
# Key Milestones in CMS Programs

Below are some of the key legislative milestones that have shaped our programs—Medicare, Medicaid, CLIA, HIPAA and SCHIP

1965 Medicare and Medicaid were enacted as Title XVIII and Title XIX of the Social Security Act, extending health coverage to almost all Americans aged 65 or older (e.g., those receiving retirement benefits from Social Security or the Railroad Retirement Board), and providing health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities. Seniors were the population group most likely to be living in poverty; about half had insurance coverage.

1966 Medicare was implemented and more than 19 million individuals enrolled on July 1.

1967 An Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) comprehensive health services benefit for all Medicaid children under age 21 was established.

1972 Medicare eligibility was extended to individuals under age 65 with long-term disabilities and to individuals with end-stage renal disease (ESRD). Medicare was given the authority to conduct demonstration programs. Medicaid eligibility for elderly, blind and disabled residents of a state could be linked to eligibility for the newly enacted Federal Supplemental Security Income program (SSI).

1973 The HMO Act provided for start-up grants and loans for the development of health maintenance organizations (HMOs); HMOs meeting Federal standards relating to comprehensive benefits and quality were given preferential treatment in the marketplace.

1977 The Health Care Financing Administration (HCFA) was established to administer the Medicare and Medicaid programs.

1980 Coverage of Medicare home health services was broadened. Medicare supplemental insurance, also called "Medigap," was brought under Federal oversight.

1981 Freedom of choice waivers (1915b) and home and community-based care waivers (1915c) were established in Medicaid; states were required to provide additional payments to hospitals treating a disproportionate share of low-income patients (i.e., DSH hospitals).

1982 The Tax Equity and Fiscal Responsibility Act made it easier and more attractive for health maintenance organizations to contract with the Medicare program. In addition, the Act expanded the Agency's quality oversight efforts through Peer Review Organizations (PROs).

1983 An inpatient acute hospital prospective payment system for the Medicare program, based on patients' diagnoses, was adopted to replace cost-based payments.

1985 The Emergency Medical Treatment and Labor Act (EMTALA) required hospitals participating in Medicare that operated active emergency rooms to provide appropriate medical screenings and stabilizing treatments.

1986 Medicaid coverage for pregnant women and infants (up to 1 year of age) to 100 percent of the Federal Poverty Level (FPL) was established as a state option.

1987 The Omnibus Budget Reconciliation Act of 1987 (OBRA87) strengthened the protections for residents of nursing homes.

1988 The Medicare Catastrophic Coverage Act, which included the most significant changes since enactment of the Medicare program, improved hospital and skilled nursing facility benefits, covered mammography, and included an outpatient prescription drug benefit and a cap on patient liability.

Medicaid coverage for pregnant women and infants to 100 percent FPL was mandated; special eligibility rules were established for institutionalized persons whose spouses remained in the community to prevent "spousal impoverishment"; Qualified Medicare Beneficiary (QMBs) program was established to pay Medicare premiums and cost sharing charges for beneficiaries with incomes and resources below established thresholds.

The Clinical Laboratory Improvement Amendments (CLIA) strengthened quality performance requirements for clinical laboratories in order to assure accurate and reliable laboratory tests and procedures.

1989 The Medicare Catastrophic Coverage Act of 1988 was repealed after higher-income elderly protested new premiums. A new Medicare fee schedule for physician and other professional services, a resource-based relative value scale, replaced charge-based payments. Limits were placed on physician balance billing above the new fee schedule. Physicians were prohibited from referring Medicare patients to clinical laboratories in which their physicians, or physicians' family members, have a financial interest.

Medicaid coverage of pregnant women and children under age 6 to 133 percent FPL was mandated; expanded EPSDT requirements were established.

1990 Phased in Medicaid coverage of children ages 6 through 18 under 100 percent FPL was established; Medicaid prescription drug rebate program was established; Specified Low-Income Medicare beneficiary eligibility group was established (SLMBs) for Medicaid programs to pay Medicare premiums for beneficiaries with incomes at least 100 percent but not more than 120 percent of the FPL and limited financial resources.

