

Health Care Reform: Next Steps for AHCCCS¹

Section Number	Summary	Effective Date
PPACA: Title II – Role of Public Programs		
Subtitle A – Improved Access to Medicaid		
<p>1. Section 2001 – <i>Medicaid Coverage for the Lowest Income Populations</i></p> <p>See §10201(c)(6)</p>	<p>a. Expands Medicaid up to 133% FPL.</p> <p>b. MOE Children: Cannot make any changes to eligibility for CHIP <i>and</i> Medicaid children</p> <p>c. MOE Adults: Cannot make any changes to eligibility for adults.</p> <p>d. MOE political subdivisions: Limits states’ ability to increase the share of Medicaid expenditures from political subdivisions beyond what was in place as of Dec. 31, 2009, to be eligible for an increased FMAP. <i>Exception:</i> voluntary contributions to be further defined. Retroactive to stimulus period –ARRA</p> <p>e. Newly eligible = 100-133% FPL. 100% FMAP 2014-2016, 95% in 2017, 94% in 2018, 93% in 2019 and 90% in 2020.</p> <p>f. Reconciliation bill increased FMAP for childless adults. 83% in 2014; 86% in 2015; 89% in 2016; 89% in 2017; 91% in 2018, 93% in 2019; and 90% in 2020.</p> <p>g. Benefits: benchmark or benchmark equivalent for newly eligibles consistent with § 1937 of SSA – at least essential benefits as described in exchange.</p> <p>h. Option to cover childless adults up to 133% FPL under State Plan.</p>	<p>a. Jan. 1, 2014</p> <p>b. Mar. 23, 2010 – Dec. 31, 2019</p> <p>c. Mar. 23, 2010 – Dec. 31, 2013 (or when Secy determines Ex operational)</p> <p>d. Mar. 23, 2010</p> <p>e. Jan. 1, 2014</p> <p>f. Jan. 1, 2014</p> <p>g. Jan. 1, 2014</p> <p>h. Apr. 1, 2010</p>
<p>2. Section 2002 – <i>Income Eligibility for Nonelderly Determined Using</i></p>	<ul style="list-style-type: none"> • Bases eligibility on modified adjusted gross income (MAGI) with no asset or resource test. Applies special adjustment of 5% points to bring effective income eligibility to 138%. • Maintains existing income counting rules for elderly and groups eligible 	<p>Jan. 1, 2014</p>

¹ Last updated 4-19-10

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	<i>Modified Gross Income</i> See also § 1004(e) of HR4872	through another program, like foster care, low-income Medicare beneficiaries and SSI. <ul style="list-style-type: none"> Requires states to establish equivalent income thresholds to implement the MOE requirements for children using MAGI that ensure individuals eligible on Jan. 1, 2014 do not lose coverage. 	
3.	<i>Section 2003 – Requirement to Offer Premium Assistance for Employer-Sponsored Insurance</i>	Requires states to offer premium assistance and wrap-around if cost-effective, based on current law requirements.	Jan. 1, 2014
4.	<i>Section 2004 – Medicaid Coverage for Former Foster Care Children</i>	Allows all individuals 18-25 formerly in foster care and on Medicaid for at least 6 months, to remain eligible for Medicaid until age 25.	Jan. 1, 2014
<i>Subtitle B – Enhanced Support for the Children’s Health Insurance Program</i>			
5.	<i>Section 2101 – Additional Federal Financial Participation for CHIP</i> § 10203(d)(2)(D)	<ul style="list-style-type: none"> a. MOE: No changes to CHIP eligibility b. Reconciliation bill allows CHIP children to enter exchange. c. Increases FMAP additional 23%. (AZ FMAP would be 99%) d. Reconciliation Bill makes some children of state employees eligible for CHIP if state premium contribution for family coverage is less than 1997 levels (adjusted for inflation) or if employee’s premiums and cost sharing exceed 5% of family income. e. Enrollment bonus payments for children end. f. Extends and increases CHIPRA funding for Medicaid and CHIP enrollment and renewal from \$100M through 2013 to \$140M through 2015. g. Requires that CHIP eligible children who cannot enroll in CHIP due to federal allotment caps must be screened for Medicaid; if not, eligible for 	<ul style="list-style-type: none"> a. Mar. 23, 2010 – Dec. 31, 2019 b. Oct. 1, 2015 c. Oct. 1, 2015 d. Mar. 23, 2010 e. Oct. 1, 2013 f. Mar. 23, 2010 g. By Apr. 2015

