Order Code RL30718

Medicaid, SCHIP, and Other Health Provisions in H.R. 5661: Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

Updated January 4, 2001

(name redacted)
Elicia Herz
Specialists in Social Legislation

Evelyne Baumrucker
Analyst in Social Legislation
Domestic Social Policy Division

Medicaid, SCHIP and Other Health Provisions in H.R. 5661: Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

Summary

While largely comprised of Medicare provisions, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (H.R. 5661), a compromise agreement between House and Senate committees and the leadership, includes a number of important changes to Medicaid and the State Children's Health Insurance Program (SCHIP). It also includes major provisions amending other programs. The provisions of H.R. 5661 are incorporated, by reference into H.R. 4577, the Consolidated Appropriations Act 2001. H.R. 4577 was passed by the House and Senate on December 15, 2000 and was signed into law on December 21 (P.L. 106-554).

Among the major Medicaid modifications are several provisions affecting disproportionate share hospital (DSH) payments provided to hospitals that treat a disproportionate share of uninsured and Medicaid enrollees. The agreement increases the disproportionate share hospital allotments for states. It also extends a special DSH payment rule for public hospitals in California to qualifying facilities in all states, and provides additional funds to certain public hospitals not receiving DSH payments. In addition to these DSH provisions, the bill replaces cost-based reimbursement with a prospective payment system for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). The agreement also modifies proposed rules governing upper payment limits on inpatient and outpatient services provided by certain types of facilities, and requires that the final regulations be issued by the end of 2000.

One major SCHIP provision extends the availability of unused funds from FY1998 and FY1999 and redistributes these unused funds among both those states that spend and those that do not spend their full original allotments for these years. Current law requires that these unused funds be distributed only to those states that spend their allotments.

Among other major provisions, the agreement requires that outreach efforts be implemented to identify individuals who may be eligible for Medicaid payment of Medicare cost-sharing and to notify these persons of the availability of such assistance. It increases the authorization of annual appropriations for the Maternal and Child Health Services Block Grant under Title V. In addition, the bill extends for 1 year, to FY2003, the authority for grants to be made for both the Special Diabetes Program for Type I Diabetes and the Special Diabetes Programs for Indians and increases total funding for FY2001 through FY2003. Finally, the agreement provides an additional FY2001 direct appropriation for the Ricky Ray Hemophilia Relief Fund.

For information on the Medicare provisions, see CRS Report RL30707, *Medicare Provisions in H.R. 5661: Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000* (available upon request).

Contents

Medicaid, SCHIP and Other Health Provisions In H.R. 5661: Medicare, Medicaid, And SCHIP Benefits Improvement and Protection Act of 2000

Introduction

Medicaid is a joint federal-state entitlement program that pays for medical assistance primarily for low-income persons who are aged, blind, disabled, members of families with dependent children, and certain other pregnant women and children. Within broad federal guidelines, each state designs and administers its own program. Total program outlays in FY1999 were $180.9 billion. Federal outlays were $102.5 billion and state outlays were approximately $78.4 billion. The federal government shares in a state's Medicaid costs by means of a statutory formula designed to provide a higher federal matching rate to states with lower per capita incomes. In FY1999, federal matching rates ranged from 50% to 76% of a state's expenditures for Medicaid items and services. Overall, the federal government finances about 57% of all Medicaid costs.

The 105th Congress made important changes to the Medicaid program through the Balanced Budget Act of 1997 (BBA 97; P.L. 105-33).[1] That legislation included provisions to achieve net Medicaid savings of about $13 billion between FY1998 and FY2002, largely from reductions in supplemental payments to hospitals that serve a disproportionate share of Medicaid and low-income patients. BBA 97 also significantly increased the flexibility that states have to manage their Medicaid programs. In particular, it gave states the option of requiring most beneficiaries to enroll in managed care plans without seeking a federal waiver, and replaced federal reimbursement requirements imposed by the Boren amendments with a public notice process for setting payment rates for institutional services. The Act also required that the previously existing cost-based reimbursement system for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) be phased out over a 6-year period. Spending items in the Act included Medicaid coverage for additional children, and increased assistance for low-income individuals to pay Medicare Part B premiums.

The 106th Congress made additional changes to Medicaid in 1999. On November 29 of that year, the President signed the Consolidated Appropriations Act for FY2000 (P.L. 106-113). Included in that bill by reference was the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA 99), a bill largely comprised of Medicare provisions, but which also included a number of changes to Medicaid and the State Children's Health Insurance Program (SCHIP; described below).

In addition to technical amendments to BBA 97, BBRA 99 included provisions allowing for increased Medicaid disproportionate share payments to hospitals for certain states and the District of Columbia, and for extended access to a special $500 million fund to pay for Medicaid eligibility determinations resulting from welfare reform for a longer period of time than allowed under previous law. BBRA 99 also modified the schedule for phasing out cost-based reimbursement for FQHCs and RHCs that had been included in the BBA 97.

