FOCUS *on* Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

MEDICAID AND CHIP HEALTH REFORM IMPLEMENTATION TIMELINE

This timeline highlights the implementation dates for Medicaid and the Children's Health Insurance Program for provisions in the Patient Protection and Affordable Care Act (P.L. 111-148) which was signed on March 23, 2010 along with changes made to the law by The Health Care and Education Reconciliation Act of 2010 which was signed on March 30, 2010. While major expansions to Medicaid occur in 2014, there are many other health reform provisions that become effective between 2010 and 2014. A timeline reflecting key implementation dates for provisions beyond Medicaid and CHIP can be found at: http://www.kff.org/healthreform/8060.cfm.

A summary of the new health reform law compared to pre-reform law for Medicaid and CHIP can be found at: http://www.kff.org/healthreform/7952.cfm.

2010

- Creates a state option to cover childless adults though a Medicaid State Plan Amendment (April 1).
- Creates a state option to provide Medicaid coverage for family planning services to certain low-income individuals through a Medicaid State Plan Amendment up to the highest level of eligibility for pregnant women (March 23).
- Creates a new option for states to provide CHIP coverage to children of state employees eligible for health benefits if certain conditions are met (March 23).
- Requires coverage for smoking cessation for pregnant women without cost sharing (October 1).
- Requires coverage for free standing birth center services (March 23 except if state legislation is required).
- Increase the Medicaid drug rebate percentage for brand name drugs to 23.1% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans (January 1 except for rebates for managed care which are effective March 23, 2010).
- Provides funding for and expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid) (January 1 except for managed care rebates which is effective upon enactment).
- 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 (October 1).
- Establishes a global payments demonstration project for up to 5 states from 2010 to 2012 for large safety-net hospital systems (October 1).
- 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 with $75 million in funding (Available October 1, 2010 through December 31, 2015).
- 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 (By December 31).
- 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 (By March 1).
- 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 (Regulations by September 19).
- 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 (March 23).Requires data reporting to MMIS to detect waste, fraud and abuse; mandates states' use of national correct coding initiative (January 1).
- Requires states to implement fraud, waste, and abuse programs by January 1, 2011 and increases funding for health care fraud and abuse control funding by $10 million per year for fiscal year 2011 through 2020.

2011

- Establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program) (Effective January 1, 2011 and payout of benefits starting 2016).
- Prohibits federal payments to states for Medicaid services related to health care acquired conditions (July 1).
- Creates a new Medicaid state plan option to permit Medicaid 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. Provide states taking up the option with 90% FMAP for two years for health home related services including care management, care coordination and health promotion (January 1).
- 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 (Appropriates funds available January 1 available for 5 years).
- Creates the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based long-term care services (October 1, 2011 through September 30, 2015).
- Establishes the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities (October 1).

2011 (continued)

- 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; requires additional requires billing agents, clearinghouses and alternative payees to register under Medicaid (January 1).
- Increase spending caps for the territories (July 1, 2011 through September 30, 2019).

2012

- Establishes a bundled payment demonstration project for up to 8 states for acute and post-acute care (January 1, 2012 to December 31, 2016).
- Establishes demonstration projects in Medicaid and CHIP to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (January 1, 2012 – December 31, 2016).

2013

- Extends authorization and funding for CHIP through 2015 (2 years beyond the current authorization which is until 2013).
- Extends and increases funding provided in CHIPRA for Medicaid and CHIP enrollment and renewal activities from $100 million in 2013 to $140 million in 2015.
- Increase Medicaid payments for primary care services provided by primary care doctors with 100% federal funding (For services provided from January 1, 2013 through December 31, 2014).
- Provides states with a 1 percentage point 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 (January 1).

2014

- Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (MAGI) and provides enhanced federal matching for new eligibles (January 1).
- Establishes Medicaid coverage (with EPSDT benefits) for children under age 26 who were in foster care when they turned 18 (January 1).
- Eliminates smoking cessation drugs, barbiturates, and benzodiazepines from excluded drug list (January 1).
- 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 (January 1).
- 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.
- Reduce states' Medicaid Disproportionate Share Hospital (DSH) allotments (Beginning in FY 2014).
- 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.

2015 and later

- 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.
- 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.
- Provides for a 23 percentage point increase in the CHIP match rate up to a cap of 100% beginning in October 1, 2015.

For additional information, see http://www.kff.org/healthreform/8064.cfm.

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