



National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

Health Reform Bills Side by Side
(12/24/09 Draft)

Bill Provision Description	House Bill HR 3962: Affordable Health Care for America Act (10/29/09)	Senate Bill H.R. 3590: Manager’s Amendment to the Senate’s Patient Protection & Affordable Care Act 12/24/09)
INSURANCE REFORM		
Grandfather current coverage for individuals	Yes, with conditions	Allows any individual enrolled in any form of health insurance to maintain their coverage as it existed on the date of enactment. Allows employers to enroll new employees into a grandfathered plan.
National Plans	Allows the Commissioner to enter into a contract with a QHBP offering entity for the offering of a health benefits plan with the same benefits in every state so long as such entity is licensed to offer such plan in each State and the benefits meet the requirements in each state.	Nationwide plans, are replaced by multi-state plans. Requires the Office of Personnel Management (OPM) to contract with health insurers to offer at least two multi-state qualified health plans (at least one non-profit) through Exchanges in each State. Requires OPM to negotiate contracts in a manner similar to the manner in which it negotiates contracts for Federal Employees Health Benefits Program (FEHBP), and allows OPM to prohibit multi-state plans that do not meet standards for medical loss ratios, profit margins, and premiums. Requires multi-state plans to cover essential health benefits and meet all of the requirements of a qualified health plan; States may require multi-state plans to offer

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		additional benefits, but must pay for the additional cost. Multi-state plans must comply with 3:1 age rating, except States may require more protective age rating. Multi-state plans must comply with the minimum standards and requirements of FEHBP, unless they conflict with the PPACA. Guarantees that FEHBP will maintain a separate risk pool and remain a separate program.
State Opt-out		Beginning in 2017, allows States to apply for a waiver for up to 5 years of requirements relating to qualified health plans, Exchanges, cost-sharing reductions, tax credits, the individual responsibility requirement, and shared responsibility for employers. Requires States to enact a law and to comply with regulations that ensure transparency. Requires the Secretary to provide to a State the aggregate amount of tax credits and cost-sharing reductions that would have been paid to residents of the State in the absence of a waiver. Requires the Secretary to determine that the State plan for a waiver will provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as this title would provide; and that it will not increase the Federal deficit.

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State Option for a basic health plan		States would have an opportunity to establish a state plan for people with incomes above Medicaid eligibility but below 200% of FPL. Requires the federal government to provide participating States 85 percent of the tax credits and cost-sharing reductions that would have been provided to individuals enrolled in standard health plans if they were enrolled in qualified health plans.
Interstate Health Insurance Compacts	Effective January 1, 2015, would allow 2 or more States to form Health Care Choice Compacts to facilitate the purchase of individual health insurance across State lines. Calls on the National Association of Insurance Commissioners to develop model guidelines for such compacts. Ensures that such compacts require licensure in each state and maintains authority of the State in which a covered individual resides to protect the individual. Allows States to apply for grants from the Secretary of HHS to help implement such compacts.	By 7/1/2013, HHS must issue regulations for interstate health compacts. Under a compact, qualified health plans could be offered in all participating States, but insurers would still be subject to the consumer protection laws of the purchaser's State. Insurers would be required to be licensed in all participating States (or comply as if they were licensed. Requires States to enact a law to enter into compacts and Secretarial approval. Requires that compacts provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as the reform bill would; and that it will not increase the Federal deficit or weaken consumer protections.
Limited premium variation permitted	Yes 2:1 maximum It shall not exceed 125 percent of the prevailing standard rate for comparable coverage in that market. It can be adjusted for geographic differences and family size as permitted by state insurance commissioners and the Health Choices	Establishes that premiums in the individual and small group markets may vary only by family structure, geography, the actuarial value of the benefit, age (limited to a ratio of 3 to 1), and tobacco use (limited to a ratio of 1.5 to 1).

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	Commissioner.	
Provider networks	Yes, Commissioner established requirements	Plans participating in the exchange must have essential community providers in the network.
Cost Sharing Limits	\$5,000 for individual; \$10,000 for family; increased annually by CPI; Copayment should be used instead of coinsurance.	Out of pocket limits would be tied to varying percentages of current Health Saving Account limits
No cost share for preventive services	Yes	Requires all plans to cover preventive services and immunizations recommended by the U.S. Preventive Services Task Force and the CDC, and certain child preventive services recommended by the Health Resources and Services Administration, without any cost-sharing.
Dependent coverage up to age 26	Yes beginning January 2010	Requires all plans offering dependent coverage to allow unmarried individuals until age 26 to remain on their parents' health insurance.
No exclusion of pre-existing conditions	Yes	Yes, beginning in 2014. This provision applies to children effective six months after enactment.
No annual or lifetime limits	Yes	Yes, beginning in 2014
Individual Mandate to obtain health insurance	Yes, except in cases of hardship. Those who don't obtain coverage will pay a penalty not to exceed the premium. Additional tax of 2.5% if an individual does not obtain acceptable coverage. Requires guaranteed issue and renewal of insurance policies.	Requires individuals to maintain minimum essential coverage beginning in 2014. Failure to maintain coverage will result in a penalty of \$95 in 2014, \$495 in 2015, \$750 in 2016 and indexed thereafter. Families will pay half the amount for children up to a cap of \$2,250 for the entire family. Exceptions to the individual responsibility requirement to maintain minimum essential coverage are made for religious objectors, individuals not lawfully present, and incarcerated individuals. Exemptions from the

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		penalty will be made for those who cannot afford coverage, taxpayers with income under 100 percent of poverty, members of Indian tribes, those who have received a hardship waiver and those who were not covered for a period of less than three months during the year.
Return of Profit	Any QHBP with a medical loss ratio defined by the commission must provide a rebate to enrollees to make the issuer's medical loss ratio less than a specified level.	Requires plans offering coverage in the group and individual markets (including grandfathered plans but excluding self-insured plans) to report to the Secretary the amount of premium revenues spent on clinical services, activities to improve quality, and all other non-claims costs as defined by the National Association of Insurance Commissioners and certified by the Secretary of HHS. Beginning in 2011 there will be criteria for large group plans that spend less 85 percent of premium revenue and small group and individual market plans which spend less than 80 percent of premium revenue on clinical services and quality to provide a rebate to enrollees. In addition, each hospital operating within the United States shall publish a list of standard charges for items and services provided by the hospital.
Rebalancing of Risk Factors	The Health Choices Commissioner coordinates affordability credits and risk-pooling. In order to prevent waste, fraud and abuse, institutes a special inspector general to oversee operation of the program.	Requires States to assess charges on health plans with enrollees of lower-than-average risk, and to provide payments to health plans with enrollees of higher-than-average risk. Risk adjustment applies to plans in the individual and small group markets, but