SCHIP, enacted in BBA 97, is targeted at uninsured children who live in families with income below twice the federal poverty level and who would not otherwise be eligible for Medicaid. The program began in October 1997 with total federal funding of nearly $40 billion for the period FY1998 through FY2007. States may use SCHIP funds to provide coverage through health insurance that meets specific standards for benefits and cost-sharing (known as separate state programs), or through expansions of eligibility under Medicaid, or through a combination of both options. SCHIP entitles states with approved SCHIP plans to pre-determined, annual federal allotments based on a distribution formula set in law. Each state has flexibility to define the group of targeted, low-income children who are eligible for its SCHIP. Eligibility criteria may include, for example, geography, age, income and resources, residency, disability status, access to other health insurance, and duration of eligibility for SCHIP. All 50 states, the District of Columbia and five territories had approved SCHIP plans. Among these, 22 are Medicaid expansions, 16 are new

---

[1] For a detailed description of the changes to Medicaid under BBA 97, see CRS Report 98-132, *Medicaid: 105th Congress*, by Melvina Ford and Richard Price.

or expanded separate state programs, and 17 will use both a Medicaid expansion and a separate state program.

Changes to SCHIP in BBRA 99 included provisions to improve state-level data collection; to evaluate the SCHIP (and Medicaid) programs with respect to outreach and enrollment practices; and to create a clearinghouse to coordinate and consolidate federal databases and reports on children's health. In addition, BBRA 99 included a number of changes to the formula used to distribute federal SCHIP funds among the states, increased the amounts available for U.S. territories, and minor technical changes.[2]

BBA 97 established the Program of All-Inclusive Care for the Elderly (PACE) as a permanent provider under Medicare and as a special optional benefit under Medicaid. Individuals eligible for PACE are those over age 55 who require a nursing facility level of care covered in a state Medicaid program, and who meet other eligibility requirements imposed under the program agreement. PACE providers include public entities or private, not-for-profit organizations providing health and long-term services on a capitated basis to eligible beneficiaries. They must provide all items and services covered under Medicare and Medicaid. There are no limits on amount, duration or scope of services and there are no cost-sharing requirements for PACE enrollees.

The Maternal and Child Health (MCH) Services Block Grant Program (Title V of the Social Security Act) has three components – formula block grants to 56 states and territories for primary care services to mothers and children, Special Projects of Regional and National Significance (SPRANS), and Community Integrated Service Systems (CISS) grants. The formula grant program uses appropriated funds for a wide variety of activities, including but not limited to, capacity and systems building, public information and education, outreach and program linkage, technical assistance, and direct health care services where no services are available. SPRANS activities include maternal and child health research, training, genetic services, hemophilia diagnostic and treatment centers, and maternal and child health improvement projects. CISS grants seek to reduce infant mortality and improve the health of mothers and children through development and expansion of integrated services at the community level. The block grant requires that states match $3 in funds or resources for every $4 in federal funds received, and that a minimum of 30% of block grant funds be used to support programs for children with special health care needs. For FY1994 forward, Title V authorizes to be appropriated $705 million annually.

BBA 97 created two diabetes grant programs under the Public Health Service Act. One grant program supports research into the prevention and cure of type I diabetes, or insulin-dependent diabetes. The second grant program supports prevention and treatment of diabetes in Indians. For FY1998 through FY2002, each

---

[2] For a detailed description of changes to Medicaid and SCHIP under BBRA 99, see CRS Report RL30400, *Medicaid and the State Children's Health Insurance Program (SCHIP): Provisions in the Consolidated Appropriations Act for FY2000*, by (name redacted) and Elicia Herz.

program receives $30 million annually through funds transferred from the SCHIP appropriation. BBA 97 also required evaluations of these grant programs with an interim and final report due to Congress on January 1, 2000 and January 1, 2002, respectively.

The Ricky Ray Hemophilia Relief Fund Act of 1998 (P.L. 105-369) established a 5-year trust fund to make compassionate payments of $100,000 to certain individuals with blood clotting disorders, such as hemophilia, who contracted HIV (human immunodeficiency virus) through the use of anti-hemophiliac factor between July 1, 1982 and December 31, 1987. The Act authorized appropriations to the trust fund totaling $750 million. The fund received an initial appropriation of $75 million in FY2000. H.R. 5661 provides a direct appropriation of $475 million for FY2001, in addition to $105 million appropriated in the FY2001 Miscellaneous Appropriations Act (H.R. 5666). The trust fund has, therefore, received a total of $655 million, which is estimated to be sufficient to pay all the eligible claims.

Recent Legislative Activity

In late September and early October of 2000, the committees with jurisdiction over the programs described above – the House Committee on Commerce and the Senate Committee on Finance – introduced legislation that would affect these programs. On September 27, 2000, the House Commerce Committee ordered reported a bill, the Beneficiary Improvement and Protection Act of 2000 (H.R. 5291). On October 5, 2000 William V. Roth Jr., the Senate Finance Committee Chairman, introduced the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 2000 (S. 3165).

On December 15, 2000, the Consolidated Appropriations Act 2001 (H.R. 4577) was passed by the House and Senate; it was signed into law on December 21 (P.L. 106-554). It included, by reference, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (H.R. 5661), a compromise agreement between House and Senate committees and the leadership, which contained a number of important changes to Medicaid and the State Children's Health Insurance Program (SCHIP). It also included major provisions amending other health programs.

