
# Medicaid Provisions in the House and Senate American Recovery and Reinvestment Act of 2009 (ARRA, H.R. 1, S.Amdt. 570)

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# Summary

The economy officially was considered in a recession in December 2008, but many forecasters had long recognized the downturn and some believed this economic contraction would be more severe than other post-World War II economic slowdowns. A combination of factors have combined to present policymakers with difficult decisions on how best to stimulate the economy. Troubling instability in the housing and financial services sectors have combined with weak auto manufacturing demand, and high energy costs earlier in the year to slow growth dramatically and force millions into unemployment. With declining tax revenue and increasing costs to provide unemployment and other benefits to unemployed workers, states are considering measures to rein in spending, including restricting Medicaid eligibility and services.

Congress is considering legislation aimed at stimulating economic activity in selected industrial sectors to save existing and create new jobs, reduce taxes, invest in future technologies, and fund infrastructure improvements. The House-approved the American Recovery and Reinvestment Act of 2009 (ARRA, H.R. 1) on January 22. ARRA provisions would provide temporary support to families and individuals by providing additional unemployment compensation benefits, short-term access to Medicaid, financial assistance for individuals to maintain their health coverage under provisions in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and temporary increases in Medicaid matching rates and disproportionate share hospital allotments. The full House amended and approved H.R. 1 on January 28, 2009.

Similar legislation to H.R. 1 was introduced in the Senate (ARRA, S. 350) and referred to the Committee on Finance, among others, where provisions were approved on January 27. [See the Senate Committee on Finance website for S.Amdt. 98 at http://finance.senate.gov/sitepages/leg/LEG%202009/020209%20complete%20legislative%20text%20of%20American%20Recovery%20and%20Reinvestment%20Act.pdf.] An amendment in the nature of a substitute (SAmdt. 570) was offered as a substitute for H.R. 1 and was approved by the full Senate on February 10, 2009. The Senate version of ARRA was referred to a joint Senate and House conference committee.

This report describes Medicaid provisions presented under Division B, Title III and Title V, of the House-approved version of the ARRA, and similar provisions in Titles III and V in a Senate Amendment (ARRA, S.Amdt. 570) offered in the nature of a substitute for H.R. 1. **Table 1** provides a summary of major provisions in H.R. 1 and S.Amdt. 570. For details on the Conference Agreement's Medicaid provisions, see CRS Report R40223, *American Recovery and Reinvestment Act of 2009 (ARRA): Title V, Medicaid Provisions*, coordinated by (name redacted).

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# Background

In December 2008, the National Bureau of Economic Research (NBER) announced that the economy was in a recession and that the recession began in December 2007.[1] However, some economists and forecasters have been concerned that a combination of factors might make this economic contraction much worse than other post-war slowdowns.[2] At first, economic instability seemed limited to the housing sector as housing values decreased in many markets, forcing some subprime and highly leveraged home owners into foreclosure. The problems that began in housing, quickly spread to banking and financial services and were compounded earlier in 2008 by spikes in energy prices. The solvency of automobile manufacturers rapidly deteriorated, possibly due in part to tight credit policies, rising unemployment, and high fuel costs. National unemployment rose steadily throughout 2008 reaching 7.2% in December.[3] Many states also face large tax revenue decreases, forcing them to consider reducing Medicaid eligibility and spending, just when the demand for additional public sector health care is expanding to fill the gap left when unemployed individuals no longer can afford employer-based health insurance for their families. Although by themselves the problems in housing, financial services, manufacturing, and energy sectors might not force the economy into recession, taken together these problems have contributed to the emergence of a recession and, if the underlying fundamentals have changed as some forecasters suspect, perhaps a prolonged, global economic slow down that could have widespread impact on living standards here and abroad.

Policymakers quickly moved to prevent the instability in housing and financial services from spilling over into the broader economy. Looking to the future, members of Congress and the Obama Administration have sought additional mechanisms to stimulate economic activity. Various approaches have been considered to ensure that a stimulus package could reach many different segments of the economy, provide a sustained economic boost, and wide spread job growth. Some stimulus proposals have included infrastructure spending, revenue sharing with states, middle class tax cuts, business tax cuts, unemployment benefits, and food stamps. On January 22, 2009 the House Committee on Energy and Commerce marked-up and approved selected health components of the American Recovery and Reinvestment Act of 2009 (ARRA, H.R. 1). The full House amended and approved H.R. 1 on January 28, 2009. ARRA included approval of an amendment to Division B, Title V, Medicaid Provisions, that removed a provision that would have given states the option to cover family planning services under Medicaid.

Similar legislation to H.R. 1 was introduced in the Senate (ARRA, S. 350) and referred to the Committee on Finance, where a markup of selected health components was approved on January 27.[4] The Senate Committee on Finance mark-up of S. 350 and approved S.Amdt. 98, which was offered as a substitute for H.R. 1. S.Amdt. 98 was amended further before being approved by the

[1] See CRS Report R40052, *What is a Recession and Who Decided When It Started?*, by (name redacted), for more information on how business cycles are defined and measured.

[2] For more information see CRS Report R40104, *Economic Stimulus: Issues and Policies*, by (name redacted), (name r edacted), and (name redacted).

[3] U.S. Bureau of Labor Statistics, Press Release dated January 9, 2009. Available on the internet at http://www.bls.gov/ for more information (accessed January 22, 2009).

[4] See the Senate Committee on Finance website for S.Amdt. 570 http://finance.senate.gov/sitepages/leg/LEG%202009/020209%20complete%20legislative%20text%20of%20American%20Recovery%20and%20Reinvestment%20Act.pdf

full Senate, where an S.Amdt. 570 was offered in the nature of a substitute H.R. 1. on February 10, 2009.

**Table 1** displays a summary of Medicaid provisions in H.R. 1 and S.Amdt. 570.

**Table 1. Major Provisions—American Recovery and Reinvestment Act of 2009**

| Major Provisions | H.R. 1 | S.Amdt. 570 | Comments |
|---|---|---|---|
| Temporary FMAP Increase | X | X | 5 Year CBO Estimate, $86.6 Billion in H.R. 1 and $87.7 in S.Amdt. 570 |
| Unemployed Covered Under Medicaid | X | | Temporary Optional Benefit |
| Medicaid Regulations Moratoria | X | | 60-day Extension through June 30, 2009 |
| DSH Allotment Increases | X | X | Proposals Vary |
| Medicare Special Workload Agreements | | X | $3 Billion in Proposed Funding |
| Medicaid Indian Protections | X | X | S.Amdt. 570 adds Managed Care |
| TMA Extension | X | X | Extended through 12/31/2010 |
| OIG and GAO | | X | OIG Appropriation of $31.25 million |
| QI Extension | | X | Extended through 12/31/2010 |

**Source:** CRS analysis of H.R. 1 and S.Amdt. 570.

Additional detail on major provisions and differences between H.R. 1 and S.Amdt. 570 include the following:

