Medicaid and Children's Health Insurance Program (CHIP) Provisions in Affordable Health Care for America Act (H.R. 3962)

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Summary

The 111th Congress has devoted considerable effort to health reform that seeks to increase health insurance coverage for more Americans and help to control costs, while improving quality and patient outcomes. The Affordable Health Choices for America Act (H.R. 3962) was introduced in the House of Representatives on October 29, 2009. H.R. 3962 is based on H.R. 3200, America's Affordable Health Choices Act of 2009, originally introduced on July 14, 2009, and reported separately on October 14, 2009, by three House Committees—Education and Labor, Energy and Commerce, and Ways and Means. H.R. 3962 was further modified by the manager's amendment posted on November 3, 2009. H.R. 3962, as passed by the House on November 7, 2009, proposes sweeping reforms of the health care delivery system, described in the three divisions. Division A, "Affordable Health Care Choices," focuses on reducing the number of uninsured, restructuring the private health insurance market, setting minimum standards for health benefits, and providing financial assistance to certain individuals and small employers. Division B, "Medicare and Medicaid Improvements," proposes modifications to the largest two public health insurance programs to make them consistent with provisions in Division A and to amend other provisions in existing federal statute. Division C, "Public Health and Workforce Development," would amend and expand existing health professions and nursing workforce programs. A Republican alternative amendment in the nature of a substitute, dated November 3, 2009, is addressed in a separate CRS report.

This report summarizes the major provisions affecting Medicaid and CHIP in H.R. 3962 (as passed), including modifications made by the manager's amendment. The report focuses primarily on provisions in Division B, Title VII—Medicaid and CHIP, plus selected provisions in Title IX—Miscellaneous Provisions. It also describes selected sections of Titles I and II of Division D, the Indian Health Care Improvement Act Amendments of 2009, related to improving access to Medicaid and CHIP for American Indians and Alaskan Natives. Due to the breadth of the changes proposed in H.R. 3962, some provisions of Divisions A and C also could affect Medicaid, but these are not Medicaid-specific. The Division B provisions would modify existing law and add new provisions affecting Medicaid eligibility; benefits; financing; waste, fraud, and abuse; payments to territories; demonstrations and pilot programs; and other miscellaneous Medicaid components. A major provision in Division B would expand Medicaid eligibility for traditional and non-traditional beneficiary categories up to 150% of the federal poverty level. The federal government would fully finance the costs for certain of these expanded beneficiary categories for periods before 2015, decreasing to 91% beginning in 2015. With respect to benefits, Medicaid programs would be required to cover preventive services, and would be allowed to cover nurse home visitation and birthing center services.

There are a number of financing changes that would affect Medicaid under H.R. 3962, including reducing Medicaid disproportionate share hospital (DSH) payments by $10 billion by FY2019, increasing prescription drug rebates, and raising provider payments for certain primary care services. Additional waste, fraud, and abuse provisions affecting Medicaid and the Children's Health Insurance Program (CHIP) include requirements to deny payment for health care acquired conditions, require new Medicaid Integrity Program evaluations and reports, and require states to implement a national correct coding initiative, similar to the Medicare program. Under H.R. 3962, spending caps for the territories would be increased, and a series of demonstrations would be approved, including a medical home program, an accountable care organization program, and a program for stabilization of emergency medical conditions by mental disease institutions.

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Status of House Legislation

H.R. 3962, Affordable Health Care for America Act, was introduced in the House of Representatives on October 29, 2009. H.R. 3962 is based on H.R. 3200, America's Affordable Health Choices Act of 2009, originally introduced on July 14, 2009, and reported separately on October 14, 2009, by three House Committees—Education and Labor, Energy and Commerce, and Ways and Means. H.R. 3962 was further modified by the manager's amendment posted on November 3, 2009. On November 7, 2009, H.R. 3962, as amended, was passed by the House. A Republican alternative amendment in the nature of a substitute, dated November 3, 2009, is addressed in a separate CRS report.[1]

On November 6, the Congressional Budget Office (CBO) released an updated estimate of the direct spending and revenue effects of H.R. 3962, incorporating the manager's amendment proposed on November 3, and enactment of H.R. 3548 (the Worker, Homeownership, and Business Assistance Act of 2009, signed into law on November 6. This estimate projects the bill would reduce federal deficits by $109 billion over the 10-year period of 2010-2019 and, by 2019, would insure 96% of the non-elderly, legally present U.S. population. The gross 10-year cost of the Exchange subsidies ($610 billion), increased federal Medicaid expenditures ($425 billion), and tax credits for small employers ($25 billion) would total $1.052 trillion. Taking into account employer and individual tax penalties and other issues pertaining to coverage, the net cost of the coverage provisions, according to the CBO analysis, would be $891 billion over 10 years. "Over the 2010-2019 period, the net cost of the coverage expansions would be more than offset by the combination of other spending changes, which CBO estimates would save $427 billion, and receipts resulting from the income tax surcharge on high-income individuals and other provisions, which JCT [the Joint Committee on Taxation] and CBO estimate would increase federal revenues by $574 billion over that period."[2] The Office of the Actuary, within the Centers for Medicare and Medicaid Services (CMS), has issued an alternative estimate of the financial effects of H.R. 3962 as passed by the House on November 7, 2009.

