards, methods and procedures that are no more restrictive than June 16, 2009. Without an MOE, states may have a fiscal incentive to drop coverage for groups at income levels beyond the new federal minimums. In these cases, individuals could lose critical benefit and cost-sharing protections provided under Medicaid coverage that may not be offered through subsidized private coverage plans in the exchange. Overall, the Act could increase participation of individuals currently eligible for Medicaid but not enrolled.

- **How would Medicaid expansions be financed?**
  Under the current Medicaid structure, financing for the program is shared by the federal government and the states according to a formula set in law based on states' relative per capita income. Particularly in the current economic recession, states are struggling to pay for their current Medicaid programs and maintain that they do not have the fiscal capacity to finance Medicaid expansions. Recognizing these constraints, the America's Affordable Health Choices Act would provide full federal financing for all new coverage for childless adults and for childless adults currently covered by waivers. Full federal financing would also be provided for new Medicaid coverage of traditional eligibles above states' current eligibility levels up to 133% FPL and for traditional eligibles current covered by waivers from 1931 minimums and up to 133% FPL. Temporary coverage of newborns without acceptable coverage would also have full federal financing.

- **How much would Medicaid expansions cost and how many people would be covered?**
  The Congressional Budget Office estimates that the America's Affordable Health Choices Act would reduce the number of uninsured by 37 million from an estimated 54 million leaving 17 million uninsured. Medicaid coverage would increase by 11 million from 35 million and an estimated 30 million would participate in the Exchange in 2019. The result would be that 94% of the non-elderly population would be insured or 97% excluding unauthorized immigrants. CBO estimates that the average subsidy for enrollees subsidized in the exchange would be $6,000 by 2019. CBO estimates that the net impact of the coverage provisions in the Act would increase federal costs by $1.042 trillion over the 2010 to 2019 period. Medicaid costs are expected to increase by $438 billion and exchange subsidies account for $773 billion of the total increase from 2010 to 2019. CBO also estimates state spending on Medicaid and CHIP would be reduced by about $10 billion over the 2010 to 2019 period.

Medicaid and CHIP Interface with a Health Insurance Exchange and Low-Income Subsidies

- **How would Medicaid enrollees access coverage?**
  States have the option under current law to provide services for Medicaid beneficiaries through managed care arrangements or through fee-for-service. On average, 64.1% of Medicaid enrollees are in managed care. Under the America's Affordable Health Choices Act Medicaid beneficiaries would continue to receive care through the current Medicaid program structure. Adults without dependent children (non-traditional Medicaid eligibles) with incomes at or below 133% of poverty who had private health insurance within the last six months would be able to choose whether to enroll in Medicaid or the Health Insurance Exchange.

- **How does Medicaid work with the Exchange?**
  States must enter into a Memorandum of Understanding (MOU) with the Health Choices Commissioner to coordinate enrollment of individuals in Exchange-participating health plans and under the state's Medicaid program. States may be authorized to determine eligibility for subsidies or affordability credits through the Health Insurance Exchange. There is a "Medicaid screen and enroll obligation" that would require states to enroll non-traditional Medicaid-eligible individuals (childless adults) in Medicaid if they apply for coverage in the exchange and are found to be Medicaid eligible. Under an MOU, states must accept without further determination these individuals screened 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. If individuals apply for Medicaid but are not eligible, there is no requirement that they be auto-enrolled in the exchange.

- **What happens to the Children's Health Insurance Program (CHIP)?**
  The Children's Health Insurance Program, which covers uninsured, low-income children with incomes above Medicaid levels, was reauthorized through 2013. The America's Affordable Health Choices Act would require CHIP enrollees to obtain coverage through the exchange in 2013 or year one of enactment; however, CHIP enrollees with incomes between 100% and 133% of poverty would be transitioned to Medicaid instead of the exchange. There is a CHIP MOE similar to the Medicaid MOE that would remain in place until CHIP enrollees are transitioned into the exchange. This transition would take place in year one (2013) or 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. Children transitioned from CHIP to the exchange could face higher cost-sharing and could lose access to certain benefits such as EPSDT (Early Periodic Screening Diagnostic and Treatment Services) especially if they were in a Medicaid-expansion CHIP program.

- **How do low-income subsidies work?**
  The America's Affordable Health Choices Act would provide for subsidies for eligible low-income individuals to purchase insurance coverage through the exchange. The Act would provide affordability premium credits to individuals with incomes up to 400% FPL to purchase insurance through the Health Insurance Exchange. The premium credits will be set on a sliding scale so that premium contributions are limited to 1.5% of income for individuals with income at or below 133% FPL and no more than 11% of income for individuals at 400% FPL. The Act would also provide a sliding scale for cost-sharing credits that would have the effect of increasing the actuarial value of the basic benefit plan to 97% for those with incomes 133-150% or poverty and to 70% for those with incomes from 350-400% of poverty. The Act would limit annual cost-sharing to $5,000/individual and $10,000/family and does not impose annual or lifetime limits on coverage. Individuals with access to employer sponsored coverage (or other qualified coverage such as Medicaid or Medicare) are not eligible to participate in the exchange and receive premium or cost-sharing credits unless the employer based coverage premium exceeds 11% of the individual's income. Individuals with employer sponsored coverage may face higher cost-sharing than what is available to individuals in the exchange.