- **FMAP.** Although the House-passed and Senate Finance versions of a temporary increase in the federal medical assistance percentage (FMAP) are broadly similar, they differ on the degree to which funds are targeted at states experiencing unemployment rate increases and whether the temporary FMAP increase applies to expenditures for individuals who are eligible for Medicaid because of an increase in a state's income eligibility standards.
- **Unemployed Covered Under Medicaid**. Under H.R. 1, but not S.Amdt. 570, states would have a temporary option to cover unemployed workers under Medicaid. States would receive 100% FMAP for this temporary Medicaid expansion for both medical services and related administrative expenditures.
- **Medicaid Regulations Moratoria.** H.R. 1 includes a 60-day extension until July 1, 2009, of moratoria on six controversial Medicaid regulations, and a new moratorium on a seventh regulation. S.Amdt. 570 does not have a provision to extend the Medicaid moratoria.
- **DSH Allotment Increases**. H.R. 1 would temporarily, but uniformly, increase states' DSH allotments by 2.5% for FY2009 and FY2010. S.Amdt. 570 also would increase temporarily states' DSH allotments, but the enhanced allotments would be provided only to low-DSH states (states with DSH spending below 3% of their total Medicaid expenditures in FY2006). States with higher DSH spending would not receive enhanced allotments under S.Amdt. 570.
- **Medicare Special Workload Agreements**. S.Amdt. 570 includes a provision that would require the HHS Secretary, in consultation with the SSA Commissioner, to negotiate agreements with states on the Medicare Special Disability Workload program. H.R. 1 does not have a similar provision.

- **Medicaid Indian Protections**. H.R. 1 and S.Amdt. 570 both include provisions that would exempt Indians from Medicaid and SCHIP cost sharing and premiums as well as provide for the creation of a Tribal Technical Advisory Panel within CMS. Under S.Amdt. 570, in order to receive Medicaid payment, managed care entities would need to fulfill certain conditions. The Senate amendment would also apply specific provisions affecting Medicaid managed care to SCHIP.
- **TMA and QI Extensions**. H.R. 1 would extend the work-related Transitional Medical Assistance (TMA) program through December 2010. Similar to H.R. 1, S.Amdt. 570 would extend the work-related TMA program through December 2010, as well as the Qualified Individual (QI) program through the end of 2010.
- **OIG and GAO**. Under S.Amdt. 570, but not H.R. 1, funds would be appropriated to OIG for Medicaid integrity activities related to increased recession spending. Also under S.Amdt. 570 and not H.R. 1, GAO would be tasked with preparing a report on the effect of recessions since 1974 on Medicaid.
- **NH Prompt Pay**. Under S.Amdt. 570, states would need to comply with Medicaid's prompt payment rules to receive recessionary FMAP increases.
- **Sunset.** Under S.Amdt. 570, all of the provisions in Title III, Subtitle D, Other Provisions, would sunset at the end of the recession period, December 31, 2010, including Indian protections (Sec. 3301, 3302, 3303) and nursing home prompt pay requirements (Sec. 3304).

For a discussion of the Medicaid provisions approved in the Joint House and Senate Conference Agreement, see CRS Report R40223, *American Recovery and Reinvestment Act of 2009 (ARRA): Title V, Medicaid Provisions*, coordinated by (name redacted).

# ARRA Medicaid Provisions Approved by the House and Senate

The American Recovery and Reinvestment Act of 2009 (ARRA, H.R. 1) is intended to stimulate additional economic activity in selected industrial sectors to save existing and create new jobs, reduce taxes, invest in future technologies, and fund infrastructure improvements. In addition, ARRA contains provisions to provide temporary support to families and individuals in need by providing additional unemployment compensation benefits, short-term access to Medicaid, financial assistance for individuals eligible under COBRA[5] to purchase health insurance through their former employer, temporary increases in federal Medicaid matching rates for states, and other Medicaid changes.

[5] In 1985, Congress extended temporary access to health insurance for individuals who lost coverage due to employment changes. Under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272), an employer with 20 or more employees must provide employees and their families the option of continuing their coverage under the employer's group health insurance plan. The coverage, usually for 18 months, can last up to 36 months, depending on the nature of the triggering event. Employers are not required to pay for this coverage; instead, beneficiaries can be required to pay up to 102% of the premium. (For more details, see CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*, by (name redacted) and CRS Report RL34251, *Federal Programs Available to Unemployed Workers*, by (name redacted) and (name redacted)).

On January 26, 2009, the Congressional Budget Office (CBO) issued a preliminary estimate of the impact of H.R. 1 as it was reported to the House. The Medicaid provisions in the version of H.R. 1 introduced in the House, were in two titles, Title III, Health Insurance Assistance, and Title V, State Fiscal Relief, of Division B, Direct Spending. CBO preliminarily estimated that the Medicaid provisions in H.R. 1, as approved by the House, would increase federal spending by $37 billion in FY2009 and $100.1 billion over the five-year period FY2009-2013.

On January 28, 2009, CBO issued estimated budget impacts of the House-approved version of ARRA. These estimates do not include separate line items for all Medicaid provisions, but summarize spending by Titles. CBO indicated that their preliminary individual provision estimates did not change from the introduced version of H.R. 1 to the House-approved version.

The Medicaid provisions in Title III and Title V of the House-approved version of ARRA included:

**Title III—Health Insurance Assistance:**

- Temporary Optional Medicaid Coverage for the Unemployed.

**Title V—State Fiscal Relief:**

- Temporary Increase in Medicaid Federal Medical Assistance Percentage (FMAP),
- Moratoria on Certain Regulations,
- Transitional Medical Assistance (TMA),
- Protections for Indians under Medicaid and the Children's Health Insurance Program (CHIP),
- Consultation with Indian Health Programs,
- Temporary Increase in Disproportionate Share Hospital (DSP) Allotments.

Title IV, Health Information Technology, in the House-approved version of ARRA, also includes Medicaid provisions related to health technology.[6]

On January 27, 2009, an economic stimulus bill S. 336, American Recovery and Reinvestment Act of 2009 (ARRA), was introduced in the Senate and referred to the Committee on Appropriations. A related stimulus bill, S. 350, with the same name, was introduced on January 29, 2009, and referred to the Committee on Finance. The Committee on Finance amended and approved S. 350 on January 30, 2009. On February 2, 2009, S. 350 was combined with provisions from S. 336 and an amendment, S.Amdt. 570, was offered as a replacement for the House-approved stimulus bill, H.R. 1. The full Senate approved S.Amdt. 570 on February 10, 2009.

Medicaid provisions in Title III and Title V of Senate-approved ARRA included:

[6] See CRS Report R40181, *Selected Health Funding in the American Recovery and Reinvestment Act*, coordinated by (name redacted) for more information.

