



Agency for Health Care Administration

Overview of National Health Care Reform Proposals

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Appropriations Committee

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Proposals

- Senate: HR 3590 – Patient Protection and Affordable Care Act (Manager’s Amendment 12/24/2009)
- House: HR 3962 – Affordable Health Care for America Act (11/7/2009)

Key Elements

- Individual mandate for health insurance coverage
- Assistance for premiums and cost sharing
- Requirements for businesses to offer employee coverage
- New regulations/requirements for health insurers
- Creation of health insurance exchanges or cooperatives
- Public Option
- State Opt Out
- Medicaid and CHIP Maintenance of Effort
- Federal pharmacy rebate pricing
- Reduction in Disproportionate Share funding to states
- Medicaid Fraud and Abuse Requirements
- Medicaid Expansion
- CHIP Changes
- Administrative Costs for States

Key Elements: Maintenance of Effort

- Medicaid and CHIP maintenance of effort requirements
- Senate
 - All provisions including waivers must continue as in place at the time of enactment
- House
 - Provisions including waivers cannot be more restrictive than those in place as of June 16, 2009

Key Element: Federal Pharmacy Rebates

➤ House:

- Increased for single source drugs by 8% from 15.1% to 23.1% after 12/31/09.
- Extends Medicaid pharmacy rebates to Medicaid Managed Care. Payments made to Medicaid agency rather than MCO.
- Florida Medicaid has done a good job negotiating state supplemental rebates at a higher level than the Florida required minimum total of 29.1%, and overall rebate collections generate a 43% return.

➤ Senate:

- Increased for single source drugs by 8% from 15.1% to 23.1% and for generic drugs to 13%, after 12/31/09.
- Extends Medicaid pharmacy rebates to Medicaid Managed Care.
- Federal Government will keep 100% of the increased federal rebate.
- Florida statute already requires minimum combined rebate of 29.1% for PDL inclusion, therefore no new rebate revenue will be generated --however, Florida will lose its current share of the 8% “gap”.

Key Element: Changes to Disproportionate Share (DSH)

- House:
 - Requires the Secretary of Health and Human Services to report, by January 1, 2016, regarding the extent to which there is a continuing role for DSH
 - Requires the Secretary to reduce payments to states:
 - \$1.5 billion for FY 2017
 - \$2.5 billion for FY 2018
 - \$6 billion for FY 2019
- Senate:
 - State DSH amounts to be by up to reduced 50% (reduced 25% for low DSH states) depending on the percentage of DSH allotment used by the state.
- Florida's current DSH allotment is \$328,156,355

Key Elements: Medicaid Fraud and Abuse Requirements

- House and Senate
 - Extend period for states to repay overpayments
 - Require states to terminate providers if terminated by Medicare or other state Medicaid program
 - Add requirements for repayment of overpayment by providers and suppliers

Where Florida is Now?

- According to 2008 Census Bureau statistics, there are 3,641,933 uninsured persons in Florida
 - 1,259,378 of those people are under 133% of the Federal poverty level
 - 1,467,337 of those people are under 150% of the Federal poverty level
- Florida is expected to spend more than \$18 billion on Medicaid in 2009-10 and currently has nearly 2.7 million people enrolled in Medicaid
- Florida offers coverage to most children up to 100% FPL under the Medicaid program and the remainder of children up to 200% FPL under the CHIP program
- Florida currently covers pregnant women up to 185% of the FPL

Where Florida is Now?

- Currently, under the enhanced federal funding provided through the American Reinvestment and Recovery Act (ARRA), the federal government contributes 67.64% of every dollar spent on Medicaid services for FY 2009-2010
- For FY 2010-11, the blended FMAP will be 61.54% with an FMAP of 67.64% for July – December 2010 and an FMAP of 55.45% for January-June 2011
- The current House Affordable Health Care for America Act would extend the ARRA enhanced FMAP for two additional quarters:
 - Currently, ARRA enhanced FMAP will end December 31, 2010
 - Under the House Proposal, ARRA enhanced FMAP will end June 30, 2011
 - Maintenance of Effort requirements under ARRA will remain in place if extended