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		tax credits in plan certified by Secy to be CHIP comparable.	
<i>Subtitle C – Medicaid and CHIP Enrollment Simplification</i>			
6.	<i>Section 2201 – Enrollment Simplification and Coordination with State Health Insurance Exchanges</i>	<p>a. Requires states to allow individuals to apply or renew Medicaid through website with electronic signature and allow individuals to also apply for Exchange and compare benefits of Exchange with those of Medicaid/CHIP, especially for children.</p> <p>b. Requires State Medicaid and CHIP programs and the Exchange to coordinate enrollment procedures to provide seamless enrollment for all programs.</p> <p>c. Directs HHS to create a single form to apply for Medicaid, CHIP, or tax subsidies in the Gateways. A state may elect to create and use their own form.</p> <p>d. Exchanges can enter into a contract with the State Medicaid agency to determine eligibility for the tax credits</p> <p>e. Requires states to conduct outreach to enroll vulnerable and underserved populations through Medicaid and CHIP.</p>	<p>a. Jan. 1, 2014</p> <p>b. Jan. 1, 2014</p> <p>c. Jan. 1, 2014</p> <p>d. Jan. 1, 2014</p> <p>e. Jan. 1, 2014</p>
7.	<i>Section 2202 – Permitting Hospitals to make Presumptive Eligibility Determinations for all Medicaid Eligible Populations</i>	Allows any hospital the option to make a presumptive eligibility determination; must have state verification of capability.	Jan. 1, 2014
<i>Subtitle D – Improvements to Medicaid Services</i>			
8.	<i>Section 2301 – Coverage for Freestanding Birth Center Svcs.</i>	Requires coverage of services provided by free-standing birth centers.	Mar. 23, 2010, unless state legislation required
9.	<i>Section 2302 – Concurrent Care for</i>	Allows children to receive hospice without foregoing curative treatment related to a terminal illness.	None given – assume Mar. 23, 2010

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	<i>Children</i>		
10	Section 2303 – <i>State Eligibility Option for Family Planning Svcs.</i>	State plan option for new categorical group for non-pregnant women up to highest level applicable to pregnant women under Medicaid or CHIP and at state option, individuals eligible under standards and processes of existing 1115 family planning waivers. Benefits would be limited to family planning services and supplies and related medical diagnosis and treatment services.	Mar. 23, 2010
11	Section 2304 – <i>Clarification of Definition of Medical Assistance</i>	“Medical assistance”: encompasses both payment for services provided and the services themselves.	Mar. 23, 2010
<i>Subtitle E – New Options for States to Provide Long-Term Services and Supports</i>			
12	Section 2401 – <i>Community First Choice Option</i>	<ul style="list-style-type: none"> To provide community-based attendant supports and services to individuals up to 150% FPL with disabilities who require an institutional level of care; SPA option. Provide states enhanced match – additional 6% for reimbursable expenses in the program. 	--Oct 1, 2011 --Sunsets after 5 years
13	Section 2402 – <i>Removal of Barriers to Providing Home and Community-Base Svcs.</i>	<ul style="list-style-type: none"> New option to provide HCBS via State Plan for individuals with incomes up to 300% SSI payment and who have higher level of need Permit states to extend full Medicaid benefits to individuals receiving HCBS under State Plan. 	Oct 1, 2010
14	Section 2403 – <i>Money Follows the Person Rebalancing Demonstration</i>	Extends program through Sept 30, 2016 and changes eligibility by requiring individuals reside in inpatient facility for not less than 90 days.	30 days after enactment
15	Section 10202 – <i>Incentives for States to Offer HCBS as Alternative to NF</i>	Creates State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services. Selected states eligible for FMAP increases for medical assistance expenditures for non-institutionally based long-term care services and supports with \$3B in federal matching funds.	Oct. 1, 2011 – Sept. 30, 2015