**Title III—Health Insurance Assistance:**

- Extension of Transitional Medical Assistance (TMA).
- Extension of the Qualified Individual (QI) Program.
- Premiums and Cost Sharing Protections Under Medicaid, Eligibility Determinations Under Medicaid and CHIP, and Protection of Certain Indian Property from Medicaid Estate Recovery.
- Rules Applicable Under Medicaid and CHIP to Managed Care Entities with Respect to Indian Enrollees and Indian Health Care Providers and Indian Managed Care Entities.
- Consultation on Medicaid, CHIP, and Other Health Care Programs Funded Under the Social Security Act Involving Indian Health Programs and Urban Indian Organizations.
- Application of Prompt Pay Requirements to Nursing Facilities.
- Period Of Application; Sunset.

**Title V—State Fiscal Relief:**

- Temporary Increase in Medicaid Federal Medical Assistance Percentage (FMAP).
- Extension and Update of Special Rule for Increase of Medicaid DSH Allotments for Low-DSH States.
- Payment of Medicare Liability to States as a Result of the Special Disability Workload Project.
- Funding for the Department of Health and Human Services Office of the Inspector General.
- GAO Study and Report Regarding State Needs During Periods of National Economic Downturn.

CBO prepared estimates of the effect of S.Amdt. 570 on federal spending.[7] In its analysis, CBO did not make separate estimates for each Medicaid provision contained in Division B, Direct Spending. CBO estimated that all S.Amdt. 570's Title III, Health Insurance Assistance, provisions would increase direct spending by $28.6 billion over the period FY2009-FY2019. The Medicaid provisions in Title III by themselves would increase federal spending by $2.6 billion over the same 10-year period FY2009-2019.[8] CBO estimated that the S.Amdt. 570's Title V, State Fiscal Relief, provisions would increase federal expenditures by $36 billion in FY2009 and by $90 billion over 10 years from FY2009-2019.

This report follows the organization of the Medicaid provisions in the House-passed version of ARRA, so the House-passed provisions are presented first, with comparable Senate provisions

[7] For more detail, see Congressional Budget Office, Cost Estimate, H.R. 1 (An Amendment in the Nature of a Substitute, Introduced on January 31, 2009), February 2, 2009, http://www.cbo.gov/ftpdocs/99xx/doc9977/hr1senate.pdf.

[8] CRS analysis of CBO Cost Estimate of S.Amdt. 570, dated February 2, 2009.

following, unless the House-passed version of ARRA does not have a comparable provision to the Senate version; then the Senate provisions are presented first. This report will not be updated. For additional information on ARRA Conference Agreement's Medicaid provisions, see CRS Report R40223, *American Recovery and Reinvestment Act of 2009 (ARRA): Title V, Medicaid Provisions*, coordinated by (name redacted).

# H.R. 1. TITLE III—Health Insurance Assistance for the Unemployed

## Medicaid Coverage of the Unemployed

### H.R. 1. Sec. 3003. Temporary Optional Medicaid Coverage for the Unemployed.

#### *Explanation of Provision*

Under this provision, states would temporarily have the option to cover unemployed workers and their families under Medicaid.[9] Under this optional benefit, states could extend Medicaid benefits to three categories of workers that involuntarily had lost their jobs (including spouses and children under age 19), since September 1, 2008. **Table 2** summarizes the three categories of workers that would be covered under this provision, requirements for coverage, and rules states would need to follow in adding this optional coverage to their state Medicaid plans.

**Table 2. Provision Summary: Temporary Medicaid Coverage for the Unemployed**

ARRA, H.R. 1

| Unemployed Worker Category/Category Characteristics | Category A | Category B | Category C |
|---|---|---|---|
| **Eligibility** | 1. Individuals must be receiving Unemployment Compensation (UC) Benefits; or<br>2. Have exhausted UC benefits on or after July 1, 2008. | 1. Individuals must be unemployed and lost job on or after Sept. 1, 2008 and before Jan. 1, 2011.<br>2. Gross family income at or below 200% FPL. | 1. Individuals must be unemployed and lost job on or after Sept. 1, 2008 and before Jan. 1, 2011<br>2. Receiving Supplemental Nutrition Assistance (food stamps). |
| **Requirements Applicable to all Categories** | 1. Individuals would not otherwise qualify for Medicaid.<br>2. No other creditable health insurance coverage.<br>3. Spouse and dependent children under age 19 also eligible. | | |

[9] For more information on policy issues related to unemployment and health insurance, see CRS Report R40165, *Unemployment and Health Insurance: Current Legislation and Issues*, by (name redacted).

| Unemployed Worker Category/Category Characteristics | Category A | Category B | Category C |
|---|---|---|---|
| **Requirements Applicable to Specific Categories** | 1. States may not impose income or resource tests.<br>2. The HHS Secretary may define an additional comparable sub-category that would apply to independent contractors. | 1. States may impose eligibility and resource tests. | 1. States may not impose income or resource tests. |

**Source:** CRS Analysis of H.R. 1.

As shown in **Table 2**, the HHS Secretary would have the option to define an additional comparable category through rules or guidance that could include independent contractors in Category A.

States would receive 100% FMAP for individuals who were eligible for Medicaid under this provision until January 1, 2011. In addition, states would receive 100% matching for administrative activities related to this provision, such as outreach, modification and operation of eligibility information systems, enrollment, and eligibility determination. In its preliminary estimate of spending effects of H.R. 1, issued on January 26, 2009, CBO estimated that the temporary, optional coverage for the unemployed under Medicaid provision in the House-approved version of ARRA would increase federal spending in FY2009 by $4.0 billion and by $10.8 billion from FY2009-FY2014. In the January 30, 2009, analysis of the House-approved version of ARRA,[10] CBO did not provide a separate estimate of the impact of Sec. 3003 on federal spending, but indicated its overall estimate was unchanged. On February 9, 2009, CBO estimated that an additional 1.2 million individuals (adults and children) would receive Medicaid benefits by the end of FY2009 under this provision.

S.Amdt. 570 did not include a provision to extend temporary optional Medicaid coverage to the unemployed.

# H.R. 1. TITLE V—Medicaid Provisions

## Temporary FMAP Increase

### H.R. 1. Sec. 5001. Temporary Increase of Medicaid FMAP.

#### *Explanation of Provision*

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement

[10] See Congressional Budget Office Letter to the Honorable David Obey, Chairman, Committee on Appropriations, January 30, 2009, http://www.cbo.gov/ftpdocs/99xx/doc9976/hr1aspassed.pdf.

to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. The FMAP is calculated on an annual basis.

Exceptions to the FMAP formula have been made for certain states and situations. For example, the District of Columbia's Medicaid FMAP is set in statute at 70%, and the territories have FMAPs set at 50% (they are also subject to federal spending caps). Under the Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L. 108-27), all states received a temporary increase in Medicaid FMAPs for the last two quarters of FY2003 and the first three quarters of FY2004 as part of a fiscal relief package. In addition to Medicaid, the FMAP is used in determining the federal share of certain other programs (e.g., foster care and adoption assistance under Title IV-E of the Social Security Act) and serves as the basis for calculating an enhanced FMAP that applies to the State Children's Health Insurance Program.

