DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Center for Medicaid, CHIP and Survey & Certification

CMCS Informational Bulletin

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SUBJECT: Updates on Medicaid/CHIP and the Pre-Existing Condition Insurance Plan

This Informational Bulletin covers five important topics of interest to States:

- Provider Preventable Conditions;
- Coverage and Service Design Opportunities for Individuals living with HIV;
- Same Sex Partners and Medicaid Liens, Transfers of Assets, and Estate Recovery;
- The Pre-Existing Condition Insurance Plan; and
- CMS Medicaid EHR Incentive Program, tribal clinics and FQHCs.

Provider Preventable Conditions – Final Rule

A new provision of the Affordable Care Act ensures that Medicaid payment policies are linked to quality and safety, consistent with actions many States have already taken. Section 2702 of the Affordable Care Act prohibits Federal payments under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for health care-acquired conditions. The statute requires that the Medicare Hospital Acquired Conditions (HACs) be used as a baseline, and also that CMS identify existing State practices and incorporate them as appropriate.

The final rule:

- Identifies Health care-acquired conditions (HCACs) (defined as Medicare Hospital Acquired Conditions (with one exception for DVT/PE following total knee replacement and hip replacement, as related to children and pregnant women) and three National Coverage Determinations (wrong site, wrong surgery, wrong patient) as a baseline for those policies; and
- Authorizes States to identify other provider-preventable conditions (OPPCs) for which, with CMS approval, Medicaid payment will be prohibited.

The final rule is effective on July 1, 2011, although compliance action will not be taken until July 1, 2012 to allow States additional time to develop and adopt their policies. For more information on the final rule, please visit:
http://www.gpo.gov/fdsys/pkg/FR-2011-06-06/pdf/2011-13819.pdf.

Coverage and Service Design Opportunities for Individuals with HIV

On June 6, 2011, CMCS released a State Medicaid Director's letter, in support of President Obama's National HIV/AIDS Strategy (the Strategy), informing States of the opportunities available to provide Medicaid coverage to individuals living with HIV. This guidance informs States of coverage and service design opportunities that may assist States in increasing access to care for individuals living with HIV and provides alternatives that could alleviate the current burden to AIDS Drug Assistance Programs (ADAP).

In addition, this letter provides guidance and a template to States that wish to submit applications for section 1115 demonstrations to cover individuals living with HIV who are not otherwise eligible for Medicaid.

For more information on how these Medicaid programs can help States to extend coverage to individuals living with HIV, please visit https://www.cms.gov/smdl/downloads/11-005.pdf.

Same Sex Partners and Medicaid Liens, Transfers of Assets, and Estate Recovery

On June 10, 2011, CMCS released a State Medicaid Director's letter providing guidance to Medicaid agencies informing them of the existing options and flexibilities regarding the application of Medicaid liens, transfer of assets, and estate recovery. This guidance clarifies that States can extend the protections available under the law in these areas to the same-sex spouse or domestic partner of a Medicaid enrollee.

For more information, please visit: http://www.cms.gov/smdl/downloads/SMD11-006.pdf

Pre-Existing Condition Insurance Plan

New rules for the Pre-Existing Condition Insurance Plan (PCIP) were announced on May 31, 2011. The PCIP was created under the Affordable Care Act to ensure more Americans with pre-existing conditions have access to affordable health insurance, and serves as a bridge to 2014 when insurers will no longer be allowed to deny coverage to people with any pre-existing condition, like cancer, diabetes, and asthma. In 23 States and the District of Columbia, the PCIP program is Federally-administered. The remaining States operate their own PCIP programs using Federal funds provided by the Affordable Care Act.

Premiums for PCIP will drop as much as 40 percent in 18 States, and eligibility standards will be eased in 23 States and the District of Columbia to ensure more Americans with pre-existing conditions have access to affordable health insurance. In addition, starting July 1, 2011, people applying for coverage can simply provide a letter from a doctor, physician assistant, or nurse practitioner dated within the past 12 months stating that they have or, at any time in the past, had a medical condition, disability, or illness. Applicants will no longer have to wait for an insurance company to send them a denial letter. This option became available to children under age 19 in February, and this pathway is being extended to all applicants regardless of age. Applicants will still need to meet other eligibility criteria, including that they are U.S. citizens or residing in the U.S. legally and that they have been without health coverage for six months.

Beginning this fall, the Department of Health and Human Services (HHS) will begin paying agents and brokers for successfully connecting eligible people with the PCIP program. This step will help reach those who are eligible but un-enrolled. Several States have experimented with such payments with good success. This is a part of continuing HHS outreach efforts with States, insurers, providers, and agents and brokers to reach more eligible people and let them know that coverage is available. HHS is also working with insurers to notify people about the PCIP option in their State when their application for health insurance is denied.

To find a chart showing changes to PCIP premiums in the States with Federally-administered PCIP programs, visit www.HealthCare.gov/news/factsheets/pcip05312011a.html.

Consumers can find information on eligibility, plan benefits and rates and how to apply by visiting www.pcip.gov and click on "Find Your State." Then select your State from a map of the United States or from the drop-down menu. The PCIP Call Center is open from 8 a.m. to 11 p.m. Eastern Time at 1-866-717-5826 (TTY 1-866-561-1604).

CMS Medicaid EHR Incentive Program, tribal clinics and FQHCs

After consideration of stakeholder feedback, CMS modified and updated the Frequently Asked Question (FAQ) that originally required tribal clinics to be paid as Federally Qualified Health Centers (FQHCs) in order to be treated as FQHCs for the Medicaid Electronic Health Record (EHR) Incentive Program. We will now allow all tribal clinics to be treated as FQHCs with respect to the Medicaid EHR Incentives. Please note that tribal clinics are not eligible for the Medicare and Medicaid EHR Incentive Program, but the eligible professionals at these locations may be eligible when they meet all other program requirements. This updated FAQ means that eligible professionals in tribal clinics may be subject to the "needy individual patient volume threshold," rather than the "Medicaid patient volume threshold," which will help these eligible professionals to qualify for the incentives.

For more information on the EHR incentives, including information about program eligibility and payments, please visit the CMS EHR Incentive Program website: http://www.cms.gov/EHRIncentivePrograms/. The new FAQ can be found here and is also copied below. If you have any follow-up questions, please contact Michelle.Mills@cms.hhs.gov and Samuel.Schaffzin@cms.hhs.gov.

> Updated FAQ #10417:
> http://questions.cms.hhs.gov/app/answers/detail/a_id/10417/kw/tribal/session/L3NpZC8xbVN1S0F3aw%3D%3D
>
> > Can tribal clinics be treated as Federally Qualified Health Centers (FQHCs) for the Medicaid Electronic Health Record (EHR) Incentive Program?
> >
> > CMS previously issued guidance stating that health care facilities owned and operated by American Indian and Alaska Native tribes and tribal organizations ("tribal clinics") with funding authorized by the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) must be reimbursed as FQHCs in order to be considered FQHCs in the Medicaid EHR Incentive Program. CMS revised this policy and will allow any such tribal clinics to be

considered as FQHCs for the Medicaid EHR Incentive Program, regardless of their reimbursement arrangements. For more information on how FQHCs are defined, please see FAQ #10127.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

I hope you will find this information helpful.