- **What are the benefit packages for plans offered in the exchange?**
  The America's Affordable Health Choices Act would create an essential benefits package that provides a comprehensive set of services and covers 70% of the actuarial value of the covered benefits. The Health Benefits Advisory Council, chaired by the Surgeon General, will make recommendations on specific services to be covered by the essential benefits package as well as cost-sharing levels. The essential benefits must include well baby, well child, oral health, vision, hearing, equipment and supplies for children under 21 and preventive services with no cost-sharing. An amendment in the Education and Labor Committee added EPSDT for children under 21 to the essential benefits package. The essential benefits are included in the basic plan and then there may be optional offerings of an enhanced plan, premium plan and premium plus plan. The Health Choices Commissioner can specify that plans contract with essential community providers.

Medicaid Benefits and Access Changes

- **Does the Affordable Health Choices Act change Medicaid benefits?**
  Under current law Medicaid covers a broad range of acute and long-term care services designed to serve low-income and high-need populations. States must cover certain mandatory services but are permitted to cover important services that are "optional". Medicaid provides comprehensive coverage for children through the EPSDT benefit. Some services covered typically are not included in private plans such as 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). The America's Affordable Choices Act would retain current Medicaid benefits and require coverage for preventive services, payment for services at school-based clinics, establish a medical home pilot program and eliminate exclusions for smoking cessation drugs. There would be optional coverage for nurse home visitation services and free standing birth center services. The Act would also specify that payment for Graduate Medical Education is included in the definition of medical assistance.

- **Do health reform bills increase Medicaid provider 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 and other practitioner 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. To help promote provider participation and improve access to providers, the America's Affordable Health Choices Act would phase in Medicaid payment rates for primary care services to 100% of Medicare rates by 2012. The cost of the rate increases would be 100% federally financed over a 2009 base.

- **What would happen to DSH?**
  Medicaid disproportionate hospital share (DSH) payments are supplemental payments that states can use to reimburse hospitals that serve high levels of Medicaid and uninsured patients. Federal DSH funds are capped and represent about 5% of all Medicaid spending. Because the America's Affordable Health Choices Act is expected to reduce uninsured rates, the Act would reduce 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. The Act 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.

- **Are there changes to Medicaid reimbursement for 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 Act includes changes to payments to pharmacists, prescription drug rebates and extends prescription drug discounts to managed care enrollees.

- **What would happen to duals and long-term care?**
  Medicaid provides assistance to 8.8 million low-income elderly and disabled 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. The America's Affordable Health Choices would create a new Office within CMS to help coordinate care for the duals. The Act would also increase the asset test for the Medicare Savings Program which could increase costs to Medicaid. An amendment in the Energy and Commerce Committee was accepted to establish 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.

- **Are there changes to Medicaid quality and program integrity?**
  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. The Act would specify that Medicaid would not pay for certain health care acquired conditions, would require reports under the Medicaid Integrity Program and would require providers and suppliers to adopt programs to reduce waste fraud and abuse.

- **Do states have fiscal, administrative and provider capacity for health reform proposals?**
  If health reform passes, HHS would need to issue regulations and guidance to clarify new roles for states for Medicaid and other aspects of health reform. States may need to change state law, state regulations, provide additional funding in their budgets and build capacity to handle new responsibilities. New coverage requires additional systems to process applications and additional providers to serve those newly eligible. These changes and additional capacity will not be in place immediately after health reform passes. Adequate time for states to be ready for the multitude of changes required by changes in the America's Affordable Health Choices Act and other health reform proposals is necessary.

SIDE-BY-SIDE OF MEDICAID, CHIP AND LOW-INCOME PROVISIONS TO CURRENT LAW

This analysis compares the Medicaid provisions in the House Tri-Committee, America's Affordable Health Choices Act 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. This side-by-side will be regularly updated to reflect changes in the proposals and to incorporate major new proposals as they are announced. 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 of 2009
Date plan announced		Introduced July 14, 2009
Status		Bill passed out of Ways and Means and Education and Labor Committees.
Overall approach to expanding access to coverage		Requires 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.
MEDICAID COVERAGE AND FINANCING 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. 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:* 40 states < 133% FPL 11 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.	• 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. • States that currently cover children between 100% and 133% FPL under a separate CHIP program would be required to shift that coverage to Medicaid. • Extends Medicaid eligibility status to any newborn who does not have acceptable coverage for 60 days (until transition to Medicaid or other qualified coverage).