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16	Section 2404 – <i>Protection for Recipients of HBCS against Spousal Impoverishment</i>	Requires states to apply spousal impoverishment rules to beneficiaries who receive HCBS; applies for 5-year period.	Jan. 1, 2014
17	Section 2405 – <i>Funding to Expand State Aging & Disability Resource Centers</i>	Allocates \$10M/year to continue Aging and Disability Resource Center initiatives	2010 through 2014
18	Section 2406 – <i>Sense of Senate regarding LTC</i>	Includes Sense of Senate that Congress should address LTC services and supports in comprehensive way to guarantee elderly and disabled receive care they need that is also available in community in addition to institutions.	Mar. 23, 2010
<i>Subtitle F – Medicaid Prescription Drug Coverage</i>			
19	Section 2501 – <i>Prescription Drug Rebates</i> <i>See also § 1206 (reconciliation)</i>	<ul style="list-style-type: none"> • Extends drug rebate to Medicaid MCOs (excludes 340B programs). • Increase rebate percentage for brand name drugs to 23.1% (from 15.1%) except for rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%. • Increase rebate for non-innovator, multiple source drugs to 13% of AMP • Limits total rebate liability to 100% AMP with revenue due to federal govt. • For purposes of applying additional rebate, 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. 	Managed care rebate, effective Mar. 23, 2010 Jan 1, 2010
20	Section 2502 – <i>Elimination of Exclusion of Coverage of Certain Drugs</i>	Removes smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid’s excludable drug list.	Jan. 1, 2014
21	Section 2503 – <i>Providing Adequate Pharmacy Reimbursement</i>	Requires Secretary to calculate Federal Upper Limit as no less than 175% of weighted average of most recently reported monthly average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies.	180 days after enactment

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<i>Subtitle G – Medicaid Disproportionate Share Hospital (DSH) Payments</i>			
22.	Section 2551 – <i>Disproportionate Share Hospital Payments</i> <i>See also § 1206 (reconciliation)</i>	<ul style="list-style-type: none"> Reduces aggregate DSH allotments by \$.5B in 2014; \$.6B in 2015; \$.6B in 2016; \$1.8B in 2017; \$5B in 2018; \$5.6B in 2019; and \$4B in 2020. Requires Secy to develop methodology to distribute DSH reductions that imposes largest reduction for states with lowest percentage of uninsured, imposes smaller reductions for low-DSH states and accounts for DSH allotments used for 1115 waivers. 	FFY 2014 - 2020
<i>Subtitle H – Improved Coordination for Dual Eligible Beneficiaries</i>			
23.	Section 2601 – <i>5-Year Period for Demonstration Projects</i>	Medicaid waivers for coordinating care for duals can be authorized for as long as 5 years.	None given – Mar. 23, 2010
24.	Section 2602 – <i>Providing Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries</i>	Creates new office within CMS – Federal Coordinated Health Care Office – to more effectively integrate Medicaid and Medicaid and improve access to and quality of care for duals.	Mar 1, 2010
<i>Subtitle I – Improving the Quality of Medicaid for Patients and Providers</i>			
25.	Section 2701 – <i>Adult Health Quality Measures</i>	<ul style="list-style-type: none"> Directs Secretary to develop quality measures for adults similar to measures for children in CHIP; sets deadlines for development of measures, standardization of reporting formats, requires report to Congress. 	-Jan. 1, 2011 recommendations -Jan. 1, 2012 publish initial core set of measures -Jan. 1, 2013, standard reports -Jan. 1, 2014 report to Congress
26.	Section 2702 – <i>Payment Adjustment for Health Care-Acquired Conditions</i>	<ul style="list-style-type: none"> Prohibit federal payments to states for Medicaid services related to health care acquired conditions. Secretary will develop list based on Medicare through regulation 	July 1, 2011.
27.	Section 2703 – <i>State Option to Provide Health Homes for Enrollees with Chronic Conditions</i>	<ul style="list-style-type: none"> Provides \$25M to Secy for planning grants for states to create new Medicaid state plan option to permit enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. 	Jan 1, 2011