Changes to Medicaid and CHIP

KEY ELEMENT	Senate Patient Protection and Affordable Care Act (12/24/2009)	House Affordable Health Care for America Act (11/7/2009)
Medicaid Expansion	Expand eligibility to 133% Federal Poverty Level – beginning 1/1/2014 •133% FPL for a family of 4: \$29,326	Expand eligibility to 150% Federal Poverty Level – beginning 1/1/2013 •150% FPL for a family of 4: \$33,075.
FMAP/ Expansion	Provides for enhanced FMAP for expansion population: •100% CY 2014 •100% CY 2015 •100% CY 2016 •57.44% + 34.3 = 91.74% CY 2017 •57.44% + 33.3 = 90.74% CY 2018 •57.44% + 32.3 = 89.74% in CY 2019 and beyond	Provides for enhanced FMAP for expansion population: •100% CY 2013 •100% CY 2014 •91% CY 2015 •91% CY 2016 •91% CY 2017 •91% CY 2018 •91% CY 2019 and beyond
FMAP/ Current Eligibility Level	Regular FMAP (57.44%)	Regular FMAP (57.44%)
CHIP Transition	Children under 133% FPL move from Title XXI CHIP Program to Title XIX Medicaid program 1/1/2015 (Through regular annual eligibility redetermination process)	Children under 150% FPL move from Title XXI CHIP Program to Title XIX Medicaid Program 1/1/2014
FMAP/ CHIP	Enhanced FMAP for CHIP Population begins 10/1/2013 (134% Federal Poverty Level and above) •10/1/2013 - 70.21+23.0=93.21% •Note: Detailed analysis shows impact from 1/1/2014 forward.	CHIP Program ends 12/31/2013. Those below 150% FPL move to Medicaid and those above 150% FPL move to exchange and receive subsidies and tax credits to assist with cost of coverage
Increased Rate for Practitioners	Not addressed	Increases payments to Medicaid Primary Care Providers to the Medicare rate. Phased in over three years. Federal government to pay: •100% CY 2010-2014 •90% CY 2015 and beyond

Impact of Proposals – Assumptions

- **Newly Eligible Population**
 - Assumed 40% of new enrollees for the first year of expansion (beginning 1/1/2013 for the House and 1/1/2014 for the Senate)
 - Assumed 90% of new enrollees for the second year of expansion (beginning 1/1/2014 for the House and 1/1/2015 for the Senate)
 - Assumed 100% of new enrollees for the third year of expansion and beyond (beginning 1/1/2015 for the House and 1/1/2016 for the Senate)
- **Eligible but not enrolled:**
 - Assumed that 20% of the uninsured population would be eligible for Medicaid under the current program and for those enrollees the state would receive the normal FMAP. A weighted average FMAP is then used to calculate the cost to the program of the total caseload, including that 20%. Assumed the Title XIX expansion population will receive the enhanced FMAP beginning 1/1/2013 for House and 1/1/2014 for Senate.

Impact of Proposals – Assumptions

- **Crowd Out:**
 - Assumed that 80% of those under 133%/150% FPL (respectively for Senate and House analysis) who are currently privately purchasing insurance (excludes employer sponsored insurance) will enroll in Medicaid under these proposal.
 - Assumed that 40% would enrolled year 1, 90% year 2, 100% year 3). Assumed enhanced FMAP would be received for these enrollees.
- **Children transitioning from CHIP to Medicaid:**
 - House: Assume that for children under 150% FPL who move from CHIP to Title XIX we receive “enhanced” CHIP FMAP (70.21%).
 - Senate: Assume that for children under 133% FPL who move from CHIP to Title XIX we receive regular Medicaid FMAP.

Impact of Proposals – Assumptions

- **Expenditures:**
 - Expenditures are based on November 10, 2009, SSEC estimate for SFY 2012-13 and then held flat for remainder of analysis.
 - FMAP used is based on estimates from November 2, 2009, FMAP Estimating Conference for SFY 2012-13 and then held flat for remainder of analysis
- **Caseload**
 - Caseloads are based on October 19, 2009, Caseload Conference estimate for SFY 2012-13 and then held flat for remainder of analysis
 - The expansion caseload is based on 2008 U.S. Census data regarding the uninsured. Increased by 1.6% through 2014 and then held flat for remainder of analysis

Impact of Proposals – Assumptions

- **House - Primary Care Practitioner Rates:**
 - Increased reimbursement to primary care providers is phased in: 80% of Medicare rate in 2010, 90% of Medicare rate in 2011, 100% of Medicare rate in 2012.
 - Increased reimbursement to primary care providers is 100% federally funded through 2014, and then 90% federally funded going forward.
- **Other Assumptions**
 - Based on analysis of those under 64 years of age
 - House: There is some indication that the House intends for the expansion to extend to those 65 and over. This would increase the caseload of dual eligibles in Florida by more than 600,000.
 - Senate: Some state employees are made eligible for Medicaid enrollment. Fiscal impact of this component is not included at this time.