During a recession adjustment period that begins with the first quarter of FY2009 and runs through the first quarter of FY2011, the proposal agreed to by the House would hold all states harmless from any decline in their regular FMAPs, provide all states with an increase of 4.9 percentage points, and provide high unemployment states with an additional increase. It would also allow each territory to choose between an FMAP increase of 4.9 percentage points along with a 10% increase in its spending cap, or its regular FMAP along with a 20% increase in its spending cap.

States would be evaluated on a quarterly basis for the additional unemployment-related FMAP increase, which would equal a percentage reduction in the state share. The percentage reduction would be applied to the state share after the hold harmless increase and *before*, the 4.9 percentage point increase. For example, after applying the 4.9 point increase provided to all states, a state with a regular FMAP of 50% (state share of 50%) would have an FMAP of 54.90%. If the state share were further reduced by 6%, the state would receive an additional FMAP increase of 3 points (50 * 0.06 = 3). The state's total FMAP increase would be 7.9 points (4.9 + 3 = 7.9), providing an FMAP of 57.90%.

The additional unemployment-related FMAP increase would be based on a state's unemployment rate in the most recent 3-month period for which data are available (except for the first two and last two quarters of the recession adjustment period, for which the 3-month period would be specified) compared to its lowest unemployment rate in any 3-month period beginning on or after January 1, 2006. The criteria would be as follows:

- unemployment rate increase of at least 1.5 but less than 2.5 percentage points = 6% reduction in state share;
- unemployment rate increase of at least 2.5 but less than 3.5 percentage points = 12% reduction in state share;
- unemployment rate increase of at least 3.5 percentage points = 14% reduction in state share.

If a state qualifies for the additional unemployment-related FMAP increase and later has a *decrease* in its unemployment rate, its percentage reduction in state share could not decrease until the fourth quarter of FY2010 (for most states, this corresponds with the first quarter of SFY2011). If a state qualifies for the additional unemployment-related FMAP increase and later has an *increase* in its unemployment rate, its percentage reduction in state share could increase.

The full amount of the temporary FMAP increase would only apply to Medicaid (excluding disproportionate share hospital payments). A portion of the temporary FMAP increase (hold harmless plus 4.9 percentage points) would apply to Title IV-E foster care and adoption assistance. States would be required to maintain their Medicaid eligibility standards, methodologies, and procedures as in effect on July 1, 2008, in order to be eligible for the increase. They would be prohibited from depositing or crediting the additional federal funds paid as a result of the temporary FMAP increase to any reserve or rainy day fund. States would also be required to ensure that local governments do not pay a larger percentage of the state's nonfederal Medicaid expenditures than otherwise would have been required on September 30, 2008. (For more details, see CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by (name redacted)).

CBO estimated that the FMAP provision in the House-approved version of ARRA would increase federal spending on Medicaid by about $87 billion and on Title IV-E by about $0.8 billion over the five-year period from FY2009-2013.

## S.Amdt. 570. Sec. 5001. Temporary Increase of Medicaid FMAP.

### *Explanation of Provision*

Similar to the House-passed version, the Senate Finance version would hold all states harmless from any decline in their regular FMAPs. However, it would provide a larger across-the-board increase of 7.6 percentage points and a smaller unemployment-related increase. It would increase spending caps in the territories by 15.2%.

As in the House-passed version, the Senate Finance version would calculate the unemployment-related increase as a percentage reduction in the state share. However, the percentage reduction would be applied to the state share *after* the across-the-board increase of 7.6 percentage points. The Senate Finance version would evaluate states based on the same unemployment data, except that it would not specify the three-month period to be used for the first two and last two quarters of the temporary FMAP increase. The criteria would be as follows: unemployment rate increase of at least 1.5 but less than 2.5 percentage points = 2.5% reduction in state share; increase of at least 2.5 but less than 3.5 percentage points = 4.5% reduction; increase of at least 6.5 percentage points = 6.5% reduction. Similar to the House-passed version, a state's percentage reduction could increase over time as its unemployment rate increases, but it would not be allowed to decrease until the last quarter of FY2010.

Unlike the House-passed version, the Senate Finance version would not apply the temporary FMAP increase to expenditures for individuals who are eligible for Medicaid because of an increase in a state's income eligibility standards above what was in effect on July 1, 2008. It would also prohibit states from receiving the temporary increase if they are not in compliance with existing requirements for prompt payment of health care providers under Medicaid, and require them to report to the Secretary of HHS on their compliance with such requirements. Otherwise, the Senate Finance version is similar to the House-passed version. (For more details, see CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by (name redacted)).

CBO estimated that the FMAP provision in the Senate Finance version of ARRA would increase federal spending on Medicaid by $85.5 billion and on Title IV-E by about $1.2 billion over the five-year period from FY2009-FY2013.

# Medicaid Regulations Moratoria

## H.R. 1. Sec. 5002. Moratoria on Certain Regulations

### *Explanation of Provision*

In 2007 and 2008, the Centers for Medicare and Medicaid Services (CMS), issued seven Medicaid regulations, which generated controversy during the 110th Congress. To address concerns with the impact of the regulations, several laws passed during the 110th Congress imposed moratoriums on six of the Medicaid regulations until April 1, 2009 (excluding the rule on outpatient hospital facility and clinic services). The seven Medicaid regulations issued during the most recent Congress covered the following Medicaid areas:

- Graduate Medical Education,
- Cost Limit for Public Providers,
- Rehabilitation Services,
- Case Management,
- School-Based Services,
- Provider Taxes, and
- Outpatient Hospital Services.

*Graduate Medical Education.* Most states make Medicaid payments to help cover the costs of training new doctors in teaching programs. The proposed rule would have eliminated federal reimbursement for graduate medical education and changed how Medicaid upper payment limits for hospital services were calculated. (For more details, see CRS Report RS22842, *Medicaid and Graduate Medical Education*, by (name redacted) and (name redacted)).

*Intergovernmental Transfers.* Intergovernmental transfers (IGTs) are used by some states to finance the non-federal share of Medicaid costs. Certain IGTs are specifically allowed for funding the state share of program costs. Some states have instituted programs where the state share of Medicaid spending is paid by hospitals or nursing homes that are public providers, but not units of government, or are units of government, but the state share is returned to the provider sometimes through Medicaid payments. This regulation would have clarified the types of IGTs allowable for financing a portion of Medicaid costs, imposed a limit on Medicaid reimbursement for government-owned hospitals and other institutional providers, and required certain providers to retain all Medicaid reimbursement. (For more details, see CRS Report RS22848, *Medicaid Regulation of Governmental Providers*, by (name redacted)).