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		not to grandfathered health plans.
Parity in Mental health and substance abuse benefit disorders	Yes, benefits must include mental health and substance abuse treatment services.	Benefits must include mental health and substance abuse treatment services.
Screening & Brief Intervention, Referral, and Treatment for Mental Health & Substance Abuse Disorders	The Secretary shall establish a program to provide grants, contracts, and cooperative agreements on mental health and substance abuse screening, brief intervention, referral, and recovery services for individuals in primary care settings. In order to be eligible the entity must be a public or private non-profit that provides primary care services, seeks to integrate mental health and substance abuse services into its services system, has developed a working relationship with providers, demonstrates a need for inclusion of mental health & substance abuse services in its service system, and agrees to submit an evaluation to the Secretary and to use the necessary performance measures.	
Centers of Excellence for Depression		Directs the Administrator of the Substance Abuse and Mental Health Services Administration to award grants to centers of excellence in the treatment of depressive disorders.
Coverage requirements	Hospitalization, outpatient hospital and outpatient clinic (including ER), professional services of physicians and other health professionals services, equipment and supplies relating to health professional service, prescription drugs,	Essential benefits include: Ambulatory patient services; Emergency services; Hospitalization; Maternity and newborn care; Mental health and substance use disorder services, including behavioral health treatment; Prescription drugs; Rehabilitative

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	rehabilitative and habilitative services, mental health and substance use disorder services, preventive services, maternity care, well baby and well child care and oral health, vision and hearing services, equipment and supplies for children under 21, and durable medical equipment, prosthetics, orthotics and related supplies.	and habilitative services and devices; Laboratory services; Preventive and wellness services and chronic disease management; Pediatric services, including oral and vision care, which must be equal in scope to the benefits of a typical employer plan.
Rates and Payments	Applies Medicare's prompt payment requirements to plans in the Exchange.	
Advisory Council	Health Benefits Advisory Committee: Surgeon General shall chair this committee which will recommend benefit standards.	
Employer Responsibility	Employers are responsible for paying to the issuer of the coverage or required to make a contribution to the Health Insurance Exchange.	Requires an employer with more than 50 full-time employees that does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit to make a payment of \$750 per full-time employee. An employer with more than 50 full-time employees that requires a waiting period before an employee can enroll in health care coverage will pay \$400 for any full-time employee in a 30-60 day waiting period and \$600 for any full-time employee in a 60-90 day waiting period. An employer with more than 50 employees that does offer coverage but has at least one full-time employee receiving the premium assistance tax credit will pay the lesser of \$3,000 for each of those employees receiving a tax credit or \$750 for each of their full-time employees total. A large employer

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		<p>requiring a waiting period before an employee may enroll in coverage of longer than 60 days will pay a fine of \$600 per full-time employee.</p> <p>The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments.</p> <p>Requires employers that offer coverage and make a contribution to provide free choice vouchers to qualified employees for the purchase of qualified health plans through Exchanges. The free choice voucher must be equal to the contribution that the employer would have made to its own plan. Employees qualify if their required contribution under the employer's plan would be between 8 and 9.8 percent of their income. Excludes free choice vouchers from taxation and voucher recipients are not eligible for tax credits.</p>
Revenue	The wealthiest 0.3% of Americans would pay a surcharge on the portion of their income above \$500,000 (individuals) and \$1 million (couples). This would affect the top 1.2% of those with small business income.	Levies an excise tax of 40 percent on insurance companies and plan administrators for any health coverage plan that is above the threshold of \$8,500 for single coverage and \$23,000 for family coverage. The tax would apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). The tax

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		would apply to the amount of the premium in excess of the threshold. The threshold would be indexed at CPI-U plus one percentage point, and a transition rule would increase the threshold for the 17 highest cost States for the first 3 years. An additional threshold amount of \$1,350 for singles and \$3,000 for families is available for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions.
Antitrust Exemption	Repeals health insurance and malpractice insurance exemptions from Federal antitrust law.	

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INSURANCE EXCHANGE/GATEWAY		
Eligibility for Exchange	Individuals without insurance.	Allows qualified individuals, defined as individuals who are not incarcerated and who are lawfully residing in a State, to enroll in qualified health plans through that State’s Exchange. Allows qualified employers to offer a choice of qualified health plans at one level of coverage; small employers qualify to do so, and States may allow large employers to qualify beginning in 2017. Requires insurers to pool the risk of all enrollees in all plans (except grandfathered plans) in each market, regardless of whether plans are offered through Exchanges. Requires the offering of only qualified health plans through Exchanges to Members of Congress and their staff. Requires the Secretary to establish procedures under which States may allow agents or brokers to enroll individuals in qualified health plans and assist them in applying for tax credits and cost-sharing reductions.
Grants for connector/ exchange	Commission would establish a health insurance exchange trust fund to operate the exchange and affordability credits.	Requires the Secretary to award loans for start-up costs and grants to meet solvency requirements, until July 1, 2013, to member-run nonprofits that will offer qualified health plans. Establishes an Advisory Board with members appointed by the Comptroller General, to terminate by 2016.
Premium Review	Directs the Commissioner to review premium increases, and the insurance companies to provide	

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	justification for any increases. Allows the state to recommend excluding insurers from the exchange due to excessive or unjustified premium increases. Appropriates \$1 Billion over 5 years in formula grants to states for monitoring premiums.	
Provides consumers with information on the cost of premiums, and the availability of in and out of network providers	Yes, the Commissioner is required to make this information available.	States must create a website that contains cost/quality information. Must also develop “rating system” to categorize plans by cost/quality.
State Eligibility in Gateway	State Medicaid programs must accept Medicaid eligibility determinations done through the gateway. Medicaid programs can enter into an agreement to perform eligibility for premium assistance in the gateway.	Requires the Secretary to establish a system for the residents of each State to apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. The system will ensure that if any individual applying to an Exchange is found to be eligible for Medicaid or a State children’s health insurance program (CHIP), the individual is enrolled for assistance under such plan or program.
Access to coverage: Exchange eligible individual	All individuals unless enrolled in another QHBP or other acceptable coverage	Initially limited to individuals and small employers, phasing in larger employers
Staggered participation of plans in exchange	Y1 – individuals/smallest employers Y2 – Above, plus small employers Y3 – Above, plus commission approved large employers	Yes; in 2015 States must begin to accept businesses with up to 100 employees; beginning in 2017 States may allow businesses with more than 100 employees into the exchange
Options for states and territories to operate exchange	One or more state/territory may apply to Commission to operate exchange if approved by Commission per specified requirements. Commissioner will approve	Requires the Secretary to award grants, available until 2015, to States for planning and establishment of American Health Benefit Exchanges. By 2014,