Impact of Proposals – Assumptions

- Senate: Enhanced match rate for CHIP begins 10/1/2013.
 - Cost of eligible but not enrolled (10/1/2013 – 12/31/2014)
 - Total: \$18,939,669
 - State: \$1,214,265
 - Savings to CHIP Program for those between 134-200% FPL due to increased match rate (10/1/2013 – 12/31/2014)
 - State: (\$15,785,174)



Preliminary Estimated

Fiscal Impact for Coverage of Florida Medicaid and CHIP Population

KEY ELEMENTS	Senate Patient Protection and Affordable Care Act (Manager's Amendment 12/24/09)		House Affordable Health Care for America Act (11/7/2009)	
	<i>Fiscal Impact</i>	<i>Additional Enrollment</i>	<i>Fiscal Impact</i>	<i>Additional Enrollment</i>
Total Cost CY 2013	N/A	N/A	\$5,359,960,991	
State Cost CY 2013	N/A		\$218,423,625	762,216
Total Cost CY 2014	\$2,819,204,311		\$9,424,790,000	
State Cost CY 2014	\$149,481,226	708,623	\$515,633,373	1,655,305
Total Cost CY 2015	\$6,300,697,417		\$10,483,426,913	1,920,406
State Cost CY 2015	\$431,478,573	1,594,401	\$1,434,357,370	1,920,406
Total Cost CY 2016	\$7,005,497,158		\$10,519,449,822	
State Cost CY 2016	\$484,633,596	1,771,556	\$1,445,088,595	1,936,403
Total Cost CY 2017	\$7,005,497,158		\$10,519,449,822	
State Cost CY 2017	\$937,060,310	1,771,556	\$1,445,088,595	1,936,403
Total Cost CY 2018	\$7,005,497,158		\$10,519,449,822	
State Cost CY 2018	\$991,833,520	1,771,556	\$1,445,088,595	1,936,403
Total Cost CY 2019	\$7,005,497,158		\$10,519,449,822	
State Cost CY 2019	\$1,046,606,730	1,771,556	\$1,445,088,595	1,936,403

Senate Patient Protection and Affordable Care Act 12/24/09)		Cost Title XIX: Expansion to 133% FPL	Cost Title XIX: Currently Eligible but not enrolled	Cost Title XIX: "Crowd Out" Expansion to 133%/ Previously Private Insured	Cost Title XIX: Under 133% FPL in CHIP program moving into the Title XIX Program	Savings CHIP : Under 133% FPL now in the CHIP program moving into the Title XIX Program	Cost CHIP: Currently eligible but not enrolled 134-200% FPL	Savings CHIP: Enhanced FMAP for current population between 134-200% FPL	Total: All Key Elements
2014	FMAP	100%	57.44%	100%	N/A	N/A	93.21%		
	State Cost	\$0	\$202,907,800	\$0	N/A	N/A	\$9,714,120	(\$63,140,694)	\$149,481,226
	Total Cost	\$1,907,032,503	\$476,757,050	\$283,897,406	N/A	N/A	\$151,517,352		\$2,819,204,311
	Enrollment	443,301	110,825	87,211	N/A	N/A	67,286		708,623
2015	FMAP	100%	57.44%	100%	57.44%	70.21	93.21%	93.21%	
	State Cost	\$0	\$456,543,924	\$0	\$83,094,308	(\$66,875,734)	\$21,856,769	(\$63,140,694)	\$431,478,573
	Total Cost	\$4,290,822,055	\$1,072,706,589	\$638,766,722	\$195,240,385	(\$237,752,376)	\$340,914,042		\$6,300,697,417
	Enrollment	997,427	249,357	196,224	105,581	(105,581)	151,393		1,594,401
2016	FMAP	100%	57.44%	100%	57.44%	70.21	93.21%	93.21%	
	State Cost	\$0	\$507,270,417	\$0	\$83,094,308	(\$66,875,734)	\$24,285,299	(\$63,140,694)	\$484,633,596
	Total Cost	\$4,767,579,106	\$1,191,894,776	\$709,741,887	\$195,240,385	(\$237,752,376)	\$378,793,380		\$7,005,497,158
	Enrollment	1,108,252	277,063	218,027	105,581	(105,581)	168,214		1,771,556
2017	FMAP	91.74%	57.44%	91.74%	57.44%	70.21	93.21%	93.21%	
	State Cost	\$393,802,034	\$507,270,417	\$58,624,680	\$83,094,308	(\$66,875,734)	\$24,285,299	(\$63,140,694)	\$937,060,310
	Total Cost	\$4,767,579,106	\$1,191,894,776	\$709,741,887	\$195,240,385	(\$237,752,376)	\$378,793,380		\$7,005,497,158
	Enrollment	1,108,252	277,063	218,027	105,581	(105,581)	168,214		1,771,556
2018	FMAP	90.74%	57.44%	90.74%	57.44%	70.21	93.21%	93.21%	
	State Cost	\$441,477,825	\$507,270,417	\$65,722,099	\$83,094,308	(\$66,875,734)	\$24,285,299	(\$63,140,694)	\$991,833,520
	Total Cost	\$4,767,579,106	\$1,191,894,776	\$709,741,887	\$195,240,385	(\$237,752,376)	\$378,793,380		\$7,005,497,158
	Enrollment	1,108,252	277,063	218,027	105,581	(105,581)	168,214		1,771,556
2019	FMAP	89.74%	57.44%	89.74%	57.44%	70.21	93.21%	93.21%	
	State Cost	\$489,153,616	\$507,270,417	\$72,819,518	\$83,094,308	(\$66,875,734)	\$24,285,299	(\$63,140,694)	\$1,046,606,730
	Total Cost	\$4,767,579,106	\$1,191,894,776	\$709,741,887	\$195,240,385	(\$237,752,376)	\$378,793,380		\$7,005,497,158
	Enrollment	1,108,252	277,063	218,027	105,581	(105,581)	168,214		1,771,556