*Rehabilitation Services.* Medicaid rehabilitation services include a full range of treatments designed to reduce physical or mental disability or restore eligible beneficiaries to their best possible functional levels. There has been enough misunderstanding about what Medicaid pays for and what constitutes rehabilitation services that both the executive and legislative branches have addressed this benefit repeatedly. The rehabilitation services proposed rule was intended to define the scope of the rehabilitation benefit and to identify services that could be claimed under Medicaid. (For more details, see CRS Report RL34432, *Medicaid Rehabilitation Services*, by (name redacted)).

*Case Management.* Case management services assist Medicaid beneficiaries in obtaining needed medical and related services. Targeted case management (TCM) refers to case management for specific beneficiary groups or for individuals who reside in state-designated geographic areas. Similar to rehabilitative services, there has been considerable ambiguity about what services are covered and what is legitimately considered TCM. The case management regulation addressed a provision of the Deficit Reduction Act of 2005 (DRA; P.L. 109-171), where Congress added new language to clarify and narrow the case management definition and directed the Secretary of HHS to issue regulations to guide states' claims for matching federal reimbursement for case management. (For more details, see CRS Report RL34426, *Medicaid Targeted Case Management (TCM) Benefits*, by (name redacted)).

*School-Based Services.* As a condition of accepting funds under the Individuals with Disabilities Education Act (P.L. 108-446, IDEA), public schools must provide special education and related services necessary for children with disabilities to benefit from public education. States can finance only a portion of these costs with federal IDEA funds. Medicaid may cover IDEA required health-related services for enrolled children as well as related administrative activities. According to federal investigations and congressional hearings, Medicaid payments to schools have sometimes been improper. To address these problems, CMS issued this regulation that was intended to restrict federal Medicaid payments for school-based administrative activities (e.g., outreach, service coordination, referrals performed by school employees or contractors), and for certain transportation services (e.g., from home to school and back for certain school-age children). (For more details, see CRS Report RS22397, *Medicaid and Schools*, by (name redacted)).

*Provider Taxes.* States use provider-specific taxes to help finance their share of the Medicaid program. Under these funding methods, states collect funds (through taxes or other means) from providers and pay the money back to those providers as Medicaid payments, and claim the federal matching share of those payments. Once the state share has been subtracted, the federal matching funds may be used to raise provider payment rates, to fund other portions of the Medicaid program, or for other non-Medicaid purposes. Provider taxes must be consistent with federal laws and regulations, which may have been ambiguous or changing. CMS issued a provider tax regulation to address issues related to provider taxes. (For more details, see CRS Report RS22843, *Medicaid Provider Taxes*, by (name redacted)).

*Outpatient Hospital Services.* Under Medicaid, outpatient hospital (OPH) services are a mandatory benefit for most beneficiaries. OPH services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided under the direction of a physician or a dentist in the hospital. These outpatient facilities may be located on or off the hospital campus or in satellite facilities. States use a number of different reimbursement methods for different types of services provided in OPH departments and clinics. CMS issued a regulation intended to limit the definition and scope of Medicaid-covered OPH. Given the moratorium on a related regulation covering cost limits for government providers, CMS excluded from the regulatory language methods for demonstrating compliance with the upper payment limit for Medicaid OPH and clinic services provided in privately operated facilities. (For more details, see CRS Report RS22852, *Medicaid and Outpatient Hospital Services*, by (name redacted) and (name redacted)).

This provision would extend the moratoriums on the first six regulations beyond April 1, 2009, when the moratoriums expire, to July 1, 2009. The regulations covered under the extension would include those regulations that have been under moratoria, including (1) Graduate Medical Education, (2) Cost Limit for Public Providers, (3) Rehabilitative Services, (4) Case Management, (5) School-Based Services, and (6) Provider Taxes. In addition, this provision

specifically would prohibit the Health and Human Services Secretary from taking any action until after June 30, 2009 (through regulation, regulatory guidance, use of federal payment audit procedures, or other administrative action, policy, or practice, including Medical Assistance Manual transmittal or state Medicaid director letter) to implement a final regulation covering OPH facilities.[11] CBO's preliminary estimate of the effect of extending the Medicaid moratoria described in the House-approved version of ARRA would be an increase in federal spending of $200 million in FY2009 and the same $200 million increase for the five-year period from FY2009-2013.

S.Amdt. 570 had no comparable provision to H.R. 1.

# Transitional Medical Assistance (TMA)

## H.R. 1. Sec. 5003. Transitional Medical Assistance (TMA).

### *Explanation of Provision*

States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation is called transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families who lose Medicaid eligibility due to increased child or spousal support collections, as well as those who lose eligibility due to an increase in earned income or hours of employment. However, Congress expanded work-related TMA under Section 1925 of the Social Security Act in 1988, requiring states to provide at least six, and up to 12, months of coverage. Since 2001, these work-related TMA requirements have been funded by a series of short-term extensions, most recently through June 30, 2009. (For more details, see CRS Report RL31698, *Transitional Medical Assistance (TMA) Under Medicaid*, by (name redacted)).

The provision would extend work-related TMA under Section 1925 through December 31, 2010. States could opt to treat any reference to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months) for purposes of the initial eligibility period for work-related TMA, in which case the additional 6-month extension would not apply. States could opt to waive the requirement that a family have received Medicaid in at least three of the last six months in order to qualify. Under the TMA provision, states would be required to collect and submit to the Secretary of Health and Human Services (and make publicly available) information on average monthly enrollment and participation rates for adults and children under work-related TMA, and on the number and percentage of children who become ineligible for work-related TMA and whose eligibility is continued under another Medicaid eligibility category or who are enrolled in the State Children's Health Insurance Program. CBO's preliminary estimate of the fiscal impact of the House-approved version of ARRA was for no spending increase for the TMA extension in FY2009, but a $1.3 billion increase for the five years FY2009-2013.

[11] See Medicaid Program; Clarification of Outpatient Hospital Facility (Including Outpatient Hospital Clinic) Services Definition, Final Rule, Federal Register, Vol. 73, No. 217, November 7, 2008.

### S.Amdt. 570. Sec. 3101. Extension of Transitional Medical Assistance (TMA).

#### *Explanation of Provision*

Same as the House-passed version (see H.R. 1, Sec. 5003, below). CBO estimated that this provision would increase federal spending by $1.3 billion over the FY2009-FY2014 five-year period.