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	<p>if state or states demonstrate A).ability: to negotiate and contract with QHBPs; to enroll exchange eligible individuals and employers in plans; to establish enough local offices; administer affordability credits; and enforcement activities consistent with Federal requirements. B) there is no more than one exchange per state; C) there will not be an increase in cost to the Federal government; D) the state would report necessary information to the Commissioner; and E) the state would meet any other requirements the Commissioner may specify.</p>	<p>requires States to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and includes a SHOP Exchange for small businesses.</p> <p>Allows States to require benefits in addition to essential health benefits, but States must defray the cost of such additional benefits. Requires Exchanges to certify qualified health plans, operate a toll-free hotline and Internet website, rate qualified health plans, present plan options in a standard format, inform individuals of eligibility for Medicaid and CHIP, provide an electronic calculator to calculate plan costs, and grant certifications of exemption from the individual responsibility requirement. Beginning in 2015, requires Exchanges to be self-sustaining and allows them to charge assessments or user fees.</p> <p>Allows Exchanges to certify qualified health plans if they meet certification criteria and offering them is in the interests of individuals and employers. Allows regional or interstate Exchanges if the States agree to, and the Secretary approves, such Exchanges.</p> <p>Requires Exchanges to award grants to Navigators that educate the public about qualified health plans, distribute information on enrollment and tax credits, facilitate enrollment, and provide referrals on grievances, complaints, or questions.</p>
Coordination of enrollment	Requires the Commissioner to enter into	Allows individuals to apply for and enroll in

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between Medicaid and Exchanges	Memorandums of Understanding with state Medicaid agencies to coordinate enrollment in Medicaid and the Exchange for Medicaid-eligible individuals.	<p>Medicaid, CHIP or the Exchange through a State-run website. Requires State Medicaid and CHIP programs and the Exchange to coordinate enrollment procedures to provide seamless enrollment for all programs.</p> <p>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. Medicaid/CHIP/Gateways operate secure data systems to determine eligibility via the single form, and/or data exchange.</p> <p>Exchanges can enter into a contract with the State Medicaid agency to determine eligibility for the tax credits.</p>
Individuals eligible for CHIP may elect to enroll in CHIP or in a qualified health plan	CHIP individuals must enroll in a qualified health plan or Medicaid in 2014.	CHIP-eligible children who cannot enroll in CHIP due to Federal allotment caps would be eligible for tax credits in the State Exchange.
Level of benefits	Four levels of benefits will be available basic, enhanced, premium, and premium plus. Premium plus is an optional level.	<p>For the individual and small group markets, requires one of the following levels of coverage, under which the plan pays for the specified percentage of costs: Bronze: 60 percent; Silver: 70 percent; Gold: 80 percent; Platinum: 90 percent.</p> <p>In the individual market, a catastrophic plan may be offered to individuals who are under the age of 30 or who are exempt from the individual responsibility</p>

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		requirement because coverage is unaffordable to them or they have a hardship. A catastrophic plan must cover essential health benefits and at least 3 primary care visits, but must require cost-sharing up to the HSA out-of-pocket limits. Also, if an insurer offers a qualified health plan, it must offer a child-only plan at the same level of coverage.
Employer Credits	Provide small employers with fewer than 25 employees and average wages of less than \$40,000 with a health coverage tax credit. The full credit of 50% of premium costs paid by employers is available to employers with 10 or fewer employees and average annual wages of \$20,000 or less. The credit phases-out as firm size and average wage increases.	Provides a sliding scale tax credit to small employers with fewer than 25 employees and average annual wages of less than \$50,000 that purchase health insurance for their employees. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000. To be eligible for a tax credit, the employer must contribute at least 50 percent of the total premium cost or 50 percent of a benchmark premium. In 2010 through 2013, eligible employers can receive a small business tax credit for up to 35 percent of their contribution toward the employee's health insurance premium. Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 25 percent of their contribution. In 2014 and beyond, eligible employers who purchase coverage through the State Exchange can receive a tax credit for two years of up to 50 percent of their contribution. Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 35 percent of their contribution.

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Affordability Credits/Individual Subsidies	<p>Provide affordability premium credits to individuals and families with incomes up to 400% FPL (who is not a Medicaid eligible individual, other than an individual during a transition period and who is not enrolled in acceptable coverage (subject to special rule for Indians)) to purchase insurance through the Health Insurance Exchange.</p> <p>The premium credits will be based on the average cost of the three lowest cost basic health plans in the area and will be set on a sliding scale such that the premium contribution is no more than 1.5% of income for individuals with income between 133% FPL and 150% FPL and no more than 11% (initial) and 12 % (final) of income for individuals with income between 350% FPL and 400% FPL.</p> <p>Provide affordability cost-sharing credits to individuals and families with incomes up to 400% FPL. The cost-sharing credits are offered on a sliding scale basis such that the cost-sharing limit for those with income with income between 133% FPL and 150% FPL is \$500 per individual and \$1000 per family and for those with income between 350% FPL and 400% FPL is \$5,000 per individual and \$10,000 per family.</p>	<p>The premium assistance credit amount is calculated on sliding scale starting at two percent of income for those at or above 100 percent of poverty and phasing out to 9.8 percent of income for those at 400 percent of poverty. The reference premium is the second lowest cost silver plan available in the individual market in the rating area in which the taxpayer resides. The premium assistance credits do not take into account benefits mandated by States. Employees offered coverage by an employer under which the plan’s share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs or the premium exceeds 9.8 percent of the employee’s income are eligible for the premium assistance credit.</p> <p>The standard out-of-pocket maximum limits (\$5,950 for individuals and \$11,900 for families) would be reduced to one-third for those between 100-200 percent of poverty, one-half for those between 200-300 percent of poverty, and to two-thirds for those between 300-400 percent of poverty. The plan’s share of total allowed costs of benefits would be increased to 90 percent for those between 100-150 percent of poverty (i.e., the individual’s liability is limited to 10 percent on average) and to 80 percent for those between 150-200 percent of poverty (i.e., the individual’s liability is limited to 20 percent on</p>