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		<ul style="list-style-type: none"> Provides 90% FMAP for 2 years for health home services, including care management, care coordination and health promotion, transitional care, patient and family support, referral to community and social support services, use of HIT where feasible and appropriate. 	
28.	Section 2704 – <i>Demonstration Project to Evaluate Integrated Care Around a Hospitalization</i>	Establishes demo to pay bundled payments for episodes of care that include hospitalizations – up to 8 states.	Jan. 1, 2012 – Dec. 31, 2016
29.	Section 2705 – <i>Medicaid Global Payment System Demonstration Project</i>	<ul style="list-style-type: none"> Demo for up to 5 states to change payment structure to safety net hospitals from FFS to global capitated payments. Demo to work in coordination with Center for Medicare and Medicaid Innovation (estab in § 3021 of PPACA) designed to test, evaluation and expand in Medicare, Medicaid and CHIP different payment structures and methodologies to foster patient-centered care, improve quality and slow Medicare cost growth. 	FFY 2010 - 2012
30.	Section 2706 – <i>Pediatric Accountable Care Organization Demonstration Project</i>	Allows pediatric ACOs to share in cost savings of demos as long as meet performance guidelines.	Jan. 1, 2010 – Dec. 31, 2016
31.	Section 2707 – <i>Medicaid Emergency Psychiatric Demonstration Project</i>	Authorizes demo to allow Medicaid payments to IMDs for adults who require stabilization of an emergency medical condition for individuals 21 – 65 who require stabilization under these settings under EMTALA; appropriates \$75M.	FFY 2011 - 2015
<i>Subtitle J – Improvements to the Medicaid and CHIP Payment and Access Commission</i>			
32.	Section 2801 – <i>MACPAC Assessment of Policies Affecting All Medicaid Beneficiaries</i>	Broadens scope of 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.	Mar. 23, 2010
<i>Subtitle K – Protections for American Indians and Alaska Natives</i>			

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33.	Section 2901 – <i>Special Rules relating to Indians</i>	Adds I.H.S, I/T/Us to serve as Express Lane agencies for Medicaid and CHIP eligibility.	Jan. 1, 2010
34.	Section 2902 – <i>Elimination of Sunset for Reimbursement for All Medicare Part B Svcs. Furnished by Certain Indian Hospital and Clinics</i>	Allows I.H.S, I/T/Us to continue to be reimbursed by Medicare Part B.	Jan. 1, 2010
Subtitle L – Maternal and Child Health Services			
35.	Section 2951 – <i>Maternal, Infant, and Early Childhood Home Visiting Programs</i>	<ul style="list-style-type: none"> Provides funding to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s). Model options would be targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency. Requires state to submit a needs assessment and grant application. 	Needs assessment due not later than 6 months after date of enactment
36.	Section 2952 – <i>Support, Education, and Research for Postpartum Depression</i>	Provides support services to women suffering postpartum depression and psychosis and helps educate mothers and their families about these conditions; provides research support.	Secy to establish grant requirements for FFY 2011-2012
37.	Section 2953 – <i>Personal Responsibility Education</i>	State grants to educate on prevention of teen pregnancy	FFY 2010 - 2014
38.	Section 2954 – <i>Restoration of Funding for Abstinence Education</i>	Restores \$50M per year through FY2014 for abstinence education.	FFY 2010 - 2014
39.	Section 2955 – <i>Inclusion of</i>	<ul style="list-style-type: none"> States must supply information and opportunity for children aging out of foster care system to designate medical POA prior to emancipation from 	Oct. 1, 2010