## Medicaid and CHIP Protections for Indians

### H.R. 1. Sec. 5004. Protections for Indians Under Medicaid and CHIP.

#### *Explanation of Provision*

This provision would specify that no enrollment fee, premium or similar charge, and no deduction, co-payment, cost-sharing, or similar charge shall be imposed against an Indian who receives Medicaid-coverable services or items directly from the Indian Health Service (IHS), an Indian Tribe (IT), Tribal Organization (TO), or Urban Indian Organization (UIO), or through referral under the contract health service. In addition, Medicaid payments due to the IHS, an IT, TO, or UIO, or to a health care provider through referral under the contract health service for providing services to a Medicaid-eligible Indian, could not be reduced by the amount of any enrollment fee, premium or similar charge, as well as any cost-sharing or similar charge that would otherwise be due from an Indian, if such charges were permitted. A rule of construction would specify that nothing in this provision could be construed as restricting the application of any other limitations on the imposition of premiums or cost-sharing that may apply to a Medicaid-enrolled Indian. This language would also add Indians receiving services through Indian entities to the list of individuals exempt from paying premiums or cost-sharing under the DRA option for alternative premiums and cost-sharing under Medicaid. This provision would be effective October 1, 2009.

Further, the Indian protection provisions would prohibit consideration of four different classes of property from resources in determining Medicaid eligibility of an Indian. The provision would also apply this new language to SCHIP in the same manner it would apply to Medicaid and provide that certain income, resources, and property would remain exempt from Medicaid estate recovery if they were exempt under Section 1917(b)(3) of the Social Security Act (allowing the Secretary to specify standards for a state hardship waiver of asset criteria) under instructions regarding Indian tribes and Alaskan Native Villages as of April 1, 2003. The Secretary would be permitted to provide additional estate recovery exemptions for Indians under Medicaid. CBO's preliminary estimate of the effect of the Indian protection provisions on federal spending in the House-approved version of ARRA was for no spending increase in FY2009 or for the period FY2009-2013.

### S.Amdt. 570. Sec. 3301. Premiums and Cost Sharing Protections Under Medicaid, Eligibility Determinations Under Medicaid and CHIP, and Protection of Certain Indian Property from Medicaid Estate Recovery.

#### *Explanation of Provision*

This provision is nearly the same as H.R. 1, Sec. 5004, Protections for Indians Under Medicaid and SCHIP. The only difference is that S.Amdt. 570 does not specify an effective date.

## Indian Consultation on Medicaid and CHIP

### H.R. 1. Sec. 5005. Consultation on Medicaid and CHIP.

#### *Explanation of Provision*

The provision would require the Secretary to maintain within CMS a Tribal Technical Advisory Group (TTAG), previously established in accordance with requirements of a charter dated September 30, 2003. The provision also would require that the TTAG include a representative of the UIOs and IHS. The UIO representative would be deemed an elected official of a tribal government for the purposes of applying Section 204(b) of the Unfunded Mandates Reform Act of 1995, which exempts elected tribal officials from the Federal Advisory Committee Act for certain meetings with federal officials.

The provision also would require certain states to establish a process for obtaining advice on a regular, on-going basis from designees of Indian Health Providers (IHPs) and UIOs regarding Medicaid law and its direct effects on those entities. Applicable states would include those in which one or more IHPs or UIOs provide health care services. This process must include seeking advice prior to submission of state Medicaid plan amendments, waiver requests, or proposed demonstrations likely to directly affect Indians, IHPs, or UIOs. This process may include appointment of a medical care advisory panel. The advisory panel could include IHP and UIO designees who would provide input to states on their Medicaid plans. These consultation provisions also would apply to SCHIP.

Finally, the provision would prohibit construing these amendments as superseding existing advisory committees, working groups, guidance or other advisory procedures established by the Secretary or any state with respect to the provision of health care to Indians. In their preliminary estimate of the impact of the consultation with Indian health programs on federal spending, CBO forecasted less than a $50 million increase in federal outlays for FY2009 and the same $50 million amount for five-year period FY2009-2013 for this provision of the House-approved version of ARRA.

### S.Amdt. 570. Sec. 3303. Consultation on Medicaid, CHIP, and Other Health Care Programs Funded Under the Social Security Act Involving Indian Health Programs and Urban Indian Organizations.

#### *Explanation of Provision*

This provision is comparable to the House-approved provision in H.R. 1. Both versions would require the Secretary to maintain within CMS a Tribal Technical Advisory Group (TTAG), previously established in accordance with requirements of a charter dated September 30, 2003. The provision also would require that the TTAG include a representative of UIOs and the IHS. The UIO representative would be deemed an elected official of a tribal government for the purposes of applying Section 204(b) of the Unfunded Mandates Reform Act of 1995, which exempts elected tribal officials from the Federal Advisory Committee Act (FACA) for certain meetings with federal officials. Unlike in H.R. 1, however, under this provision in S.Amdt. 570, the TTAG would include a representative of a national urban Indian Health organization, rather than a representative of the UIOs. The non-application of FACA would still hold for a representative of a national UIO. CBO has not specifically estimated the effect of this provision on federal spending, but in scoring H.R. 1, CBO estimated there would be no effect on federal spending either in FY2009 or over five years.

## Temporary DSH Increase

### H.R. 1. Sec. 5006. Temporary Increase in DSH Allotments During Recession.

#### *Explanation of Provision*

This provision would increase states' FY2009 annual Disproportionate Share Hospital (DSH) allotments by 2.5% above the allotment they would have received in FY2009 (in FY2009, regular and low-DSH allotments increased by 4% over FY2008 allotment levels). In addition, states' DSH allotments in FY2010 would be equal to the FY2009 DSH allotment (with the adjustment) increased by 2.5%. After FY2010, states' annual DSH allotments would return to 100% of the annual DSH allotments as determined under current law. If under this provision states' annual DSH allotments grew at a greater rate than what they would have received without the 2.5% adjustment, then states would receive the higher DSH allotments without the recession adjustment. CBO's preliminary estimate of the financial impact of the temporary DSH allotment increase in the House-approved version of ARRA would be approximately $200 million in FY2009 and FY2010 and $500 million over the five-year period from FY2009-2013.

### S.Amdt. 570. Sec. 5002. Extension and Update of Special Rule for Increase of DSH Allotments for Low Income DSH States.

#### *Explanation of Provision*

Under this provision, states that reported to the Health and Human Services Secretary, as of August 31, 2009, FY2006 total (federal and state) disproportionate share hospital (DSH) allotments of less than 3% of the state's total state plan medical assistance expenditures would receive a special DSH allotments established under the Medicare Modernization Act of 2003

(MMA, P.L. 108-173).[12] This provision may affect the number of states that are determined to be low-DSH states since the provision would rely on a different base year than that used under MMA. Under this provision, low-DSH states would receive the following revised DSH allotments:

- for FY2009, the DSH allotment would be the FY2008 DSH allotment increased by 16%;
- for FY2010, the DSH allotment would be the FY2009 DSH allotment increased by 16%;
- for FY2011, for the first quarter (through December 31, 2010), the DSH allotment would be ¼ of the DSH allotment for FY2010 increased by 16%;
- for FY2011, the remainder of the fiscal year (January 1, 2011-September 30, 2011), the DSH allotment would be ¾ of the FY2010 DSH allotment for each qualified state without the changes contained in this provision;
- for FY2012, qualified states' DSH allotments would be FY2010 DSH allotment (as if this provision had not been enacted);
- for FY2013 and subsequent years, qualified states would receive the DSH allotment for the previous fiscal year with an inflation adjustment, as described in the Social Security Act (SSA), Section 1923(f)(5).