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	Commissioner must verify that individuals are citizens and legal immigrants in order to receive affordability credits.	average). The cost-sharing assistance does not take into account benefits mandated by States.
Treatment of State Mandated benefits	Benefits required if state enters into an agreement to reimburse Commission for additional costs	Allows insurers in the individual and small group markets to offer a qualified health plan nationwide, which is subject to only the State benefit mandate laws of the State in which the plans are issued; but requires such plans to provide the essential benefits package. Allows States to enact a law to opt out of allowing the offering of nationwide plans. Requires insurers to file plan forms with each State in which they will offer nationwide plans for review
FQHCs	Provides an additional \$12B in funding for FQHCs over the next 5 years (FY 11 -15).	Provides an additional \$33B in funding for FQHCs over the next 6 years (FY 10 – 15) Ensures that any payments by QHP to FQHCs are at least as high as payments to FQHCs under Medicaid. Establishes a prospective payment system (PPS) for FQHCs under Medicare
Changes for Retirees	Allows a temporary reinsurance program for retirees 55 -65.	Establishes a temporary reinsurance program to provide reimbursement to participating employment-based plans (applies to plans sponsored by State and local governments) for part of the cost of providing health benefits to retirees (age 55-64) and their families.
Medicare Advantage Plans	Reduces Medicare Advantage benchmarks to fee-for-service levels over three years.	Sets Medicare Advantage payment based on the average of the bids from Medicare Advantage plans in each market. Creates performance bonus payments based on a plan's level of care coordination and care

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		management and achievement on quality rankings. Provides a four-year transition to new benchmarks beginning in 2011
Increasing Health Care Competition (Public Plan/CO-Op options)	Provides for a public health insurance option through the Health Insurance Exchange. This option must comply with the requirements applicable to the other Exchange participating health benefit plans. Also authorizes start-up loans to assist states with the creation of health insurance cooperatives.	Provides funding for the Consumer Operated and Oriented Plan program to foster the creation of nonprofit, member run health insurance companies that serve individuals in one or more states.
MEDICAID MODIFICATIONS		
Basic Approach to Medicaid	Requires all individuals to have health insurance. Creates an Exchange which requires employers to either provide coverage or pay into the Health Insurance Exchange Trust Fund. Expands Medicaid to individuals up to 150% FPL.	Requires all individuals to have health insurance. States must create exchange(s) for individual market and small group market. Requires employers with greater than 50 employees to provide coverage or pay a penalty. Expands Medicaid to individuals up to 133 % FPL.
Medicaid Eligibility		
All individuals currently eligible will remain eligible for Medicaid	Yes	Yes
Mandatory eligibility level	150% of Federal Poverty Level for those under age 65 and not eligible for Medicare. CHIP-eligible children move to the Exchange or Medicaid in 2014. A state cannot require a non-traditional eligible	On 4/2010, States would be provided the option to cover childless adults up to 133% FPL under a SPA at current FMAP. Effective 1/2014 eligibility for parents, children age 6 and older, and all childless adults otherwise ineligible for Medicaid would increase to 133% of FPL. Individuals at or below 100% of FPL are exempt from the penalty. These

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	<p>individual in managed care unless the state demonstrates to the Secretary that there is adequate capacity of the network to meet health, mental health and substance abuse needs of the individuals.</p>	<p>individuals would not be eligible for tax credits in the exchange and would access coverage through Medicaid. All newly eligible non pregnant adults would be guaranteed a benchmark benefit package consistent with section 1937 of SSA.</p> <p>Medicaid cost sharing rules and out-of-pocket limit of 5% of family income would continue to apply to children.</p> <p>States would be required to report on changes in Medicaid enrollment.</p> <p>Clarifies that new mandatory coverage of childless adults in territories is pegged to current eligibility levels for parents in the territories.</p>
<p>Maintenance of effort for current Eligibility Categories</p>	<p>Yes, as of June 16, 2009 (also for CHIP), however, a state is not precluded from imposing limitations described in 2110(b)(5)(C)(i)(II) to limit expenditures under its annual allotment. Maintenance of eligibility ends upon expiration of CHIP program on December 31, 2013.</p> <p>Permits an exception to the maintenance of effort requirement for certain populations who receive a premium or cost sharing subsidy for individual or group health coverage as of June 16, 2009, under</p>	<p>States are not permitted to reduce income eligibility levels for adults on Medicaid until 12/31/2013. States cannot reduce income eligibility levels for children until 9/30/2019 (both Medicaid and CHIP).</p> <p>Between 1/1/11 and 1/1/14, a state is exempt from MOE for optional non-pregnant non-disabled adult populations above 133% of the FPL if the state certifies that the state is currently experiencing a budget deficit or projects a budget deficit in the following SFY.</p>

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	<p>section 1115 waivers.</p> <p>States must not apply any asset or resource test in determining eligibility beginning on or after Y1 of the America's Affordable Health Choices Act of 2009.</p> <p>Benchmark packages must meet the minimum benefits and cost sharing standards of a basic plan offered through the health exchange.</p>	<p>On 1/1/14, income calculations for Medicaid and CHIP would change to Modified Gross Income (MGI), which is based on IRS Gross Income used in the state exchanges. Income disregards would not be allowed in Medicaid. An exception for the MGI rule would be made for people with disabilities, the elderly and groups that are eligible for Medicaid, through another program, e.g., foster children. The change to MGI would not apply to beneficiaries who were enrolled in Medicaid on 1/1/14 until the later of 3/31/14 or their next redetermination date.</p>
Former foster care children		<p>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 January 1, 2014</p>
Coverage of Newborns	<p>Non-traditional Medicaid enrollees and elected Medicaid; after 1 year deemed traditional Medicaid unless eligible under other acceptable coverage. Initial Medicaid coverage is 60 days while a determination is completed to enroll the newborn in appropriate insurance. The federal government would pay 100% of the costs of Medicaid coverage for these newborns.</p>	
Family Planning	<p>State plan option to provide only family-planning services. Allows state Medicaid programs to cover such services through a presumptive eligibility</p>	<p>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</p>

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	period.	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. Presumptive eligibility would be permitted.
Optional coverage of low-income HIV infected individuals	State plan option to provide medical assistance to individuals with an HIV infection and income/resources below the maximum level set for mandatory eligibility categories for people with disabilities in the State; excludes this group from funding limitation for territories. This option sunsets on January 1, 2013, when broad based coverage will be available through the Exchange or expanded Medicaid.	
Unlawful residents	Nothing in the legislation shall change current prohibitions of payment under Medicaid or CHIP for individuals that are not lawfully present in the U.S.	Includes technical corrections to the CHIPRA legislation that barred people residing in the country illegally from Medicaid and CHIP.
Legal Immigrants		Makes legal immigrants whose income is less than 133 percent of the Federal Poverty Level (FPL), and who are not eligible for Medicaid by virtue of the five year waiting period, eligible for the basic health program.
State option to disregard certain income for individuals with high prescription drug costs	Allows state Medicaid programs to cover individuals with family income up to \$150,000 who have orphan drug costs exceeding \$200,000 and have exhausted their private health insurance coverage for prescription drugs.	