Additional federal standards for Medicare supplemental insurance were enacted.

1991 Medicaid Disproportionate Share Hospital (DSH) spending controls were established, and provider-specific taxes and donations to states were capped.

1996 Welfare Reform—The Aid to Families with Dependent Children (AFDC) entitlement program was replaced by the Temporary Assistance for Needy Families (TANF) block grant; the welfare link to Medicaid was severed; a new mandatory low income group not linked to welfare was added; and enrollment/termination of Medicaid was no longer automatic with receipt/loss of welfare cash assistance.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) had several provisions. First, it amended the Public Health Service Act, the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986 to provide for new

Federal rules improving continuity or "portability" of coverage in the large group, small group and individual health insurance markets. CMS implements HIPAA provisions affecting the small group and individual markets. Second, it created the Medicare Integrity Program which dedicated funding to program integrity activities and allowed CMS to competitively contract for program integrity work. Third, it created national administrative simplification standards for electronic health care transactions. Fourth, it required HHS to issue privacy regulations if Congress failed to enact substantive privacy legislation.

1997 Balanced Budget Act of 1997 (BBA)—State Children's Health Insurance Program (SCHIP) was created; limits on Medicaid payments to disproportionate share hospitals were revised; new Medicaid managed care options and requirements for states were established. Medicare changes include:

- Establishing an array of new Medicare managed care and other private health plan choices for beneficiaries, offered through a coordinated open enrollment process;
- Expanding education and information to help beneficiaries make informed choices about their health care;
- Requiring CMS to develop and implement five new prospective payment systems for Medicare services (for inpatient rehabilitation hospital or unit services, skilled nursing facility services, home health services, hospital outpatient department services, and outpatient rehabilitation services);
- Slowing the rate of growth in Medicare spending and extending the life of the trust fund for 10 years;
- Providing a broad range of beneficiary protections;
- Expanding preventive benefits; and
- Testing other innovative approaches to payment and service delivery through research and demonstrations.

1998 The internet site www.medicare.gov was launched to provide updated information about Medicare.

1999 The toll-free number, 1-800-MEDICARE (1-800-633-4227), was available nationwide. The first annual Medicare & You handbook was mailed to all Medicare beneficiary households.

1999 The Ticket to Work and Work Incentives Improvements Act of 1999 (TWWIIA) expanded the availability of Medicare and Medicaid for certain disabled beneficiaries who return to work. Established optional

Medicaid eligibility groups and allowed states to offer a buy-in to Medicaid for working-age individuals with disabilities.

The Balanced Budget Refinement Act of 1999 (BBRA) increased payments for some Medicare providers and increased the amount of Medicaid DSH funds available to hospitals in certain States and the District of Columbia. Other related legislation improved Medicaid coverage of certain women's health services.

2000 The Benefits Improvement and Protection Act (BIPA) further increased Medicare payments to providers and managed health care organizations, reduced certain Medicare beneficiary co-payments, and improved Medicare's coverage of preventive services.

BIPA created a new Medicaid prospective payment system for Federally Qualified Health Centers and Rural Health Clinics and it modified the amount of Medicaid DSH funds available to hospitals, while it provided a one-year extension on the sunset of transitional medical assistance provided to families eligible for welfare.

2003 The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) made the most significant changes to Medicare since the program began. MMA creates a prescription drug discount card until 2006, allows for competition among health plans to foster innovation and flexibility in coverage, covers new preventive benefits, and makes numerous other changes. In 2006, the new voluntary Part D outpatient prescription drug benefit will be available to beneficiaries from private drug plans as well as Medicare Advantage plans. Employers who provide retiree drug coverage comparable to Medicare’s will be eligible for a federal subsidy.

Medicare will consider beneficiary income for the first time: beneficiaries with incomes less than 150% of the federal poverty limit will be eligible for subsidies for the new Part D prescription drug program; beneficiaries with higher incomes will pay a greater share of the Part B premium starting in 2007.