On November 13, 2009, CMS's Office of the Actuary approximated potential monetary and coverage impacts of the non-tax provisions in H.R. 3962.[3] According to the CMS report, the cost of H.R. 3962, ignoring the tax offsets, is $935 billion. This is only slightly higher than CBO's estimate of $891 billion, which includes the tax provisions. In addition, the CMS memorandum projected that H.R. 3962 would insure an additional 34 million legal residents, or 93 % of the U.S. population. The Office of the Actuary also estimated possible impacts on the health care system as a whole.

[1] See CRS Report R40906, *Overview of Provisions in the Amendment in the Nature of a Substitute to H.R. 3962 Offered by Mr. Boenher of Ohio,* coordinated by (name redacted), (name redacted), and (name redacted).

[2] Congressional Budget Office, letter to Rep. John D. Dingel, "Analysis of the Affordable Health Care for America Act," http://www.cbo.gov/ftpdocs/107xx/doc10710/hr3962Dingell_mgr_amendment_update.pdf.

[3] Centers for Medicare & Medicaid Services, "Estimated Financial Effects of the "America's Affordable Health Choices Act of 2009," http://republicans.waysandmeans.house.gov/UploadedFiles/OACT_Memorandum_on_Financial_Impact_of_H_R__3962__11-13-09_.pdf.

Overview of H.R. 3962

H.R. 3962 proposes sweeping reforms of the U.S. health insurance and health care system. The three major components of the bill are designated Divisions A, B, and C. Division A, "Affordable Health Care Choices," focuses on reducing the number of uninsured, restructuring the private health insurance market, setting minimum standards for health benefits, and providing financial assistance to certain individuals and, in some cases, small employers. Division B, "Medicare and Medicaid Improvements," proposes modifications to the largest two public health insurance programs to make them consistent with the changes proposed in Division A and to amend other provisions in existing federal statute. Division B also introduces a number of technical changes intended to improve quality of care, reduce federal and state expenditures, and address coverage gaps for both Medicare and Medicaid. For Medicaid, among other major proposals, Division B would expand Medicaid eligibility for traditional and non-traditional beneficiary categories up to 150% of the federal poverty level (FPL). Division C, "Public Health and Workforce Development," would amend and expand existing health professions and nursing workforce programs.

Report Overview

This report provides a discussion of the Medicaid and CHIP provisions contained in H.R. 3962, and is divided into seven major categories:

- Eligibility.
- Benefits.
- Financing.
- Waste, Fraud, and Abuse.
- Payments to Territories.
- Demonstrations and Pilot Programs.
- Miscellaneous.

Each topic contains a brief summary of existing Medicaid law and related background to provide context for the description of changes proposed by H.R. 3962.

Eligibility

Medicaid is a means-tested entitlement program operated by states within broad federal guidelines. To qualify, an individual must meet both categorical (i.e., must be a member of a covered group such as children, pregnant women, families with dependent children, the elderly, or the disabled) and financial eligibility requirements. Medicaid's financial requirements place limits on the maximum amount of assets and income individuals may possess to participate in Medicaid. Additional guidelines specify how states should calculate these amounts. The specific asset and income limitations that apply to each eligibility group are set through a combination of federal parameters and state definitions. Consequently, these standards vary across states, and different standards apply to different population groups within states.

Of the approximately 50 different eligibility "pathways" into Medicaid, some are mandatory while others may be covered at state option. Examples of groups that states *must* provide Medicaid to include pregnant women and children under age six with family income below 133% of the federal poverty level (FPL), and poor individuals with disabilities or poor individuals over age 64 who qualify for cash assistance under the SSI program. Examples of groups that states *may* choose to cover under Medicaid include pregnant women and infants with family income exceeding 133% FPL up to 185% FPL, and "medically needy" individuals who meet categorical requirements with income up to 133% of the maximum payment amount applicable under states' former Aid to Families with Dependent Children (AFDC) programs based on family size.[4] "Childless adults" (nonelderly adults who are not disabled, not pregnant and not parents of dependent children), for example, are generally not eligible for Medicaid, regardless of their income.