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Coverage of Incarcerated Youth	The state must assure that a youth who was eligible for Medicaid upon being incarcerated must retain eligibility and receive benefits upon release. During incarceration, the state must establish a process that ensures that the state does not claim FFP for services excluded by 1905(a)(28)(A) and the youth receives services for which federal participation is available.	
Improvements to Facilitate Enrollment and Retention		
Medicaid Enrollment	Yes, if approved by the Commissioner, Medicaid can provide eligibility determinations through the Exchange. Requires State Medicaid programs to enter into a memorandum of understanding to coordinate enrollment with the Exchange.	State Medicaid programs would be required to operate a website that coordinates with state exchange websites for enrollment in CHIP, Medicaid or the exchange.
CHIP Enrollment		Makes some children of public employees eligible for CHIP. Increases outreach and enrollment grants by \$40 million.
Eligibility Determinations	If approved by the Commissioner, criteria utilized to establish income levels for eligibility premium credits in the Exchange may also be used to determine eligibility for Medicaid/CHIP.	State Medicaid programs would be required to operate a website that coordinates eligibility determinations for Medicaid, CHIP or credits in the exchange with state exchange websites. Requires state CHIP, Medicaid and Exchanges to coordinate enrollment procedures.
Continuous Eligibility under CHIP	12 month continuous eligibility must be provided under CHIP for children with family income below 200% FPL. Prevents the application of a waiting period under	

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	CHIP for children under 2 who lost coverage (due to the termination of an individual's employment, the reduction of an individual's work hours, elimination of an individual's retiree benefits, or termination of an individual's group health plan offered through an employer) or for whom health insurance is unaffordable.	
Interaction of CHIP and the Exchange		Children who can't enroll in the Children's Health Insurance Program (CHIP) because allotments are capped are deemed ineligible for CHIP and, therefore, eligible for tax credits in the exchanges. Precludes transitioning coverage from CHIP to the Exchange without Secretarial certification.
Expanded Outstationing	Expands requirements to receive and process applications at places such as DSH hospitals and FQHCs to all Medical Assistance applications and affordability credits	Hospitals would have the option to make presumptive eligibility determinations, based on preliminary information, for any individual who may be eligible for Medicaid.
Medicaid Interaction with the Exchange	The Medicaid agencies must have an agreement with the Commissioner with regard to the enrollment of individuals in Exchange participating plans. States are required to accept individuals determined eligible for Medicaid through the exchange. Individuals in the exchange are eligible for wrap around benefits. Individuals who are Medicaid eligible and Exchange-eligible but have not elected to enroll in the Exchange will be automatically enrolled into	Individuals below 100 % FPL would not receive affordability credits in the Exchange. Instead, these individuals would be determined eligible for Medicaid by the exchange.

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	<p>Medicaid.</p> <p>A non-traditional Medicaid eligible as determined by the Commissioner will be accepted in Medicaid by the state without any further determination. The State will also accept without further determinations individuals determined to be traditional Medicaid eligible by the Commissioner.</p> <p>The state shall provide Medicaid available during presumptive eligibility periods.</p> <p>If the Commissioner determines the state has the capacity, the state will conduct eligibility determination for Affordability credits and the Commissioner will reimburse the state for the costs of doing the determinations.</p> <p>CHIP individuals considered exchange eligible unless eligible for Medicaid.</p>	
Financing		
Federal Payments for Newly Eligible Individuals	<p>The federal government will pay 100% of Medical costs for newly eligible individuals under 150% of the FPL until 2015. Beginning in 2015, the FMAP for the individuals under 150% FPL will reduce to 91% and extend indefinitely.</p> <p>Provides 100% FMAP for coverage of newborns up</p>	<p>From 2014 through 2016, the Federal government will pay 100 percent of the cost of covering newly-eligible individuals. Newly eligibles are defined based on the coverage level as of 12/1/09. In 2017 and 2018, States that initially covered less of the newly-eligible population would receive more assistance than those States that covered at least</p>

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	to 60 days old without other health insurance. Requires the Comptroller General to study the FMAP rate and the effect of removing the 50% floor and the 83% ceiling and report to Congress by February 15, 2011. Requires the Comptroller General to study Medicaid Administrative Costs and report to Congress by February 15, 2011. Establishes within CMS a Center for Medicare and Medicaid Payment Innovation	some non-elderly, non-pregnant individuals (“Expansion States”). To qualify as an expansion state the benefit package must include inpatient hospital services. Non-expansion states would receive a FMAP increase (only for services to newly-eligible individuals) of 34.3 in 2017 and 33.3 in 2018. Expansion States would receive 30.3 in 2017 and 31.3 in 2018. Beginning in 2019 and extending indefinitely, all States would receive an FMAP increase of 32.3 percentage points for such services.
Equitable Support for Certain States		<p>During the period that begins on 1/1/14 and ends on 9/30/19 notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to a fiscal year occurring during this period shall be increased by 2.2 percentage points for states that meet the following: 1) an expansion state; 2) the secretary determines the state will not receive any payments under an increased FMAP under subsection y (the criteria for getting higher FMAP for expansion states) for newly eligible individuals and 3) and the state has not been approved to divert DSH for health insurance under an 1115 waiver in effect as of 7/2009.</p> <p>To get a .5 bump, the state has to meet 1 and 2 above, and be the state with the highest percentage of</p>

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		<p>insured in the 2008 CPS (Massachusetts).</p> <p>For Nebraska, the amount of FMAP for the newly eligible on or after January 1, 2017 shall be determined under subsection (y)(1)(A) -- 100% for newly eligibles.</p> <p>Requires states to share the benefit of increased federal match with political subdivisions that contribute to the non-federal share of Medicaid costs.</p>
Study of Federal Poverty Level Definition		Directs the Secretary of HHS to study adjusting the definition of “federal poverty level” to reflect cost of living variations among different geographic areas within the United States.
Additional Federal financial participation for CHIP		<p>Extends the current reauthorization period of CHIP for two years, through 9/30/15.</p> <p>States would be required to maintain income eligibility levels for CHIP through September 30, 2019. From fiscal year 2016 to 2019, States would receive a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent.</p> <p>After October 1, 2013, the enrollment bonus payments for children ends.</p>
ARRA FMAP	Extends ARRA increase in federal Medicaid payments to states with high unemployment rates.	