	Current Law	House Tri-Committee America's Affordable Health Choices Act of 2009
MEDICAID COVERAGE AND FINANCING CHANGES (continued)		
Eligibility for adults without dependent children (Non-traditional Medicaid eligibles)	Adults without dependent children are not generally covered by Medicaid unless a state has a waiver to cover this population. Medicaid Waivers for Childless Adults: 6 states with benefits comparable to Medicaid and 11 states with limited benefits or limited enrollment.	• Establishes new Medicaid coverage for childless adults under age 65 ("Non-Traditional" Medicaid Eligible Individuals) up to 133% FPL.
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.
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.
Medicaid financing for new coverage	Medicaid financing is shared across state and federal governments. On average the federal government pays for 57% of Medicaid costs, but this varies by state according to a formula set in statute that relies on states per capita income. In 2003 and again in 2009, Congress passed legislation to provide for an enhanced federal match (FMAP) 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.
CBO scoring		• The Congressional Budget Office estimates that the Act would reduce the number of uninsured by 37 million from an estimated 54 million leaving 17 million uninsured. Medicaid coverage would increase by 11 million from 35 million and an estimated 30 million would participate in the Exchange. 94% of the non-elderly population would be insured or 97% excluding unauthorized immigrants. • CBO estimates that the average subsidy for enrollees subsidized in the exchange would be $6,000 by 2019. • CBO estimates that the net impact of the coverage provisions in the Act would increase federal costs by $1.042 trillion over the 2010 to 2019 period. Medicaid costs are expected to increase by $438 billion and exchange subsidies account for $773 billion of the total increase from 2010 to 2019. • CBO also estimates state spending on Medicaid and CHIP would be reduced by about $10 billion over the 2010 to 2019 period.

	Current Law	House Tri-Committee America's Affordable Health Choices Act of 2009
INTERFACE BETWEEN MEDICAID / CHIP AND THE EXCHANGE AND SUBSIDIES FOR LOW-INCOME INDIVIDUALS		
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.	• CHIP expires in 2013. • 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.
Premium subsidies to low-income individuals		• Provides affordability premium credits to individuals with incomes up to 400% FPL to purchase insurance through the Health Insurance Exchange. The premium credits will be set on a sliding scale so that the premium contributions are limited to 1.5% of income for individuals with income at or below 133% FPL and no more than 11% of income for individuals at 400% FPL. • Provides a sliding scale for affordability cost-sharing credits that would have the effect of increasing the actuarial value of the basic benefit plan to 97% for those with incomes 133-150% or poverty and to 70% for those with incomes from 350-400% of poverty. • Individuals with access to employer sponsored coverage (or other qualified coverage such as Medicaid or Medicare) are not eligible to participate in the exchange or receive premium or cost-sharing credits unless the employer based coverage premium exceeds 11% of the individual's income. • Eligibility for affordability credits are based on adjusted gross income. • Exchange Commissioner directed to study income disregards and the feasibility / implications related to adjusting the FPL to reflect cost-of-living for the purposes of income eligibility for affordability credits.
Benefits in the exchange		• Creates an essential benefits package that provides a comprehensive set of services and covers 70% of the actuarial value of the covered benefits. • Limits the value of the essential benefits plan to the average prevailing employer coverage. • Health Benefits Advisory Council, chaired by the Surgeon General, will make recommendations on specific services to be covered by the essential benefits package as well as cost-sharing levels.

	Current Law	House Tri-Committee America's Affordable Health Choices Act of 2009
INTERFACE BETWEEN MEDICAID / CHIP AND THE EXCHANGE AND SUBSIDIES FOR LOW-INCOME INDIVIDUALS (continued)		
Benefits in the exchange (continued)		• Benefits must include well baby/child, oral health, vision, hearing, equipment and supplies for children under 21 and preventive services with no cost-sharing. An amendment adopted by the Education and Labor Committee would add Early and Periodic Screening Diagnostic and Treatment Services (EPSDT) to the essential benefits package for children. • The essential benefits are included in the basic plan and then there may be optional offerings of an enhanced plan, premium plan and premium plus plan. • The Health Choices Commissioner can specify that plans contract with essential community providers. • Limits annual cost-sharing to $5,000/individual and $10,000/family; and does not impose annual or lifetime limits on coverage. No cost-sharing for preventive services. • All policies, including those offered through the Exchange and outside of the Exchange (except certain grandfathered plans) must provide at least the essential benefits package. • Benefits in the exchange will not include key Medicaid benefits such as long-term care and other enabling services that are important for high-need populations.
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.

	Current Law	House Tri-Committee America's Affordable Health Choices Act of 2009
MEDICAID BENEFITS AND ACCESS CHANGES		
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. 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 coverage for certain preventive services and vaccines with no cost-sharing (with enhanced FMAP for these services). • Eliminates smoking cessation coverage from excluded drug list and requires coverage of tobacco cessation counseling for pregnant women. • Provides optional coverage of nurse home visitation services. • 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%.
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.	• 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.
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.	• Amendment added by Energy and Commerce 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.
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. • Increases the asset test for the Medicare Savings Program.

	Current Law	House Tri-Committee America's Affordable Health Choices Act of 2009
MEDICAID BENEFITS AND ACCESS CHANGES (continued)		
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.
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.
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.	• Changes payments to pharmacists; additional rebate for new formulations of existing drugs; increases minimum rebate for single source drugs; extends prescription drug discounts to Medicaid managed care plans.
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.)
Sources of information		http://waysandmeans.house.gov/

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