With respect to Medicaid, a number of changes are made to disproportionate share hospital (DSH) funding. First, the agreement sets each state's FY2001 DSH allotment equal to its allotment for FY2000, increased by the percentage change in the consumer price index for FY2000, subject to a ceiling of 12% of that state's total medical assistance payments. A parallel change is made for FY2002 allotments. The bill also applies the 175% hospital-specific DSH limit to certain public hospitals in all states (not just those in California as under current law) for a 2-year period. Additional funds are provided for certain state public hospitals not receiving DSH payments and having a low-income utilization rate in excess of 65%.

The are two other major Medicaid provisions in the agreement. The bill replaces the current cost-based reimbursement arrangements for Federally Qualified Health Centers and Rural Health Clinics with a new Medicaid prospective payment system. The agreement also modifies proposed HHS rules governing upper payment

limits on inpatient and outpatient services provided by certain types of facilities, and requires that final regulations be issued by the end of 2000. The proposed rules and modifications made by the agreement close a loophole under which some states are maximizing federal Medicaid payments arguably beyond the intent of federal statute. Finally, the bill extends by 1 year the availability of transitional medical assistance (TMA) for certain families no longer eligible for Medicaid on the basis of meeting former Aid to Families with Dependent Children (AFDC) rules and adds several entities to those qualified to make Medicaid presumptive eligibility determinations for children. Under Medicaid presumptive eligibility rules, states are allowed to temporarily enroll children whose family income appears to be below Medicaid income standards, until a final formal determination of eligibility is made.

With respect to SCHIP, the agreement extends the availability of unused FY1998 and FY1999 SCHIP allotments.[3] Following specific formulas, these unspent funds are redistributed to both those states that have and those that have not fully exhausted their original allotments within required time frames. Current law redistributes unused funds only to those states that spend their allotments. The bill also authorizes the payment of costs of SCHIP Medicaid expansions and costs of benefits provided during periods of presumptive eligibility from the SCHIP appropriation rather than the Medicaid appropriation and clarifies states' authority to conduct presumptive eligibility determinations, as defined in Medicaid law, under separate (non-Medicaid) SCHIP programs.

With respect to other programs, the agreement requires that outreach efforts be implemented to identify individuals who may be eligible for Medicaid payment of Medicare cost-sharing and that those individuals are notified of the availability of such assistance. The agreement increases the authorization of annual appropriations for the MCH Services Block Grant from $705 million to $850 million for FY2001 and thereafter. In addition, the bill extends for 1 year, to FY2003, the authority for grants to be made for both the Special Diabetes Programs for Type I Diabetes and the Special Diabetes Programs for Indians. It also increases total funding to $100 million each for FY2001 through FY2003. For FY2001 and FY2002, a portion of these funds are transferred from the SCHIP appropriation. Finally, the agreement provides for a direct appropriation of $475 million for FY2001, in addition to funds appropriated in the FY2001 Labor-HHS-Education appropriations bill, for the Ricky Ray Hemophilia Relief Fund.

The Congressional Budget Office (CBO) has released preliminary cost estimates for the Benefits Improvement and Protection Act of 2000. CBO estimates that the Medicaid , SCHIP and other program provisions would *decrease* federal outlays by $16.6 billion over the 5-year period 2001 to 2005 and $69.2 billion over 10 years (2001-2010). Among all of these provisions, the most significant in terms of its impact on the federal budget is the revision to Medicaid's upper payment limit

---

[3] For a detailed description of changes to the allotment redistribution rules, see CRS Report RS20628, *State Children's Health Insurance Program (SCHIP): Proposed Funding Changes in the 106th Congress*, by (name redacted) (available upon request).

(UPL). The UPL changes in the bill would result in savings of $21.5 billion over 5 years and $76.7 billion over 10 years.[4]

The following side-by-side comparison provides a brief description of current law and the changes to these programs under the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. These provisions start at Title VII of the bill, the previous six titles being devoted to Medicare.

See CRS Report RL30703, *Medicaid and SCHIP Provisions in H.R. 5291 and S. 3165 (the 2000 Medicare "Refinement Bills"*) for a side-by-side comparison of the provisions in recent related bills. For detailed information on the Medicare provisions contained in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, see CRS Report RL30707, *Medicare Provisions in H.R. 5661: Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000* (available upon request).

[4] For a detailed description of changes to the Medicaid upper payment limit rules, see CRS Report RS20726, *Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Changes Made in H.R. 5661*, by (name redacted) (available upon request.)

Medicaid, SCHIP, and Other Provisions in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