H.R. 3962 makes several changes to Medicaid eligibility. Among the provisions that would impact eligibility, the bill would add four new mandatory eligibility groups, and add two new optional eligibility groups. In addition, it would make several modifications to existing eligibility groups, and add provisions to facilitate outreach and enrollment in Medicaid, CHIP, and the Health Insurance Exchange.[5]

New Mandatory Eligibility Expansions

H.R. 3962 would add four new mandatory eligibility groups to the Medicaid statute (i.e., one "non-traditional" eligibility group and three "traditional" eligibility groups) beginning in 2013:

1. Individuals under age 65 who are (1) not otherwise eligible for Medicaid under existing mandatory eligibility categories (e.g., childless adults), (2) not entitled to Medicare Part A, and (3) have family income up to 150% of the federal poverty level as determined using methodologies and procedures specified by the Secretary of the Department of Health and Human Services (the Secretary) in consultation with the Health Choices Commissioner. (The Commissioner is primarily in charge of enforcing new private health insurance standards and would oversee the Health Insurance Exchange, as described in Sec. 142 of H.R. 3962). Full Medicaid benefits would be available to these "non-traditional" individuals, and would be fully financed by the federal government (i.e., the applicable federal medical assistance percentage would be 100%) for the periods before 2015, decreasing to 91% beginning in 2015.
2. Individuals over age 18 and under age 65 who (1) would otherwise be eligible for Medicaid as an individual who would qualify for the Supplemental Security Income for the Aged, Blind and Disabled program, the former AFDC program, and the Foster Care or Adoption Assistance (Title IV-Part E) program; or (2) would be a member of certain low-income families eligible under Section 1931

[4] Unlike most other eligibility groups, medical expenses (if any) may be subtracted from income in determining financial eligibility for medically needy coverage, which is often referred to as "spend down,"

[5] Similar to existing state health reform models, such as the Massachusetts Connector, the Exchange would facilitate the purchase of qualified health benefit plans by individuals and businesses. The Exchange would not be a health insurer; but would provide eligible individuals and small businesses a vehicle to shop and compare insurers' health plans. For more information on the Insurance Health Exchange, see CRS Report R40885, *Private Health Insurance Provisions of H.R. 3962*, by (name redacted) et al..

(based on the income standards, methodologies, and procedures in effect as of June 16, 2009). For both groups, the upper income limit would not exceed 150% of the FPL. Full Medicaid benefits would be provided to these "traditional" eligible individuals and would be fully financed by the federal government (i.e., the applicable federal medical assistance percentage would be 100%) for the periods before 2015, decreasing to 91% beginning in 2015.

3. Children through age 18 who (1) would otherwise be eligible for Medicaid as an individual who would qualify for the Supplemental Security Income for the Aged, Blind and Disabled program, the former AFDC program, and the Foster Care or Adoption Assistance (Title IV-Part E) program, (2) are infants with family income between 133% and 150% of the FPL, (3) are children age 1 through age 5 with family income between 133% and 150% of the FPL; or (4) are age 6 through age 18 with family income between 100% and 150% of the FPL (based on the income standards, methodologies and procedures in effect as of June 16, 2009). Full Medicaid benefits would be available to these expanded "traditional" child populations and would be matched at the CHIP enhanced matching rate beginning with 2014.
4. Other children not described above under the age of 19 who would be eligible as CHIP targeted low-income children under Medicaid as of June 16, 2009. Full Medicaid benefits would be available to these "traditional" child populations and would be matched at the CHIP enhanced matching rate beginning with 2014.

All of the new mandatory eligibility groups would include individuals covered under Medicaid waivers and those receiving coverage paid for with state only funds.

The Medicaid statutory language that deems certain newborns to be eligible for Medicaid for up to one year would be extended to include children born in the U.S up to the first 60 days of life who do not have acceptable coverage upon birth. Full Medicaid benefits would be available to such children and would be fully financed by the federal government (i.e., the applicable federal medical assistance percentage would be 100%) for the periods before 2015, decreasing to 91% beginning in 2015.

States would not be permitted to enroll "non-traditional" Medicaid eligibles in a managed care entity unless the state demonstrates that the entity has the capacity to meet the health, mental health, and substance abuse needs of such individuals.

CBO's estimate of the cost for this provision is included in the estimate for expanding health insurance coverage (except for Medicare cost-sharing assistance), and is represented in the net cost of coverage provisions, estimated to be $891 billion over the FY2010-FY2019 period.