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	<i>Information about the Importance of having a Health Care Power of Attorney in Transition</i>	<p>foster care.</p> <ul style="list-style-type: none"> Requires certification of compliance by Governor 	
Title IV – Prevention of Chronic Disease and Improving Public Health			
Subtitle B – Increasing Access to Clinical Preventive Services			
40.	Section 4106 – <i>Improving Access to Preventive Services for Eligible Adults in Medicaid</i>	The current Medicaid State option to provide other diagnostic, screening, preventive and rehab services would be expanded to include: (1) any clinical preventive service recommended with grade of A or B by the U.S. Preventive Services task Force and (2) with respect to adults, immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration. States that elect to cover these additional services and vaccines, and also prohibit cost sharing for such services and vaccines, would receive an increased FMAP of 1%.	Jan. 1, 2011
41.	Section 4107 – <i>Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid</i>	Require Medicaid coverage for tobacco cessation counseling and pharmacotherapy, including over the counter medications, for pregnant women; cost sharing prohibited.	Oct. 1, 2010
42.	Section 4108 – <i>Incentives for Prevention of Chronic Diseases in Medicaid</i>	Grant program to provide incentives to beneficiaries to complete behavior modification programs promoting healthy lifestyles; must demonstrate success in lowering or controlling cholesterol and/or blood pressure, lost weight, smoking cessation, managing/preventing diabetes, and may address co-morbidities associated with these conditions, such as depression.	Jan. 1, 2011 or when program criteria developed
Title VI – Transparency and Program Integrity			
Subtitle E – Medicare, Medicaid and CHIP Program Integrity Provisions			
43.	Section 6401 – <i>Provider Screening and other Enrollment Requirements under Medicare, Medicaid</i>	<ul style="list-style-type: none"> Requires that HHS establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP. Secy required to determine level of screening according to risk of fraud, waste and abuse with respect to each category of provider or supplier. At a minimum, all providers and suppliers would be subject to licensure checks. Secy has 	<p>180 days after enactment</p> <p>Fee effective 2010</p>

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	<i>and CHIP.</i>	<p>authority to impose additional screening based on risk, including fingerprinting, criminal background checks, multi-state data base inquiries and random or unannounced site visits. Application fee of \$200 for individual practitioners and \$500 for institutional providers and suppliers. To cover cost of screening each time they re-verify (every 5 years). § 10603 removes enrollment fee for physicians.</p> <ul style="list-style-type: none"> • Providers and suppliers enrolling or re-enrolling in Medicare, Medicaid or CHIP subject to new disclosure requirements – listing current or previous affiliations with any provider or supplier that has uncollected debt, suspended payments or has been excluded from participating in federal health care program. Secy can deny enrollment if affiliations pose undue risk. 	
44.	Section 6402 – <i>Enhanced Medicare and Medicaid Program Integrity Provisions</i>	<ul style="list-style-type: none"> • Requires CMS to include claims and payment data from the following programs in the Integrated Data Repository (IDR): Medicare (Parts A, B, C, and D), Medicaid, CHIP, health related programs administered by the Departments of Veterans Affairs and Defense, the Social Security Administration, and the Indian Health Service. Allows DOJ to access IDR. • Requires Secy to issue regulation mandating all Medicaid, Medicaid and CHIP providers include NPI on enrollment applications • Authorizes Secy to withhold FFP to states who do not report encounter data in timely manner to MMIS. • Expands use of CMPs 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 a false statement 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 subject to \$50,000 penalty. • Increases funding for healthcare fraud and abuse control funding by \$10M/year. 	<p>None given</p> <p>FFY 2011-2020</p>
45.	Section 6411 – <i>Expansion of Recovery Audit Contractor (RAC) Program</i>	Requires states to establish contracts with one or more Medicare Recovery Audit Contractors to identify underpayments and overpayments and recoup overpayments made for services provided under State Medicaid plans as well as waivers.	Dec. 31, 2010