Title VII. Medicaid

Disproportionate Share Hospital Payments

	Current Law	Agreement
Section 701. (a) Modifications to DSH Allotments	The federal share of Medicaid disproportionate share hospital (DSH) payments, i.e., payments for hospitals that treat a disproportionate share of uninsured and Medicaid enrollees, is capped at specified amounts for each state for FY1998 through FY2002. A state's allotment for years after 2002 will be equal to its allotment for the previous year increased by the percentage change in the consumer price index for the previous year. In addition, each state's DSH payments for FY2003 and beyond are limited to no more than 12% of spending for medical assistance for that year.	For FY2001, sets each state's DSH allotment equal to its allotment for FY2000 increased by the percentage change in the consumer price index for that year, subject to a ceiling that would be equal to 12% of that state's total medical assistance payments in that year. For FY2002, sets each state's DSH allotment equal to its allotment for 2001 as determined above, increased by the percentage change in the consumer price index for FY2001, subject to a ceiling equal to 12% of that state's total medical assistance payments in that year. For extremely low DSH states, i.e., states whose FY1999 federal and state DSH expenditures (as reported to HCFA on August 31, 2000) are greater than zero but less than one percent of the state's total medical assistance expenditures during that fiscal year, the DSH allotments for FY2001 would be equal to 1% of the state's total amount of expenditures under their plan for such assistance during that fiscal year. For subsequent fiscal years, the allotments for extremely low DSH states would be equal to their allotment for the previous year, increased by the percentage change in the consumer price index for the previous year, subject to a ceiling of 12% of that state's total medical assistance payments in that year. Effective on the date that the final regulation for Medicaid upper payment limits is published in the *Federal Register*.

	Current Law	Agreement
Section 701. (b) Assuring Identification of Medicaid Managed Care Patients	States are required to provide disproportionate share payments to those hospitals whose Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments in the state, and those with a low-income utilization rate above 25%. The Medicaid inpatient utilization rate includes the number of inpatient days attributable to Medicaid beneficiaries. The low-income utilization rate includes the total revenues paid on behalf of Medicaid beneficiaries.	Effective for Medicaid managed care contracts in effect on January 1, 2001, the provision would clarify that Medicaid enrollees of managed care organizations (MCO) and primary care case management organizations are to be included for the purposes of calculating the Medicaid inpatient utilization rate and the low-income utilization rate. Also effective January 1, 2001, states must include in their MCO contracts information that allows the state to determine which hospital services are provided to Medicaid beneficiaries through managed care, and would also require states to include a sponsorship code for the managed care entity on the Medicaid beneficiary's identification card.

	Current Law	Agreement
Section 701. (c) Application of Medicaid DSH Transition Rule to Public Hospitals in all states	In all states but California, DSH payments to each inpatient general hospital are limited to no more than the costs of providing inpatient and outpatient services to Medicaid and uninsured patients at that hospital, less payments received from or on behalf of Medicaid and uninsured patients. These costs are considered to be unreimbursed costs. This cap – the hospital-specific or facility-specific DSH cap – was phased-in for certain public hospitals. During state fiscal years beginning before January 1995, those hospitals could receive DSH payments equal to 200% of unreimbursed costs. After January 1995, all hospitals except those in California, were limited to no more than 100% of unreimbursed costs. Hospitals qualifying for the 200% cap during the transition period were those with a "high disproportionate share". Hospitals with a "high disproportionate share" were defined as those owned or operated by a state (or by an instrumentality or unit of government within a state) with a very high Medicaid inpatient utilization rate or with more Medicaid inpatient days than any other hospital in the state. BBA 97 increased the hospital-specific limit for public hospitals in California to 175% of unreimbursed costs. The 175% hospital specific cap for California was effective for a transition period that ended in 1999. BBRA 99 later permanently extended this hospital-specific limit for qualifying public hospitals in California. Budget neutral Section 1115 waivers allow states to forego certain Medicaid rules to implement demonstrations.	Revises BBA97, as modified by BBRA 99, so that the 175% hospital-specific DSH limit allowing DSH payments in amounts up to 175% of each hospitals cost of unreimbursed care, formerly applied only to certain public hospitals in California, applies to qualifying public hospitals in all states. The higher limit would apply for two state fiscal years beginning on the first day of the state fiscal year that begins after September 30, 2002 and ends on the last day of the succeeding state fiscal year. Hospitals that would qualify for the higher hospital-specific limit would be those owned or operated by a state and meet the minimum federal requirements for disproportionate share hospitals. The permanent ceiling for California would not be affected. For states operating under waivers approved under Section 1115 of the Social Security Act, increased payments for public hospitals under this provision would be included in the baseline expenditure limit for the purposes of determining budget neutrality.
Section 701. (d) Assistance for Certain Public Hospitals	No provision.	Provides additional funds for certain public hospitals that are: owned or operated by a state (or by an instrumentality or unit of government within a state); are not receiving DSH payments as of October 1, 2000; and have a low-income utilization rate in excess of 65% as of the same date. Funds provided under this section to states with eligible hospitals are in addition to DSH allotments. The total assistance under this section for all states cannot exceed the following amounts: $15 million for FY2002; $176 million for 2003; $269 million for 2004; $330 million for 2005; and $375 million for FY2006 and each year thereafter.

	Current Law	Agreement
Section 701. (e) DSH Payment Hospital Accountability Standards	BBA 97 required each state to submit to the Secretary an annual report describing the disproportionate share payments made to each disproportionate share hospital.	Requires the Secretary to implement accountability standards to ensure that DSH payments are used to reimburse states and hospitals that are eligible for such payments and are otherwise in accordance with Medicaid statutory requirements.