Medicaid and CHIP Maintenance of Current Eligibility

As a condition of continued availability of federal Medicaid matching funds, states would not be permitted to adopt eligibility standards, methodologies, or procedures in their Medicaid or CHIP programs (including waivers)[6] that would be more restrictive than those in effect as of June 16,

[6] The Secretary of the Department of Health and Human Services would be required to extend authority and federal financial participation for Section 1115 demonstration waivers for such period as may be required for a state to meet (continued...)

2009. States would also not be eligible for federal matching funds for the application of an asset or resource test in determining (or re-determining) eligibility for individuals in specified Medicaid eligibility groups (e.g., the former AFDC program, and the Foster Care or Adoption Assistance (Title IV-Part E) program; certain first-time pregnant women who would be eligible for Temporary Assistance to Needy Families (TANF) if the child was born; pregnant women and children under age six with family income below 133⅓% of the federal poverty level (FPL); families who meet the requirements of the former AFDC programs in effect in their states on July 16, 1996; or any of the new mandatory eligibility groups added under this bill). Medicaid benchmark or benchmark equivalent coverage[7] must meet the minimum benefits and cost-sharing standards of a basic plan offered through the Health Insurance Exchange (the Exchange).

With regard to the CHIP program, the CHIP maintenance of effort (MOE) requirements would prohibit states from having in effect eligibility standards, methodologies, or procedures that are more restrictive than what was in effect on June 16, 2009. This MOE requirement would terminate on December 31, 2013, after which CHIP eligibles would receive coverage through the Exchange. The bill would also prohibit the Congress from appropriating or authorizing to be appropriated federal CHIP funds beyond the program's current authorization period (i.e., 2013). The CHIP MOE provision would not prevent a state from imposing limitations (e.g., limiting acceptance of applications or imposing a waiting list) in order to limit expenditures under dental-only separate CHIP programs (per Section 2105 of the Social Security Act) for that fiscal year.

No later than December 31, 2011 the Secretary would be required to submit a report to Congress that compares the benefits packages offered under an average State children health plan in 2011 to the benefit standards initially adopted for plans available under the Exchange. The report would be required to include recommendations to ensure that such coverage is at least comparable to the coverage provided to children under an average State child health plan, and there are procedures in effect to enroll CHIP enrollees at the end of 2013 into qualified health benefits plans, or into other acceptable coverage without interruption or a written plan of treatment.

Finally, in case of a state with a Medicaid or CHIP waiver under Section 1115 in effect on June 16, 2009, that permits childless individuals to be eligible solely to receive a premium or cost-sharing subsidy for individual health insurance coverage, effective for coverage provided in 2013, the Secretary may permit the state to amend such waiver to apply more restrictive eligibility standards, methodologies, or procedures with respect to such individuals under the waiver without regard to the Medicaid and CHIP maintenance of eligibility requirements specified above.

CBO's estimate of the cost for this provision is included in the estimate for expanding health insurance coverage, and is represented in the net cost of coverage provisions, estimated to be $891 billion over the FY2010- FY2019 period.

(...continued)

the maintenance of effort requirement.

[7] For more information on Medicaid benchmark or benchmark-equivalent coverage, see CRS Report RL33202, *Medicaid: A Primer*, by (name redacted).

Supplemental Security Income (SSI) Disregard of Compensation for Participation in Clinical Trials

Supplemental Security Income (SSI) is a means-tested program that provides cash benefits to aged, blind and disabled individuals. A person's eligibility for SSI benefits is based on his or her countable income and resources and the amount of an SSI recipient's monthly benefit is based on his or her countable income. Under current law, compensation received for participation in a clinical trial is counted as both income and resources under SSI program rules. Generally, an SSI recipient is also eligible for Medicaid, either automatically or through a separate application based on state law and policy. In addition, SSI's income and resource counting rules are used to determine eligibility for persons age 65 and older and persons with disabilities under Medicaid's SSI-related eligibility pathways.

H.R. 3962 would disregard, from the income and resources counted to determine SSI eligibility and benefit levels, the first $2,000 earned in a year in exchange for a person's participation in a clinical trial to test a treatment for a rare disease or condition, as defined by Section 5(b)(2) of the Orphan Drug Act.[8]

This provision may allow additional clinical trial participants to become or remain eligible for the SSI program. Since SSI eligibility generally results in eligibility for Medicaid, this provision may also result in increased Medicaid participation. This provision would be required to become effective for calendar months beginning after the earlier of the date the Commissioner of Social Security promulgates regulations or a 180-day period that begins with this bill's enactment.

CBO estimates this provision would have no effect on direct spending over the FY2010-FY2019 period.