House Affordable Health Care for America Act (11/7/09)		Cost to Title XIX: Expansion to 150% FPL	Cost to Title XIX: Currently Eligible but not enrolled	Cost Title XIX: "Crowd Out:	Cost to Title XIX: Under 150% FPL now in CHIP program moving into the Title XIX Program	Savings to State: Elimination of CHIP for those over 150% FPL	Total: Changes to Title XIX and Title XXI Eligibility	Total: Including Impact of Increase to Primary Care Practitioner Rates (from slide #8)
2013	FMAP	100%	57.44%	100%	N/A	70.21%		
	State Cost	\$0	\$265,753,608	\$0	N/A	(\$47,329,983)	\$218,423,625	\$218,423,625
	Total Cost	\$2,497,692,717	\$624,421,071	\$314,061,578	N/A	(\$168,265,291)	\$3,267,910,075	\$5,359,960,991
	Enrollment	592,370	148,092	96,477	N/A	(74,723)	762,216	762,216
2014	FMAP	100%	57.44%	100%	70.21%	70.21%		
	State Cost	\$0	\$520,038,458	\$0	\$42,924,898	(\$47,329,983)	\$515,633,373	\$515,633,373
	Total Cost	\$4,887,587,922	\$1,221,894,872	\$706,637,736	\$144,091,636	(\$168,265,291)	\$6,791,946,875	\$9,424,790,000
	Enrollment	1,159,174	289,793	217,073	63,988	(74,723)	1,655,305	1,655,305
2015	FMAP	91%	57.44%	91%	70.21%	70.21%		
	State Cost	\$488,758,371	\$577,821,904	\$70,663,709	\$96,581,692	(\$47,329,983)	\$1,186,495,693	\$1,434,357,370
	Total Cost	\$5,430,648,562	\$1,357,664,249	\$785,152,317	\$324,208,433	(\$168,265,291)	\$7,729,408,270	\$10,483,426,913
	Enrollment	1,287,970	321,993	241,192	143,974	(74,723)	1,920,406	1,920,406
2016	FMAP	91%	57.44%	91%	70.21%	70.21%		
	State Cost	\$488,758,371	\$577,821,904	\$70,663,709	\$107,312,917	(\$47,329,983)	\$1,197,226,918	\$1,445,088,595
	Total Cost	\$5,430,648,562	\$1,357,664,249	\$785,152,317	\$360,231,342	(\$168,265,291)	\$7,765,431,179	\$10,519,449,822
	Enrollment	1,287,970	321,993	241,192	159,971	(74,723)	1,936,403	1,936,403
2017	FMAP	91%	57.44%	91%	70.21%	70.21%		
	State Cost	\$488,758,371	\$577,821,904	\$70,663,709	\$107,312,917	(\$47,329,983)	\$1,197,226,918	\$1,445,088,595
	Total Cost	\$5,430,648,562	\$1,357,664,249	\$785,152,317	\$360,231,342	(\$168,265,291)	\$7,765,431,179	\$10,519,449,822
	Enrollment	1,287,970	321,993	241,192	159,971	(74,723)	1,936,403	1,936,403
2018	FMAP	91%	57.44%	91%	70.21%	70.21%		
	State Cost	\$488,758,371	\$577,821,904	\$70,663,709	\$107,312,917	(\$47,329,983)	\$1,197,226,918	\$1,445,088,595
	Total Cost	\$5,430,648,562	\$1,357,664,249	\$785,152,317	\$360,231,342	(\$168,265,291)	\$7,765,431,179	\$10,519,449,822
	Enrollment	1,287,970	321,993	241,192	159,971	(74,723)	1,936,403	1,936,403