New Prospective Payment System for FQHCs and RHCs

	Current Law	Agreement
Section 702. New prospective payment system for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)	States are required to pay FQHCs and RHCs amounts that are at least a percentage of the facilities' reasonable costs for providing services – 100% of costs for services during FY1998 and FY1999; 95% for FY2000, FY2001 and FY2002; 90% for FY2003; 85% for FY2004. Cost-based reimbursement expires in 2005. In the case of a contract between an FQHC or RHC and a managed care organization (MCO), the MCO must pay the FQHC or RHC at least as much as it would pay any other provider for similar services. States are required to make supplemental payments to the FQHCs and RHCs, equal to the difference between the contracted amounts and the cost-based amounts.	Creates a new Medicaid prospective payment system for FQHCs and RHCs. Beginning in January of FY2001, existing FQHCs and RHCs would be paid per visit payments equal to 100% of the average costs incurred during 1999 and 2000 adjusted for any increase or decrease in the scope of services furnished. For entities first qualifying as FQHCs or RHCs after 2000, the per visit payments would begin in the first year that the center or clinic attains qualification and would be based on 100% of the costs incurred during that year based on the rates established for similar centers or clinics with similar caseloads in the same or adjacent geographic area. In the absence of such similar centers or clinics, the methodology would be based on that used for developing rates for established FQHCs or RHCs or such methodology or reasonable specifications as established by the Secretary. For each fiscal year thereafter, per visit payments for all FQHCs and RHCs would be equal to amounts for the preceding fiscal year increased by the percentage increase in the Medicare Economic Index applicable to primary care services, and adjusted for any increase or decrease in the scope of services furnished during that fiscal year. In managed care contracts, States must make supplemental payments to the center or clinic equal to the difference between contracted amounts and the cost-based amounts. Alternative payment methods would be permitted only when payments are at least equal to amounts otherwise provided. Directs the Comptroller General to provide for a study on how to rebase or refine cost payment methods for the services of FQHCs and RHCs. The report would be due to Congress no later than 4 years after the date of enactment.

Requests for Extension of Medicaid Waivers

	Current Law	Agreement
Section 703. Streamlined approval of continued state-wide Section 1115 Medicaid waivers	Under Section 1115 of the Social Security Act, states may obtain waivers of compliance with a broad range of Medicaid requirements to conduct experimental, pilot, or demonstration projects. Waivers are approved for a period of 5 years. States wishing to obtain approval for periods beyond 5 years may submit, during the 6-month period ending 1 year before the date the waiver would otherwise expire, a written request for an extension of up to 3 years.	Defines the process for submitting requests for and receiving extensions of Medicaid demonstration waivers authorized under Section 1115 of the Social Security Act that have already received initial 3-year extensions. It would require each state requesting such an extension to submit an application at least 120 days prior to the expiration date of the existing waiver. No later than 45 days after the Secretary receives such application, the Secretary would be required to notify the state if she intends to review the existing terms and conditions of the project and would inform the state of proposed changes in the terms and conditions of the waiver. If the Secretary fails to provide such notification, the request would be deemed approved. During the 30-day period beginning after the Secretary provides the proposed terms and conditions to the state, those terms and conditions would be negotiated. No later than 120 days after the date that the request for extension was submitted (or such later date as agreed to by the chief executive officer of the state) the Secretary would be required to approve the application subject to the agreed upon terms and conditions or, in the absence of an agreement, such terms and conditions that are determined by the Secretary to be reasonably consistent with the overall objective of the waiver, or disapprove the application. If the waiver is not approved or disapproved during this period, the request would be deemed approved in the terms and conditions as have been agreed to (if any) by the Secretary and the state. Approvals would be for periods not to exceed 3 years and would be subject to the final reporting and evaluation requirements in current law.

Medicaid County-Organized Health Systems

	Current Law	Agreement
Section 704. Medicaid County-Organized Health Systems	Health insuring organizations (HIOs) are county-sponsored health maintenance organizations (HMOs). Up to three HIOs designated by the state of California are exempt from certain federal statutory requirements for Medicaid HMO contracts. The exemption only applies if the HIOs enroll no more than 10% of all Medicaid beneficiaries in California (not counting qualified Medicare beneficiaries).	Allows the current exemption for three California Health Insuring Organizations (HIOs) from certain Medicaid HMO contracting requirements to apply as long as no more than 14% of all Medicaid beneficiaries in California are enrolled in those HIOs. Effective as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985.