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Special Adjustment to FMAP for certain states recovering from a major disaster		Reduces projected decreases in Medicaid funding for States that have experienced major, statewide disasters.
Changes to Medicaid best price for pharmacy	Sets the Federal upper reimbursement limit at no less than 130% of Average manufacture prices	The federal upper limit would be changed to no less than 175% of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufactured price.
Prescription drug rebates	<p>Increases minimum rebate percentage for single-source drugs to 23.1 percent after December 31, 2009.</p> <p>Extends Medicaid prescription drug rebates to Medicaid managed care organizations. The manufacturers must make the rebate payments to the state Medicaid agencies rather than to the Medicaid Managed Care Organizations.</p>	Would apply to managed care organizations. The rebate amounts would be increased with the minimum rebate percentage for single source and innovator multiple source drugs going from 15.1% to 23.1% and from 11% to 13% for generic drugs. The rebate for clotting factors and outpatient drugs approved by the Food and Drug Administration exclusively for pediatric indications would increase to 17.1 percent
DSH	HHS must submit a report to Congress that recommends what to do with DSH given the impact of health reform. Secretary of HHS must reduce the Medicaid DSH payments to states by \$10 billion (\$1.5 billion in FY2017; \$2.5 billion in FY2008, and \$6 billion in FY2019) using a method that includes the uninsurance rate in each state and the amount of uncompensated care provided by hospitals.	If you are a low DSH state and you have not spent more than 99.90 percent of the DSH allotment for your state on average for the period of fiscal years 2004-2008, as of 9/30/09 your applicable percentage is 25. If you are a low DSH state and you have spent more than 99.90 percent of your DSH allotments on average for the period of fiscal years 2004-2008 as of 9/30/09 your applicable percentage will be 17.5. If you are not a low DSH state and you have not spent more than 99.90 percent of the DSH allotments on

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		<p>average for the period of fiscal years 2004-2008 as of 9/30/09 your percentage will be 50. If you are not a low DSH state and you have spent more than 99.90 percent of the DSH allotments on average for the period of fiscal years 2004-2008 as of 9/30/09 your percentage is 35.</p> <p>Thereafter the state's DSH allotment would be reduced using a calculation based on further reduction in the rate of uninsured your percentage will differ whether you are a low or high DSH state and whether you have spent more or less than 99.90 percent of your DSH allotment.</p> <p>If you are a low DSH state and you have not spent more than 99.90 percent of your DSH allotment you will receive a 27.5 percent reduction. If you are a low DSH state and you have spent more than 99.90 percent of your DSH allotment you will receive a 20 percent reduction. If you are not a low DSH state and you have not spent more than 99.90 percent of your DSH allotment you will get a 55 percent reduction and if you are not a low DSH state and you have spent more than 99.90 percent of your DSH allotment you will get a 40 percent reduction.</p> <p>A state's DSH allotment would not decrease by more than 50% of the allotment in 2012.</p>

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		<p>Any portion of the state's DSH allotment that is currently being used to expand eligibility through a section 1115 waiver is exempt from the reductions.</p> <p>Gives Hawaii special rules for their Medicaid Disproportionate Share Hospital (DSH) allotment.</p>
Medicaid Rates	<p>Medicaid rates are tied to Medicare Part B rates for primary care services: 80% Medicare in 2010 90% Medicare 2011 100% Medicare 2012 and beyond; This applies to both fee for service and managed care. Physicians will receive 100% of Medicare rates for primary care services and other primary care practitioners will receive the Medicare rate for their services (usually 85 % of the physician rate).</p> <p>The required increase in Medicaid payments are financed with 100% FMAP until 2015, and 90% for 2015 and beyond.</p> <p>Requires the state to submit a plan amendment each year specifying the payment rates for services and additional data to assist the Secretary in evaluating the States compliance with the requirements including data on managed care organizations.</p>	

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	Effective 2011. States must also report annually to CMS administrator information on the determination of rates including final rates; the methodologies and the justification for the rates and an explanation of the process used by the state to allow providers, beneficiaries and their representatives and other concerned parties a reasonable opportunity to review and comment.	
60 day rule on overpayments	Would 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 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.
Transitional Medical Assistance	Extends TMA until December 31, 2012.	
Qualified Individuals	Eliminates the funding limitation and extends for 2 years	
Managed Care provider tax	Extends the delay in managed care provider tax elimination to October 1, 2010.	
Managed Care Administrative Costs	Limits MCO spending on administration, marketing and distributions to shareholders to no more than 15% of revenues from Medicaid premiums.	
Graduate Medical Education	Codifies that GME is an allowable cost under Medicaid. Establishes requirements for the payment of GME.	
Medicaid Improvement Fund	Eliminates the money available in the Medicaid	Rescinds \$700 million available from 2014 – 2018

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	Improvement Fund, and requires congress to appropriate any funding.	for “Medicaid Improvement” – including contractor oversight and demonstration project evaluation
Bundled payment demonstration		<p>Would establish a bundled payment demonstration project under Medicaid in up to eight states.</p> <p>Up to 5 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. Provides the Secretary of HHS authority to expand the payment bundling pilot if it is found to improve quality and reduce costs. Also, directs the Secretary to test bundled payment arrangements involving continuing care hospitals within the bundling pilot program.</p>
Global payment demonstrations		Establishes a demonstration project, in coordination with the CMS Innovation Center, in up to five States that would allow participating States to adjust their current payment structure for safety net hospitals from a fee-for-service model to a global capitated payment structure.
Improvements Under Center for Medicare & Medicaid Innovation		Adds payment reform models to the list of projects for the Center to consider, including rural telehealth expansions and the development of a rapid learning network. Ensures that quality measures used by the Center are consistent with the quality framework within the underlying bill, and requires the Secretary to focus on models that both improve quality and

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		reduce costs.
New 1115 Requirements		Any application or renewal of a demonstration project under title XIX or XXI that relates to eligibility or cost sharing must follow the new requirements that will be laid out by the Secretary. This requires the Secretary to promulgate regulations and administrative requirements relating to 1115 waivers.
Pediatric Accountable Care Organization demonstration project		Establishes a demonstration project that allows qualified pediatric providers to be recognized and receive payments as Accountable Care Organizations (ACO) under Medicaid. The pediatric ACO would be required to meet certain performance guidelines. Pediatric ACOs that met these guidelines and provided services at a lower cost would share in those savings.
Medicaid emergency psychiatric demonstration project.		Requires the Secretary of HHS to establish a three-year Medicaid demonstration project in up to eight States. Participating States would be required to reimburse certain institutions for mental disease (IMDs) for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition.
Puerto Rico & Territories	Specifies specific new increased funding levels for each territory for each FY between FY 2011 - 2019.	Increases the spending caps for the territories by 30 percent and the applicable FMAP by five percentage points – to 55 percent – beginning on January 1,