House Affordable Health Care for America Act (11/7/09) Impact of Increased Rates for Primary Care Practitioners		Cost to Title XIX: Increased Rates for Primary Care practitioners for the newly eligible	Cost to Title XIX: Increased Rates for Primary Care practitioners for eligible but not enrolled population	Cost to Title XIX: Increased Rates for Primary Care practitioners current population	Cost to Title XIX: Increased Rates for Primary Care Practitioners for the "Crowd Out: Population	Total: Impact of Increased Rates for Primary Care Practitioners
2013	FMAP	100%	100%	100%	100%	N/A
	State Cost	\$0	\$0	\$0	\$0	\$0
	Total Cost	\$399,636,497	\$99,908,787	\$1,542,260,410	\$50,245,222	\$2,092,050,916
	Enrollment	592,370	148,092	N/A	96,477	N/A
2014	FMAP	100%	100%	100%	100%	N/A
	State Cost	\$0	\$0	\$0	\$0	\$0
	Total Cost	\$782,025,147	\$195,505,950	\$1,542,260,410	\$113,051,618	\$2,632,843,125
	Enrollment	1,159,174	289,793	N/A	217,073	N/A
2015	FMAP	91%	91%	91%	91%	N/A
	State Cost	\$78,202,447	\$19,550,642	\$138,803,437	\$11,305,151	\$247,861,677
	Total Cost	\$868,916,081	\$217,229,358	\$1,542,260,410	\$125,612,794	\$2,754,018,643
	Enrollment	1,287,970	321,993	N/A	241,192	N/A
2016	FMAP	91%	91%	91%	91%	N/A
	State Cost	\$78,202,447	\$19,550,642	\$138,803,437	\$11,305,151	\$247,861,677
	Total Cost	\$868,916,081	\$217,229,358	\$1,542,260,410	\$125,612,794	\$2,754,018,643
	Enrollment	1,287,970	321,993	N/A	241,192	N/A
2017	FMAP	91%	91%	91%	91%	N/A
	State Cost	\$78,202,447	\$19,550,642	\$138,803,437	\$11,305,151	\$247,861,677
	Total Cost	\$868,916,081	\$217,229,358	\$1,542,260,410	\$125,612,794	\$2,754,018,643
	Enrollment	1,287,970	321,993	N/A	241,192	N/A
2018	FMAP	91%	91%	91%	91%	N/A
	State Cost	\$78,202,447	\$19,550,642	\$138,803,437	\$11,305,151	\$247,861,677
	Total Cost	\$868,916,081	\$217,229,358	\$1,542,260,410	\$125,612,794	\$2,754,018,643
	Enrollment	1,287,970	321,993	N/A	241,192	N/A

House Affordable Health Care for America Act – Fiscal Impact of Increased Reimbursement for Primary Care Practitioners

- House Affordable Health Care for America Act increase to reimbursement rates for Primary Care Providers begins in 2010 – Prior to the start date for the Medicaid program expansions contemplated in either the House or Senate proposal
- The rate increase is 100% federally funded through 2014
- The cost for the rate increase on the current Medicaid population (before the expansion) will be as follows for 2010 through 2012
 - 2010: \$1,233,808,328
 - 2011 \$1,388,034,369
 - 2012: \$1,542,260,410
- The cost for 2013 forward for both the current Medicaid population and the expansion population are captured in the comprehensive chart on slide 15 and on slide 17.