Medicaid Upper Payment Limits

	Current Law	Agreement
Section 705. Deadline for Issuance of Final Regulation Relating to Medicaid Upper Payment Limits	Medicaid statute requires states to set payment rates for services that are consistent with efficiency and economy. In accordance with these requirements, the Secretary has established, through regulation, upper payment limits (UPLs) for inpatient and outpatient services provided by certain types of facilities. Payments may not exceed estimates of what would have been paid for those services under Medicare payment principles. Recently, the Secretary determined that current regulations create a financial incentive for states to make higher than usual payments to non-state government facilities (e.g., county and city providers) allowing them to claim higher federal matching dollars. Those matching funds may be transferred from these facilities back to the state and used to cover the state share of Medicaid costs and/or for other purposes. Proposed rules to modify Medicaid UPLs establish a separate UPL for inpatient services provided by non-state government facilities. Aggregate payments for inpatient services provided by non-state public hospitals may not exceed 150% of estimated payments based on Medicare payment principles. Parallel rules are proposed for outpatient hospital and clinic services. The proposed rules also specify two transition periods for states that are currently noncompliant. These rules vary by when enhanced payment arrangements were in effect (before versus on or after October 1, 1999), the starting point for the phase-out of existing payment arrangements, the percentage reduction in payments each year, and the overall length of time permitted for full phase-out. State fiscal year 2000 will serve as the base period for determining the amount of excess payments above proposed UPLs that must be phased out.	Requires the Secretary to issue final regulations governing upper payment limits (UPLs) for inpatient and outpatient services provided by certain types of facilities no later than December 31, 2000. Requires that the final regulation establish a separate UPL for non-state-owned or operated government facilities based on a proposed rule announced in October, 2000. Requires the final regulation to stipulate a third set of rules governing the transition period for certain states. This additional set of rules would apply to states with payment arrangements approved or in effect on or before October 1, 1992, or under which claims for federal matching were paid on or before that date, and for which such payments exceed the UPLs established under the final regulation. For these states, a 6-year transition period would apply, beginning with the period that begins on the first state fiscal year that starts after September 30, 2002 and ends on September 30, 2008. For each year during the transition period, applicable states must reduce excess payments by 15%. Full compliance with final regulations is required by October 1, 2008.

Alaska FMAP

	Current Law	Agreement
Section 706. Alaska FMAP	The federal share of the cost of Medicaid services is equal to the federal medical assistance percentage (FMAP) of those costs. It is determined annually according to a statutory formula designed to pay a higher federal matching assistance percentage to states with lower per capita incomes relative to the national average. BBA 97 included a provision that set the FMAP for Alaska at 59.8% for FY1998 through FY2000.	Changes the formula for calculating the state percentage and thus the federal matching percentage for Alaska for FY2001 through FY2005. The state percentage for Alaska would be calculated by using an adjusted per capita income calculation instead of the state-wide average per capita income generally used. The adjusted per capita income for Alaska would be calculated as the three year average per capita income for the state divided by 1.05.

Welfare-to-Work Transition

	Current Law	Agreement
Section 707. 1-Year Extension of Welfare-to-Work Transition.	In 1996, Temporary Assistance for Needy Families (TANF) replaced Aid to Families with Dependent Children (AFDC) as the major cash assistance program for low-income families. TANF eligibility does not confer automatic Medicaid eligibility. Medicaid entitlement was retained for individuals who meet the requirements of the former AFDC program in effect on July 16, 1996 (and subsequently modified, if applicable). Transitional medical assistance (TMA) is provided for individuals who would otherwise lose Medicaid due to certain changes in employment or income. Specifically when eligibility under old AFDC rules is lost due to hours of or income from employment, or loss of a time-limited earned income disregard, (and the person qualified for Medicaid on the basis of old AFDC rules in at least 3 of the preceding 6 months), TMA is available for the subsequent 6 to 12 months. TMA will sunset at the end of FY2001.	Extends by 1 year (to September 30, 2002) the availability of TMA for families no longer eligible for Medicaid on the basis of meeting former AFDC rules.

Determination of Medicaid Presumptive Eligibility for Low-Income Children

	Current Law	Agreement
Section 708. Additional Entities Qualified to Determine Medicaid Presumptive Eligibility for Low-Income Children.	Under Medicaid presumptive eligibility rules, states are allowed to temporarily enroll children whose family income appears to be below Medicaid income standards, until a final formal determination of eligibility is made. For children, entities qualified to make presumptive eligibility determinations include Medicaid providers, and agencies that determine eligibility for Head Start, subsidized child care, or the Special Supplemental Food Program for Women, Infants and Children (WIC).	Adds several entities to the list of those qualified to make Medicaid presumptive eligibility determinations for children. These include agencies that determine eligibility for Medicaid or the State Children's Health Insurance Program (SCHIP); certain elementary and secondary schools; state or tribal child support enforcement agencies; certain organizations providing emergency food and shelter to the homeless; entities involved in enrollment under Medicaid, TANF, SCHIP, or that determine eligibility for federally funded housing assistance; or any other entity deemed by a state, as approved by the Secretary of HHS. Effective upon enactment.

Development of Uniform QMB/SLMB Application Form

	Current Law	Agreement
Section 709. Development of Uniform QMB/SLMB Application Form	No provision.	Requires the Secretary of HHS to develop a simplified, national application form to be used, at state option, by Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) applying for medical assistance with Medicare cost-sharing. Effective 1 year after the date of enactment.

Technical Corrections

	Current Law	Agreement
Section 710. Technical Corrections	Medicaid statute prohibits the distribution of federal matching funds for medical assistance provided to individuals whose family income exceeds 133⅓% of the amount that would be paid to a family of the same size under old AFDC rules (as modified). Certain costs to the family are subtracted to determine the applicable countable income. Specified eligibility groups are exempt from this upper income limit rule.	Makes technical amendments that exempt from the upper income limit rule those individuals made eligible for Medicaid, at state option, under the Foster Care Independence Act of 1999 and under the Breast and Cervical Cancer Prevention and Treatment Act of 2000.