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	<p>The Secretary must complete a report due not later than 10/1/13 that details a plan to transition the territories to full parity in Medicaid with the states and DC.</p> <p>Revises the FMAP formula for FY11 through FY 19 to provide the territories with an FMAP rate equal to the highest rate given to a state or DC during FY.</p> <p>Expands broad waiver authority to the Secretary to approve changes to the Medicaid rules for the territories' Medicaid Programs.</p> <p>The Secretary shall provide technical assistance regarding upgrading their computer systems to comply with the requirements relating to the achieving parity in the Medicaid program.</p> <p>Residents of Micronesia, Marshall Islands, and Palau not excluded from Medicaid by PRWORA.</p>	<p>2011 and for each fiscal year thereafter. Beginning in 2014, payments made to the territories with respect to amounts expended for medical assistance for newly eligible individuals would not count against the spending caps.</p>
Expansion of Payments to Indian Health Programs/Indian Health Care Improvement	Provides that Indian Health Programs are eligible for Medicare and Medicaid payments for all items and services, if those services meet all of the Medicare/Medicaid requirements.	Authorizes appropriations for the Indian Health Care Improvement Act, including programs to increase the Indian health care workforce, new programs for innovative care delivery models, behavioral health care services, new services for health promotion and disease prevention, efforts to improve access to health care services, construction of Indian health facilities, and an Indian youth suicide prevention

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		grant program.
Medicaid Benefits		
Medicaid Benefits Package	All people newly eligible with income under 150% of the Federal Poverty Level would receive full Medicaid benefits.	Newly-eligible, non-elderly, non-pregnant individuals would receive benchmark or benchmark-equivalent coverage consistent with the requirements of section 1937 of the Social Security Act. Benchmark and benchmark-equivalent coverage would be required to provide at least essential benefits (as defined for the Exchange) and prescription drugs and mental health services would be added to the list of services that must be covered at actuarial equivalence.
Nurse Home Visitation Services	Provides for optional coverage home visits by trained nurses to first-time pregnant women, or children under 2 years old. Visits must be proven to: <ul style="list-style-type: none"> • Improve pregnancy outcomes or increase birth intervals between pregnancies; • Reduce child abuse, neglect, and injury, improve family stability, reduce crime; or Increase self-sufficiency, employment, school-readiness, and educational achievement, or reduce dependence on public assistance.	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.
School Based Services	Creates a grant program to fund school-based health centers. Grants would be awarded at 80% Federal funds with 20% local match. Appropriates \$50 million for FY 2011 and funds-as-necessary for 2012-2015. The Secretary would be directed to give preference in awarding grants to school-based health	Authorizes a grant program for the operation and development of School-Based Health Clinics, which will provide comprehensive and accessible preventive and primary health care services to medically underserved children and families. Appropriates \$50 million each year for fiscal years

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	centers serving a large population of children eligible for Medicaid or CHIP.	2010 through 2013 for expenditures for facilities and equipment.
Therapeutic Foster Care	Specifies that nothing in the title would prevent a state from covering therapeutic foster care for eligible children in out of home placements.	
Tobacco Cessation	Deletes tobacco cessation exclusion from covered outpatient drugs. Prohibits state Medicaid programs from excluding tobacco cessation products from coverage.	States would be required to provide coverage under Medicaid for tobacco cessation services for pregnant women without cost-sharing.
Birthing Center Coverage	.Includes State-option coverage for free standing birthing centers	Requires coverage of services provided by free-standing birth centers.
Hospice		Would allow Medicaid children as defined by the State to receive hospice services without forgoing any other service to which the child is entitled under Medicaid.
Vaccines for Children	Public health clinics are included under VFC program.	
Non-emergency transportation	Requires Medicaid coverage of non-emergency transportation consistent with federal regulations 42 CFR 431.53 as in effect as of June 1, 2008.	
Accountable Care Organization Pilot	Establishes an Accountable Care Organization Pilot under Medicaid to test different models of reimbursement and to reward physicians for quality outcomes.	Establishes a demonstration project which would allow pediatric medical providers who meet certain criteria to be recognized as accountable care organizations (ACOs). Participating providers would be eligible to share in the federal and state cost savings achieved for Medicaid and CHIP. States, in consultation with the Secretary, would establish a minimum level of savings that would need to be

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		achieved by an ACO in order for it to share it the savings.
Definition of Medical assistance	Redefines medical assistance to payment for and provision of care.	Redefines medical assistance to payment for and provision of care.
Preventive Services	Requires coverage of preventive services recommended with a grade of A or B by the Task Force for Clinical Preventive Services or vaccines recommended by the Director of CDC and appropriate for individuals entitled to Medicaid. Payment is at regular FMAP. Prohibits cost sharing for preventive services.	The current Medicaid State option to provide other diagnostic, screening, preventive, and rehabilitation services would be expanded to include: (1) any clinical preventive service recommended with a 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 Federal medical assistance percentage (FMAP) of one percentage point for these services.
Maternity and adult quality measures	The Secretary must establish maternity care quality measures for use by State programs under Medicaid and CHIP and must collect data from managed care entities and providers. The Secretary must also establish adult care quality measures and develop a standardized reporting format. Appropriates \$40M for 2010 -2015 for this activity.	The Secretary would create procedures to identify health care quality measurements for Medicaid-eligible adults similar to the procedures already underway for children. The Secretary would also establish procedures for and provide grants to states to collect and voluntarily report health care quality data for Medicaid-eligible adults. The Secretary in consultation with states, would be required to identify specific preventable health care acquired conditions and would prohibit payments for services

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		related to such conditions.
Medical Home	States may apply to the Secretary for a medical home pilot project. The Secretary shall conduct an evaluation of the pilot program. In the project, States would receive 90% FMAP for the first two years, and 75% for the next three years – up to a maximum of \$1.235 Billion.	Creates a new Medicaid state plan option under which Medicaid beneficiaries with chronic conditions could designate a health home. Medicaid enrollees with at least one serious and persistent mental health condition qualify to receive services under this option.
Adult Day Health Care	Prohibits the Secretary from denying Federal matching funds to certain states for the cost of adult day health care services.	
Translation Services	Extends 75% matching rate for translation services from children to “other individuals” for whom English is not the primary language.	
Healthy Lifestyles		States could design a proposal and apply for funds to provide incentives to Medicaid enrollees who improve their health status and complete scientifically based healthy lifestyle programs.
Podiatrists	Includes podiatrists as a physician under Medicaid	
Optometrists	Requires Medicaid coverage of professional services of optometrists.	
Psychiatric Care Demonstration		Appropriates \$75 million for demonstration project(s) in up to eight states to expand the number of emergency inpatient psychiatric care beds. States could receive federal Medicaid matching payments to demonstrate that covering patients in these hospitals will improve timely access to emergency psychiatric care, reduce the burden on overcrowded emergency rooms, and improve the efficiency and