CBO estimated that the Senate amendment DSH allotment provision would increase federal spending by $400 million over the period from FY2009-2014.

# S.Amdt. 570 TITLE III—Health Insurance Assistance

## Qualifying Individual (QI) Program Extenstion

### S.Amdt. 570. Sec. 3201. Extension of the Qualifying Individual (QI) Program.

#### *Explanation of Provision*

This provision would extend the Qualifying Individual (QI) program an additional year from December 2009 to December 2010. Under the Medicare Savings Program (MSP), Medicaid pays

[12] The Medicare Modernization Act (MMA, P.L. 108-391) discontinued a special arrangement for extremely low DSH states and instead raised DSH allotments for low DSH states—defined as those states in which total DSH payments for FY2000 were less than 3% of the state's total Medicaid spending on benefits. DSH allotments for such states were raised for FY2004 through FY2008 by 16% above the prior year's DSH allotment. Under current law, for FY2009 forward, annual DSH allotments for low DSH states would be equal to the prior year's allotment amount increased by the change in the CPI-U (non-low DSH states would received the same adjustment). As a condition of receiving federal Medicaid payments for FY2004 and beyond, states were required to submit to the Secretary of HHS a detailed annual report and an independent certified audit on their DSH payments to hospitals.

Medicare Part B premiums for individuals with income between 120% and 135% of poverty (who otherwise do not qualify for Medicaid). These individuals are called Qualifying Individuals (QIs). Federal spending for the QI program is subject to annual limits. The QI program was recently extended through December 2009.[13] This provision approved by the Senate Committee on Finance would extend the QI program through December 2010 and establish specific funding limits:

- from January 1, 2010, through September 30, 2010, the total allocation amount would be $412.5 million, and
- from October 1, 2010, through December 31, 2010, the total allocation amount would be $150 million.

CBO estimated that the extension of the QI program would increase federal spending by $550 over the period FY2009-FY2014.

H.R. 1, does not have a comparable provision for QI program extension.

## Medicaid and CHIP Managed Care Rules for Indians

### S.Amdt. 570. Sec. 3302. Rules Applicable Under Medicaid and CHIP to Managed Care Entities with Respect to Indian Enrollees and Indian Health Care Providers and Indian Managed Care Entities.

#### *Explanation of Provision*

Under this provision, Medicaid managed care contracts with Managed Care Entities (MCEs) and Primary Care Case Management (PCCMs) companies would be required to meet conditions to receive Medicaid payments, including

- MCEs and PCCMs would need to demonstrate that the number of participating Indian health care providers was sufficient to ensure timely access to covered Medicaid managed care services for eligible enrollees, and
- MCEs and PCCMs would need to agree to pay Indian health care providers (IHPs) at rates equal to the rates negotiated between these organizations and the provider involved, or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which the MCE or PCCM would make for services rendered by a participating non-Indian health care provider.

In addition, this provision would specify that MCEs and PCCMs must agree to make prompt payment, as required under Medicaid rules for all providers, to participating Indian health care providers, and states would be prohibited from waiving requirements relating to assurance that payments are consistent with efficiency, economy, and quality.

[13] For more detail, see CRS Report R40082, *Medicare: Part B Premiums*, by (name redacted), and CRS Report RL34360, *P.L. 110-173: Provisions in the Medicare, Medicaid, and SCHIP Extension Act of 2007*, by (name redacted) et al.

Further, this provision would apply special payment provisions to certain Indian health care providers that are Federally Qualified Health Centers (FQHCs). For non-participating Indian FQHCs that provide covered Medicaid managed care services to Indian MCE enrollees, the MCE must pay a rate equal to the payment that would apply to a participating non-Indian FQHC. When payments to such participating and non-participating providers by an MCE for services rendered to an Indian enrollee with the MCE are less than the rate under the state plan, the state must pay such providers the difference between the rate and the MCE payment. Likewise, if the amount paid to a non-FQHC Indian provider (whether or not the provider participates with the MCE) is less than the rate that applies under the state plan, the state must pay the difference between the applicable rate and the amount paid by MCEs. Under this provision, Indian Medicaid MCEs would be permitted to restrict enrollment to Indians and to members of specific tribes in the same manner as IHPs may restrict the delivery of services to such Indians and tribal members.

Finally, the provision would apply specific sections affecting Medicaid to the SCHIP program, including (1) Section 1932(a)(2)(C) in current law regarding enrollment of Indians in Medicaid managed care (e.g., states cannot require Indians to enroll in a MCE unless the entity is the IHS, certain IHPs operated by tribes or tribal organizations, or certain urban IHPs operated by Urban Indian Organizations [UIOs]), and (2) the new Section 1932(h) as described above.

H.R. 1 does not include comparable managed care provisions. CBO did not separately estimate the effect of the Sec. 3302 provision on federal spending.

## Nursing Home Prompt Pay Requirements

### S.Amdt. 570. Sec. 3304. Application of Prompt Pay Requirements to Nursing Facilities.

#### *Explanation of Provision*

Under this provision, nursing facilities specifically would be listed in the SSA[14] as providers to receive payment for services within 30 days of the receipt of a reimbursement claim. This section of the SSA identifies requirements for state medical assistance programs. Under these requirements, states' Medicaid programs are to reimburse providers for 90% of claims submitted for payment within 30 days of receipt of the claim. Medicaid also is to process and pay 99% of claims within 90 days from the date of receipt of such claims. These requirements allow states additional time to process claims that are inaccurate, incomplete, or otherwise can not be processed. Penalties to states for failing to meet the claims processing requirements are not defined in the SSA. CBO preliminarily estimated the effect of this provision on federal spending would be an increase of $760 million in FY2009 and approximately a $290 million increase from FY2009-FY2014.[15]

H.R. 1 does not have a comparable prompt pay requirement to nursing facilities provision.

[14] For more detail, see SSA Sec. 1902(a)(37)(A).

[15] Phone conversation with Andrea Noda of the Congressional Budget Office on February 2, 2009.

## Sunset of Selected Provisions

### S.Amdt. 570. Sec. 3305. Period Of Application; Sunset.

#### *Explanation of Provision*

Under this provision, all provisions under subtitle D—Other Provisions of Title III—Health Insurance Assistance, would sunset at the end of the recession period, December 31, 2010:

- S.Amdt. 570. Sec. 3301. Premiums and Cost Sharing Protections Under Medicaid, Eligibility Determinations Under Medicaid and CHIP, and Protection of Certain Indian Property from Medicaid Estate Recovery;
- S.Amdt. 570. Sec. 3302. Rules Applicable Under Medicaid and CHIP to Managed Care Entities with Respect to Indian Enrollees and Indian Health Care Providers and Indian Managed Care Entities;
- S.Amdt. 570. Sec. 3303. Consultation on Medicaid, CHIP, and Other Health Care Programs Funded Under the Social Security Act Involving Indian Health Programs and Urban Indian Organizations; and
- S.Amdt. 570. Sec. 3304. Application of Prompt Pay Requirements to Nursing Facilities.