Title VIII. State Children's Health Insurance Program

Continued Availability and Redistribution of Unused SCHIP Funds

	Current Law	Agreement
Section 801. Special Rule for Redistribution and Availability of Unused FY1998 and FY1999 SCHIP Allotments	Funds for the SCHIP Program are authorized and appropriated for FY1998 through FY2007. From each year's appropriation, a state is allotted an amount as determined by a formula set in law. Federal funds not drawn down from a state's allotment by the end of each fiscal year continue to be available to that state for 2 additional fiscal years. Allotments not spent at the end of 3 years will be redistributed by the Secretary of Health and Human Services (HHS) to states that have fully spent their original allotments for that year. Redistributed funds not spent by the end of the fiscal year in which they are reallocated officially expire. All administrative expenses including outreach activities are subject to an overall limit of 10% of total program spending per fiscal year.	Establishes a new method for distributing unspent FY1998 and FY1999 allotments. States that use all their SCHIP allotments (for each of those years) would receive an amount equal to estimated spending in excess of their original exhausted allotment. Each territory that spends its original allotment would receive an amount that bears the same ratio to 1.05% of the total amount available for redistribution as the ratio of its original allotment to the total allotment for all territories. States that do *not* use all their SCHIP allotment would receive an amount equal to the total amount of unspent funds, less amounts distributed to states that fully exhausted their original allotments, multiplied by the ratio of a state's unspent original allotment to the total amount of unspent funds. States may use up to 10% of the retained FY1998 funds for outreach activities. To calculate the amounts available for redistribution in each formula described above, the Secretary would use amounts reported by states not later than December 15, 2000 for the FY1998 redistribution and November 30, 2001 for the FY1999 redistribution as reported on HCFA Form 64 or HCFA Form 21, and as approved by the Secretary. Redistributed funds would be available through the end of FY2002.

Authority to Pay for Medicaid Expansion SCHIP Costs From Title XXI Appropriation

	Current Law	Agreement
Section 802. Authority to Pay for Medicaid Expansion SCHIP costs from Title XXI Appropriation	States' allotments under SCHIP pay only the federal share of costs associated with separate (non-Medicaid) SCHIP programs. The federal share of costs associated with SCHIP Medicaid expansions are paid for under Medicaid. State SCHIP allotments are reduced by the amounts paid under Medicaid for SCHIP Medicaid expansion costs. Presumptive eligibility allows pregnant women and children in families with income that appears to be below a state's Medicaid income standards to enroll temporarily in Medicaid, until a final formal determination of eligibility is made. There is no express provision for presumptive eligibility under SCHIP. However, the Secretary of HHS permits states to develop equivalent procedures for separate (non-Medicaid) SCHIP programs through other Title XXI authority.	Authorizes the payment of the costs of SCHIP Medicaid expansions and the costs of benefits provided during periods of presumptive eligibility from the SCHIP appropriation rather than from the Medicaid appropriation, and as a conforming amendment, would eliminate the requirement that state SCHIP allotments be reduced by these (former) Medicaid payments. In addition, codifies proposed rules regarding the order of payments for benefits and administrative costs from state-specific SCHIP allotments. For fiscal years 1998 through 2000 only, authorizes the transfer of unexpended SCHIP appropriations to the Medicaid appropriation account for the purpose of reimbursing payments associated with SCHIP Medicaid expansion programs.

Application of Medicaid Child Presumptive Eligibility Provisions

	Current Law	Agreement
Section 803. Application of Medicaid Child Presumptive Eligibility Provisions.	Under Medicaid presumptive eligibility rules, states are allowed to temporarily enroll children whose family income appears to be below Medicaid income standards, until a final formal determination of eligibility is made. There is no express provision for presumptive eligibility under separate (non-Medicaid) SCHIP programs. However, the Secretary of HHS permits states to develop, for separate (non-Medicaid) SCHIP programs, procedures that are similar to those permitted under Medicaid.	Clarifies states' authority to conduct presumptive eligibility determinations, as defined in Medicaid law, under separate (non-Medicaid) SCHIP programs.

Title IX. Other Provisions

Extension of Transition for Current PACE Waivers

	Current Law	Agreement
Section 901. Extension of Transition for Current Waivers	OBRA 86 required the Secretary to grant waivers of certain Medicare and Medicaid requirements to not more than 10 public or non-profit private community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of institutionalization. These projects, known as the Program of All-Inclusive Care for the Elderly (PACE), were intended to determine whether an earlier demonstration program, On-Lok, could be replicated across the country. OBRA 90 expanded the number of organizations eligible for waivers to 15. BBA 97 established PACE as a permanent provider under Medicare and as an optional benefit under Medicaid. State Medicaid programs are permitted to limit the number of persons enrolled in PACE programs. The Secretary was required to issue regulations establishing requirements for PACE providers (and did so with an effective date of November 24, 1999). The Secretary may continue to operate programs under the prior law waivers for a transition period of 24 months after publication of the regulations, and states may elect to continue to operate a PACE program under special arrangements for 3 years after the Secretary's regulations.	Permits the Secretary to continue to operate the Program of All-Inclusive Care for the Elderly (PACE) under waivers for a period of 36 months (rather than 24 months), and states may do so for 4 years (rather than 3 years).