Key Elements: Administrative Costs for States

- 1.7 – 1.9 million new eligibles
 - Eligibility Determination
 - Claims processing
- Systems: ACCESS/ FLORIDA/ FMMIS
 - Enrollment Broker/ Provider Enrollment
 - Tracking eligibles for federal reporting
- Operations
 - Field Staff
 - Central Office Staff
 - Fraud and Abuse resources
- Federal funding amount/formula not clear

Key Elements: Administrative Costs for States

- Current analysis based on impact of increased enrollment under the proposals.
- Each bureau/ unit within Medicaid will be impacted differently by the reform proposals, but all will likely need additional staff
 - Staffing needs range from 20%-40% increase over current staffing levels.
 - Depending on salary levels, additional staffing costs could range from \$12 - \$20 million.
- Some of our vendors have clauses in their contracts that trigger price increases based on certain enrollment thresholds.
 - Fiscal agent, enrollment broker, peer review, prior authorization, and utilization management.
- DCF has indicated that they will need significant additional staff for eligibility determination function.



Additional Medicaid Elements in Proposals

Additional Elements	House Affordable Health Care for America Act (11/7/2009)	Senate Patient Protection and Affordable Care Act (12/24/2009)
Coverage of Newborns	Initial Medicaid coverage is 60 days while a determination is completed to enroll the newborn in appropriate insurance. The federal government will pay 100% of cost of Medicaid coverage for these newborns	Not Addressed
Additional Funding for Federally Qualified Health Centers	Additional \$12 billion over the next 5 years (FY 11-15)	Additional \$33 billion over the next 6 years (FY 10-15)
Extended Coverage for Children Formerly in Foster Care	Not Addressed	All Individuals who were in foster care and receiving Medicaid as of the date they turned 18 (or such higher age as the state has elected) will now continue to be eligible for Medicaid through age 25. Effective 1/1/2014.
Family Planning Option	Provides for State Plan Option to provide only family planning services to certain women	Provides for State Plan Option to provide only family planning services to new categorical group for non-pregnant women and those currently eligible under 1115 Family Planning Waiver
ARRA FMAP Extension	Extends ARRA increase in FMAP to state with high unemployment rates for 2 additional quarters	Not Addressed

Additional Medicaid Elements in Proposals

Additional Elements	House Affordable Health Care for America Act (11/7/2009)	Senate Patient Protection and Affordable Care Act (12/24/2009)
FMAP Adjustments for Disaster Recovery States	<i>Not Addressed</i>	Reduces projected decreases in Medicaid funding for states that have experienced major, statewide disasters
Managed Care Administrative Costs	Limits MCO spending on administrative costs to no more than 15% of revenues from Medicaid premiums	<i>Not Addressed</i>
Graduate Medical Education	Codifies that GME is an allowable cost under Medicaid. Establishes requirements for the payment of GME	<i>Not Addressed</i>
Community First Choice Option	Allow coverage of community-based attendant services and supports in the home to those who are eligible for institutional Medicaid coverage. States eligible for enhanced FMAP	Create state plan option under section 1915 to provide community-based attendant supports and services to individuals with disabilities who are Medicaid eligible and require an institutional level of care. States eligible for increase FMAP of 6%



Additional Medicaid Elements in Proposals

Additional Elements	House Affordable Health Care for America Act (11/7/2009)	Senate Patient Protection and Affordable Care Act (12/24/2009)
Maternal/ Infant/ Early Childhood Nurse Visitation Services	Option for coverage of home visits by trained nurses to first time pregnant women or children under 2 years old	Funding to develop and implement one or more evidence based Maternal, Infant and Early Childhood Visitation models
Expansion of Payments to Indian Health Programs	Indian Health Programs eligible for Medicare and Medicaid payments for all items and services, if those services meet Medicare and Medicaid Requirements	Authorizes appropriations for the Indian Health Care Improvement Act, including programs for new delivery models, behavioral healthcare, health promotion and disease prevention, to increase the Indian health care workforce, and others.
Tobacco Cessation	Prohibits state Medicaid programs from excluding tobacco cessation products from coverage.	Requires states to provide Medicaid coverage for tobacco cessation services for pregnant women.
Birthing Center Coverage	Provides state option for coverage for free standing birthing centers	Requires state to provide Medicaid coverage for free standing birthing centers