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		cost-effectiveness of inpatient psychiatric care.
Dual Eligibles		
Dual eligibles	Establishes within the Centers for Medicare and Medicaid Services a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Dedicated funding is provided to allow for testing of models that require benefits not currently covered by Medicare. Successful models can be expanded within both programs.	The bill would clarify the Medicaid demonstration authority for coordinating care for dual eligibles is as long as five years.
Federal Coordinated Health Care Office	Requires CMS to establish a dedicated office or program to improve coordination of benefits and other policies for beneficiaries dually eligible for Medicare and Medicaid.	Would establish a new office in CMS, the Federal Coordinated Health Care Office for Dual Eligible Beneficiaries. The office would be tasked with improving programmatic and regulatory coordination between Medicare and Medicaid, improving access to services, and increasing dual eligible enrollee satisfaction.
Study on Coverage of Dual Eligibles		Would require HHS Secretary to monitor drug coverage and access of Part D beneficiaries in Medicare and Medicaid.
Long Term Care		
Community Living Assistance Services & Support (CLASS)	The Secretary will establish this national voluntary LTC insurance program. CLASS would provide individuals with support to live in the community.	Establishes a voluntary, self-funded public long-term care insurance program. Requires the Secretary to develop an actuarially sound benefit plan that ensures

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	Funded by wage-based premiums. Requires states to designate or create fiscal agents for personal care attendant workers in CLASS.	solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides cash benefit averaging at least \$50 per day.
Incentives for states to provide Home & Community Based Services (HCBS)		Adds a new policy that creates financial incentives for States to shift Medicaid beneficiaries out of nursing homes and into home and community based services (HCBS). The provision provides Federal Medical Assistance Percentage (FMAP) increases to States to rebalance their spending between nursing homes and HCBS.
Community First Choice Option	Sense of Congress that states are permitted to implement a Community First Choice Option. This will allow coverage of community-based attendant services and supports furnished in the home at the individual’s option to those who are eligible for institutional Medicaid coverage. States will be eligible for an enhanced FMAP and they must meet minimum federal standards to ensure quality of supports and services.	Establishes the Community First Choice Option, which would create a state plan option under section 1915 of the Social Security Act to provide community based attendant supports and services to individuals with disabilities who are Medicaid eligible and who require an institutional level of care. States choosing the Community First Choice Option would be eligible for increased FMAP of 6% for reimbursable expenses in the program.
Spousal Impoverishment		Requires States to apply spousal impoverishment rules to beneficiaries who receive HCBS. This provision would apply for a five-year period beginning on January 1, 2014.
Cost Sharing for Certain Dual Eligibles		Eliminates cost sharing for beneficiaries receiving care under a home and community-based waiver program who would otherwise require institutional

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		care.
Quality, Transparency and Program Integrity		
Assuring transparency of information	Requires states, as a condition of receiving federal Medicaid matching funds, to establish and maintain laws to require disclosure of information on hospital charges and quality and to make such information public.	
Health Care Acquired Conditions	Medicaid non-payment for certain health care acquired conditions. Also for CHIP.	Effective 7/1/11 would prohibit payments to states for Medicaid services related to health care acquired conditions.
Fraud, Waste and Abuse	<p>There will be a Special Inspector General for the Health Insurance Exchange. If the Secretary determines there are certain risks related to certain providers the Secretary can apply enhanced screening and oversight and an enrollment moratorium against those types of providers. If the Secretary determines that previous affiliation of a provider poses an undue risk of fraud or abuse the Secretary may apply enhanced safeguards to reduce such a risk.</p> <p>Conduct evaluations and submit an annual report to the Secretary. Places new requirements on providers and suppliers to establish compliance plans to combat waste and abuse.</p> <p>Additionally, it allows for the adjustment in the federal payment to be made within 1 year in the case</p>	<p>Requires that HHS establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP.</p> <p>Requires CMS to include claims and payment data from the following programs in the integrated data repository: 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.</p> <p>Requires states to establish contracts with one or more Medicare Recovery Audit Contractor.</p> <p>Requires States and Medicaid managed care entities to submit data elements from MMIS as determined necessary by the Secretary for program integrity,</p>

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	of overpayments due to fraud, whether or not the recovery was made.	program oversight, and administration.
Health Care Quality	Development of quality measures.	HHS directed to develop Medicaid quality measures. HHS also directed to implement quality measure reporting programs for long-term care hospitals, inpatient rehabilitation facilities, and hospice providers in FY2014.
Termination of Providers	Requires all Medicaid and CHIP programs to terminate the participation of providers if the provider is terminated under Medicare or any other State CHIP/Medicaid program.	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.
Registration of Alternate Payees	Requires all alternate payees that submit claims for providers to register in the State and with HHS. Denies payment for any claims filed by an unregistered alternate payee.	Requires any agents, clearinghouses, or other alternate payees that submit claims on behalf of health care providers to register with the State and HHS in a form and manner specified by HHS.
Comparative Effectiveness Research	Creates a new Comparative Effectiveness Research Center at the Agency for Healthcare Research & Quality (AHRQ).	Establishes a private, nonprofit entity governed by a public-private sector board appointed by the Comptroller General to identify priorities for and provide for the conduct of comparative outcomes research. Sunsets the Federal Coordinating Council for Comparative Effectiveness Research created in the American Recovery and Reinvestment Act of 2010
Disclosure Requirements	Requires new providers/suppliers in Medicaid and CHIP to disclose affiliations during the past 10 years with any provider/supplier that has uncollected debt	Medicare, Medicaid and CHIP providers and suppliers enrolling/re-enrolling would be required to disclose current or previous affiliations with any

Bill Provision Description	House Bill HR 3962: Affordable Health Care for America Act (10/29/09)	Senate Bill H.R. 3590: Manager’s Amendment to the Senate’s Patient Protection & Affordable Care Act 12/24/09)
	or that has been suspended from Medicaid, Medicare or CHIP.	provider/supplier that has uncollected debt, has had their payments suspended, been excluded from participating in a Federal health care program, or billing privileges revoked.
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 days 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 a corresponding cost report was due, whichever is later.
Uniform Standards to Improve the Health Care System and Reduce Costs		Requires the Secretary to consult stakeholders and the National Committee on Vital and Health Statistics and the Health Information Technology Standards and Policy Committees to identify opportunities to create uniform standards for financial and administrative health care transactions, not already named under HIPAA, that would improve the operation of the health system and reduce costs.
CMS Changes to Make Improvements in Health Care Delivery		Requires the Secretary of HHS to develop a plan (and a detailed budget for the resources needed to implement such plan) to modernize the computer and data systems of the Centers for Medicare & Medicaid Services to support improvements in care delivery.

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