Continuing Certain PACE Operating Arrangements

	Current Law	Agreement
Section 902. Continuing of Certain Operating Arrangements Permitted	BBA 97 established PACE as a permanent part of the Medicare and Medicaid programs and provided for a transition of PACE from demonstration project status to permanent program status.	If prior to becoming a permanent component of Medicare, a PACE demonstration project had contractual or other operating arrangements that are not recognized under permanent program regulations, requires the Secretary, in consultation with the state agency, to permit it to continue under such arrangements as long as it is consistent with the objectives of the PACE program.

Flexibility in Exercising Waiver Authority

	Current Law	Agreement
Section 903. Flexibility in Exercising Waiver Authority	The law and regulations for PACE require that programs operate according to a protocol.	Enables the Secretary to exercise authority to modify or waive Medicare or Medicaid requirements to respond to the needs of PACE programs related to employment and the use of community care physicians. The Secretary must approve requests for such waivers within 90 days of the date the request for waiver is received.

Outreach for Medicare Beneficiaries Eligible for Medicaid Cost-Sharing Assistance

	Current Law	Agreement
Section 911. Outreach on Availability of Medicare Cost-sharing Assistance to Eligible Low-income Medicare Beneficiaries	Medicaid covers the costs of certain Medicare financial obligations for qualified Medicare beneficiaries (QMBs), specified low income Medicare beneficiaries (SLMBs) and two groups of "qualified individuals" referred to as QI-1s and QI-2s. QMBs are aged or disabled persons with incomes at or below the federal poverty line and assets below twice the SSI level. The other groups are comprised of other low income-individuals who meet all but the income definition for QMB eligibility.	Requires the Commissioner of the Social Security Administration to conduct outreach efforts to identify individuals who may be eligible for Medicaid payment of Medicare cost sharing and to notify these persons of the availability of such assistance. The Commissioner would also be required to furnish, at least annually, a list of such individuals who reside in each state to that state's agency responsible for administering the Medicaid program as well as to any other appropriate state agency. The list should include the name and address, and whether such individuals have experienced reductions in Social Security benefits. Also requires the General Accounting Office to conduct a study of the impact of the outreach activities of the Commissioner to submit to Congress no later than 18 months after such outreach begins. Effective 1 year after date of enactment.

Maternal and Child Health Block Grant

	Current Law	Agreement
Section. 921. Increase in Authorization of Appropriations for the Maternal and Child Health Services Block Grant	Title V of the Social Security Act authorizes an appropriation of $705 million for FY1994 and each fiscal year thereafter for the Maternal and Child Health Services Block Grant.	Increases the authorization of appropriations for this grant program to $850 million for FY2001 and each fiscal year thereafter.

Diabetes

	Current Law	Agreement
Section 931. Increase in Appropriations for Special Diabetes Programs for Type I Diabetes and Indians	The Balanced Budget Act of 1997 amended Title III of the Public Health Service Act to create two grant programs supporting the prevention and treatment of, and research relating to, diabetes. The first targets diabetes research and the second supports the prevention and treatment services of diabetes in Indians. Each program receives $30 million for each of the fiscal years 1998 through 2002, transferred from the SCHIP appropriation.	Extends for 1 year, to FY2003, the authority for grants to be made for both the Special Diabetes Program for Type I Diabetes and for the Special Diabetes Programs for Indians. Also expands funding available for these programs. For each grant program, increases total funding to $100 million each for FY2001, FY2002 and FY2003. For FY2001 and FY2002, $30 million of the $100 million for each program would be transferred from SCHIP; the remaining $70 million would be drawn from the Treasury out of funds not otherwise appropriated. In FY2003, the entire $100 million would be drawn from the Treasury out of funds not otherwise appropriated. In addition, extends the due date on final evaluation reports for these two grant programs from January 1, 2002 to January 1, 2003.

Appropriations for Ricky Ray Hemophilia Relief Fund

	Current Law	Agreement
Section 932. Appropriations for Ricky Ray Hemophilia Relief Fund	The Ricky Ray Hemophilia Relief Fund Act of 1998 (P.L. 105-369) established a 5-year trust fund to make compassionate payments of $100,000 to hemophiliacs who contracted HIV through the use of anti-hemophiliac factor between July 1, 1982 and December 31, 1987. The Act authorized appropriations to the fund totaling $750 million. The trust fund received an initial appropriation of $75 million in FY2000.	Provides for a direct appropriation to the Ricky Ray trust fund of $475 million for FY2001. [Note: an additional $105 million was appropriated to the fund in the FY2001 Miscellaneous Appropriations Act (H.R. 5666).]

Information on Nurse Staffing

	Current Law	Agreement
Section 941. Posting Of Information on Nursing Facility Services	Medicare and Medicaid statute delineates certain requirements for skilled nursing and nursing facilities, respectively. With regard to staffing, facilities must provide 24-hour licensed nursing service sufficient to meet the nursing needs of residents and must, in general, use the services of a registered nurse at least 8 consecutive hours a day, 7 days a week. Nurse aides must complete training and competency evaluation programs. No staffing-to-resident ratios are specified in federal statute.	Requires Medicare skilled nursing facilities and Medicaid nursing facilities to post licensed and unlicensed nurse staffing information daily for each shift in the facility, and to make such information publicly available, upon request. Effective January 1, 2003.