Additional Medicaid Elements in Proposals

Additional Elements	House Affordable Health Care for America Act (11/7/2009)	Senate Patient Protection and Affordable Care Act (12/24/2009)
Hospice for Children	Not Addressed	All Medicaid children to receive hospice services without forgoing any other service to which the child is entitled under Medicaid
Non-Emergency transportation	Requires Medicaid coverage of non-emergency transportation (as a mandatory service)	Not Addressed
Podiatrists	Includes podiatrists as a physician under Medicaid	Not Addressed
Optometrists	Requires Medicaid coverage of professional services for optometrists.	Not Addressed
Coverage of Newborns	Initial Medicaid coverage is 60 days while a determination is completed to enroll the newborn in appropriate insurance. The federal government will pay 100% of cost of Medicaid coverage for these newborns	Not Addressed



Grants, Pilots and Demonstrations

PILOT PROJECTS and DEMONSTRATIONS	House Affordable Health Care for America Act (11/7/2009)	Senate Patient Protection and Affordable Care Act (12/24/2009)
Bundled Payment Demonstration		Up to 8 states. States could create a global capitated bundled payment system for a large safety-net hospital system to evaluate changes in health care spending and outcomes
Global Payment Demonstration		Up to 5 states. Allow participating states to adjust their current payment structure for safety net hospitals to a global capitated payment structure
Accountable Care Organization Pilot	Medicaid Pilot to test different models of reimbursement and to reward physicians for quality outcomes	Qualified pediatric providers could be recognized and received payments as ACOs with potential for shared savings
Medicaid Emergency Psychiatric Demonstration		Up to 8 states. Reimburse certain Institutions for Mental Disease (IMDs) for services provided to Medicaid Beneficiaries 21-65



Grants, Pilots and Demonstrations

PILOT PROJECTS and DEMONSTRATIONS	House Affordable Health Care for America Act (11/7/2009)	Senate Patient Protection and Affordable Care Act (12/24/2009)
Healthy Lifestyles		States can apply for funds to provide incentives to Medicaid enrollees who improve health status and complete scientifically based health lifestyle programs
Medical Home	Option for states to apply for Medical Home Pilot Project. States would receive 90% FMAP for first two years and 75% for the next three years- up to max of \$1.235 billion.	New Medicaid State Plan Option- Medicaid beneficiaries with Chronic conditions could designate a health home
Dual Eligibles	Funding provided to allow for testing of models that require benefits not currently covered by Medicare	Clarifies the Medicaid Demonstration authority for coordinating care for dual eligibles is as long as 5 years
School Based Services	Creates grant program to fund school based health centers	Authorizes grant program for the operation and development of School Based health Clinics
Psychiatric Care Demonstration		Up to 8 states. \$75 million for demonstrations to expand the # of emergency inpatient psychiatric care beds ¹⁸⁷



Additional Fraud and Abuse Requirements in Proposals

Additional Elements	House Affordable Health Care for America Act (11/7/2009)	Senate Patient Protection and Affordable Care Act (12/24/2009)
General Provisions	Special Inspector General for Health Insurance Exchange	HHS to establish procedures for screening providers and suppliers participating in Medicare, Medicaid and CHIP
Data Submission		Requires states and Medicaid managed care entities to submit data elements from MMIS for program integrity, program oversight, and administration
60 day rule on overpayments	Extend from 60 days to one year for federal repayment of identified overpayments in cases of fraud	Extends the period for states to repay overpayments to one year when a final determination of the amount of overpayment has not been determined due to an ongoing judicial or administrative process



Additional Fraud and Abuse Requirements in Proposals

Additional Elements	House Affordable Health Care for America Act (11/7/2009)	Senate Patient Protection and Affordable Care Act (12/24/2009)
Termination of providers	Requires Medicaid and CHIP programs to terminate participation of providers if the provider has been terminated by Medicare or other state Medicaid program	Requires Medicaid and CHIP programs to terminate participation of providers if the provider has been terminated by Medicare or other state Medicaid program
Provider Integrity	Requires all new providers to adopt programs to reduce waste, fraud and abuse	Requires the Secretary to establish a nationwide program for national and state background checks on direct patient access employees of certain long term supports and services facilities or providers
Provider Repayment	Requires all providers and suppliers to repay a Medicaid or Medicare overpayment within 60 dates of discovering the overpayment	Requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date corresponding cost report was due

Questions?