Any Amendments made under S.Amdt. 570, Title III, Subtitle D, Other Provisions, would be in effect only during the recession period, April 1, 2009-December 31, 2010. After January 1, 2011, Title XIX of the Social Security Act (Medicaid) would be applied, as if subtitle D had not been enacted.

H.R. 1 does not have a comparable provision to S.Amdt. 570's Period of Application; Sunset.

# S.Amdt. 570 TITLE V—State Fiscal Relief

## Payment to States for SSA Special Disability Workload Project

### S.Amdt. 570. Sec. 5003. Payment of Medicare Liability to States as a Result of the Special Disability Workload Project.

#### *Explanation of Provision*

Under this provision, within three months after enactment of this law, the Secretary, in consultation with the Social Security Commissioner, would negotiate an agreement on a payment amount to be made to each state for the Medicare Special Disability Workload (SDW) project.[16] Payments to states would be subject to certain conditions:

[16] Beginning in 1999, the Social Security Administration (SSA), determined that some individuals who were determined to be eligible for Supplemental Security Income (SSI), may have been eligible for Social Security (continued...)

- states would waive the right to file or be a part of any civil action in any federal or state court where payment was sought for liability related to the Medicare SDW project;
- states would release the federal government from any further claims for reimbursement of state expenditures arising from the SDW project;
- states that are parties to civil actions in any federal or state court seeking reimbursement for the SDW project, would be ineligible to receive payment under this provision while such action is pending or if it is resolved in a state's favor.

In negotiating with states, the Secretary and SSA Commissioner would use the most recent federal data available, including estimates, to determine the amount of payment to be offered to each state that elects to enter into an agreement with the Secretary. The payment methodology would consist of the following factors:

- the number of SDW cases that were eligible for benefits under Medicare and the month when these cases initially became eligible;
- the applicable non-federal share of Medicaid expenditures made by states during the period these cases were eligible; and
- other factors determined appropriate by the Secretary and the SSA Commissioner in consultation with states.

However, as a condition of payment under a negotiated agreement for SDW cases, states would not be required to submit individual paid Medicaid claims (data).

To make payments to states for the SDW project, $3 billion would be appropriated for FY2009 from money in the treasury not otherwise appropriated. Aggregate payments to states could not exceed $3 billion. Payments to states would be provided within four months from the date of enactment of ARRA.

An SDW case would be defined as an individual determined by the SSA Commissioner to have been eligible for benefits under Title II of the SSA for a period during which such benefits were not provided to the individual and who was, during all or part of such period, enrolled in Medicaid. CBO estimated that the Medicare SDW provision would increase federal spending by $3 billion in FY2009, with no effect beyond FY2009.

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(...continued)

Disability Income (SSDI). SSI beneficiaries are eligible for Medicaid, whereas SSDI beneficiaries receive Medicare coverage after a two-year waiting period, provided their disability status is unchanged.

Individuals who were identified by SSA under the SDW program may have qualified as dual eligibles (eligible for both Medicare and Medicaid) to receive both Medicare and Medicaid. Estimates of the number of SDW individuals varies, but may be as high as 466,000, some dating back a number of years. If SDW individuals were eligible for SSDI, rather than SSI, then these SDW individuals could have been receiving Medicare benefits, after the 2-year waiting period. States may have paid for the SDW-individuals' medical care under Medicaid, rather than paying only for their Medicare premiums through Medicaid. At least 31 states are seeking restitution through administrative remedies for some or all of their expenditures under Medicaid for SDW cases.

For more detail, see, the Social Security Administrator's Identification of Special Disability Workload Cases (A-13-05-15028), Office of the Inspector General, Social Security Administration, January 2006, http://www.ssa.gov/oig/ADOBEPDF/A-13-05-15028.pdf.

H.R. 1 does not have a provision comparable to S.Amdt. 570's Payment of Medicare Liability to States as a Result of the Special Disability Workload Project.

## OIG Medicaid Integrity Funding for Recession

### S.Amdt. 570. Sec. 5004 Funding for the Department of Health and Human Services Office of the Inspector General.

#### *Explanation of Provision*

Under this provision, the Health and Human Services Office of the Inspector General (HHS OIG) is to receive $31.25 million to ensure the proper expenditure of federal funds. These funds are appropriated from any money in the Treasury not otherwise appropriated and are available throughout the recession period (defined as October 1, 2008- December 31, 2010). Amounts appropriated under this provision would be available until September 30, 2012, without further appropriation, and would be in addition to any other amounts appropriated or made available to HHSOIG. CBO has not estimated the effect of the OIG funding on federal spending.

H.R. 1 does not have a provision comparable to S.Amdt. 570's Funding for the Department of Health and Human Services Office of the Inspector General.

## GAO Study on Medicaid During Recessions

### S.Amdt. 570. Sec. 5005. GAO Study and Report Regarding State Needs During Periods of National Economic Downturn.

#### *Explanation of Provision*

Under this provision, the Comptroller General of the United States, the Government Accountability Office (GAO), would study the current (on the date of enactment of the legislation) economic recession as well as previous national economic downturns since 1974. GAO would develop recommendations to address states' needs during economic recessions, including the past and projected effects of temporary increases in the federal medical assistance percentage (FMAP) during these recessions. By April 1, 2011, GAO would submit a report to appropriate congressional committees that would include the following:

- Recommendations for modifying the national economic downturn assistance formula for temporary Medicaid FMAP adjustments (a "countercyclical FMAP," as described in GAO report number, GAO-07-97),[17] to improve the effectiveness of the countercyclical FMAP for addressing states' needs during national economic downturns:
    - what improvements are needed to identify factors to begin and end the application of a countercyclical FMAP;

[17] See http://www.gao.gov/new.items/d0797.pdf

  - how to adjust the amount of a countercyclical FMAP to account for state and regional variations; and
  - how a countercyclical FMAP could be adjusted to better account for actual Medicaid costs incurred by states during economic recessions.
- Analysis of the impact on states of recessions, including declines in private health insurance benefits coverage; declines in state revenues; and maintenance and growth of caseloads under Medicaid, SCHIP, or any other publically funded programs that provide health benefits coverage to state residents.
- CBO has not specifically estimated the effect of the GAO study and report on federal spending.

H.R. 1 does not have a comparable provision to S.Amdt. 570's GAO Study and Report Regarding State Needs During Periods of National Economic Downturn.

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