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<i>Subtitle F – Additional Medicaid Program Integrity Provisions</i>			
46.	Section 6501 – <i>Termination of Provider Participation under Medicaid if Terminated under Medicare or other State Plan</i>	Requires States to terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another State’s Medicaid program.	Mar. 23, 2010
47.	Section 6502 – <i>Medicaid Exclusion from Participation Relating to Certain Ownership, Control and Management Affiliations</i>	Requires Medicaid agencies to exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls or manages an entity that: (a) has failed to repay overpayments during the period determined by the Secy; (2) is suspended, excluded or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded or terminated from Medicaid participation.	Jan. 1, 2011
48.	Section 6503 – <i>Billing Agents, clearinghouses or other Alternate Payees Required to Register under Medicaid</i>	Requires any agents, clearinghouses or alternate payees that submit claims on behalf of health care providers to register with State and Secy in a form and manner specified by the Secy.	Jan. 1, 2011
49.	Section 6504 – <i>Requirement to Report Expanded Set of Data Elements under MMIS to Detect Fraud and Abuse</i>	Requires States and Medicaid managed care entities to submit data elements from MMIS as determined necessary by the Secretary for program integrity, program oversight, and administration.	Jan. 1, 2010
50.	Section 6505 – <i>Prohibition on Payments to Institutions or Entities Located outside of U.S.</i>	Prohibits states from making any payments for items or services provided under a Medicaid State Plan or waiver to any financial institution or entity located outside the U.S.	Jan. 1, 2011
51.	Section 6506 –	Extends the 60-day period for States to repay overpayments to one year when	Mar. 23, 2010

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	<i>Overpayments</i>	a final determination of the amount of the overpayment has not been determined due to an ongoing judicial or administrative process. When overpayments due to fraud are pending, State repayments of the Federal portion would not be due until 30 days after the date of the final judgment.	
52.	Section 6507 – <i>Mandatory State us of National Correct Coding Initiative</i>	Requires states to make MMIS methodologies compatible with Medicare’s National Correct Coding Initiative (NCCI) that promotes correct coding and controls improper coding.	Oct. 1, 2010
53.	Section 6508 – <i>General Effective Date</i>	Requires states to implement fraud, waste and abuse programs.	Jan. 1, 2011 – unless state legislation required – first day of calendar qtr after close of 1 st reg sess after 3-23
PPACA: Title X – Strengthening Quality, Affordable Health Care for All Americans			
Subtitle B – Provisions Related to Title II			
54.	Section 10201 – <i>Amendments to the Social Security Act and title II of this Act.</i>	<ul style="list-style-type: none"> Any application or renewal of a demonstration project under title XIX or XXI that relates to eligibility, benefits, enrollment, financing or cost sharing must follow the new requirements that will be laid out by the Secretary, which will include process for public notice and comment at the state level. Public process will include public hearings to ensure meaningful level of public input. 	Secy to issue regs 180 days after enactment
Reconciliation Act HB 4872			
55.	Section 1202 – <i>Payments to Primary Care Physicians</i>	<ul style="list-style-type: none"> Requires that Medicaid payment rates to primary care physicians for furnishing primary care services be no less than 100% of Medicare payment rates in 2013 and 2014. Provides 100% federal funding for the difference in rates based on rates applicable on July 1, 2009. Primary care physicians include family medicine, general internal medicine and pediatric medicine. Primary care services include evaluation and management services and service codes related to immunizations and as designated by the Secy. 	FFY 2013 and 2014