New Optional Eligibility Expansions for Family Planning Services and Individuals with HIV Infection

H.R. 3962 would add two new optional categorically needy eligibility groups to Medicaid. One new group would be comprised of (1) non-pregnant individuals with income up to the highest level applicable to pregnant women covered under a Medicaid or CHIP state plan, and (2) certain individuals eligible for existing Section 1115 waivers that provide family planning services and supplies. Benefits for such individuals would be limited to family planning services and supplies and also would include related medical diagnosis and treatment services. The provision also would allow states to make a "presumptive eligibility" determination for individuals eligible for such services through the new optional eligibility group. (Under current law, presumptive eligibility determinations can be made for children, pregnant women, and certain women with breast or cervical cancer.) That is, states may enroll such individuals for a limited period of time before full Medicaid applications are filed and processed, based on a preliminary determination by Medicaid providers of likely Medicaid eligibility. (Such individuals would then be required to formally apply for coverage within a certain timeframe to continue receiving benefits.) In addition, states would not be allowed to provide Medicaid coverage through benchmark or benchmark-equivalent plans, which are permissible alternatives to traditional Medicaid benefits for some Medicaid beneficiaries under current law, unless such coverage includes family

[8] 21 U.S.C. § 360ee(b)(2).

planning services and supplies. This provision would be effective upon enactment. CBO estimates this provision would have no effect on direct spending over the FY2010-FY2019 period.

The second new optional eligibility group under H.R. 3962 would be comprised of individuals who have HIV infection with income and resources that do not exceed the income and resource levels for that state's SSI-related Medicaid eligibility group. The federal government's share of expenditures for this new eligibility group would be based on the enhanced federal medical assistance percentage (FMAP) applicable to CHIP. The medical expenditures associated with this group in the territories would be matched without regard to the existing Medicaid spending caps. CBO estimates that this provision would cost $1.1 billion over the FY2010-FY2019 period.

Provisions of H.R. 3962 that Modify Existing Eligibility Groups

Extension of Transitional Medical Assistance (TMA) Coverage

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 employment hours.

However, in 1988, Congress expanded work-related TMA (under Section 1925 of the Medicaid statute), requiring states to provide at least six, with the option to provide up to 12, months of coverage. Since 2001, these work-related TMA requirements have been funded by a series of short-term extensions. In the latest Congressional action, the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) extends work-related TMA through December 31, 2010. H.R. 3962 would further extend work-related TMA under Section 1925 through December 31, 2012. CBO estimates this provision would cost $2.4 billion over the FY2010-FY2019 period.

Medicare Savings Program: Expansion of Qualified Medicare Beneficiaries (QMBs) and Extension of Qualified Individuals (QIs)

Certain low-income Medicare beneficiaries who are aged or have disabilities, as defined under the Supplemental Security Income (SSI) program, are eligible for Medicaid coverage of some or all of their Medicare Part B premiums, deductibles, and coinsurance under the Medicare Savings Program (MSP). Other Medicaid covered services are not covered for these individuals unless they qualify for Medicaid through other eligibility pathways (e.g. via SSI, medically needy, or the special income rule).

Medicare Savings Program groups include Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs). QMBs have incomes no greater than 100% of the FPL and until December 31, 2009, assets no greater than $4,000 for an individual and $6,000 for a couple. Beginning on January 1, 2010, individuals will be able to qualify as a QMB with assets up to $11,010 for an individual and $22,010 for a couple. Medicaid pays the Medicare premiums, coinsurance and deductibles for QMBs. SLMBs meet QMB criteria, except that their income is greater than 100% of FPL and does not exceed 120% FPL. Medicaid pays Medicare premiums on behalf of SLMBs. QIs meet the QMB criteria, except

that their income is between 120% and 135% of poverty and they are not otherwise eligible for Medicaid. Medicaid covers Medicare premiums for QIs.

For QMBs and SLMBs the federal government currently contributes at the State's regular FMAP, and for QIs the federal government pays 100% of the costs up to each state's allocation. The QI program is currently slated to terminate December 2010.

H.R. 3962 would expand the upper income eligibility threshold for QMBs to 150% of poverty. As under current law, QMBs with income up to 100% of poverty would continue to receive Medicaid coverage of their Medicare premiums, coinsurance, and deductibles. For QMBs with income from 100% up to 150% of poverty, H.R. 3962 would require Medicaid to pay Medicare coinsurance and deductibles for such individuals. CBO estimates this provision would cost $7.2 billion over the FY2010-FY2019 period.

Regarding the asset test for the Medicare Savings Program, the bill would delay the increase currently scheduled to begin on January 1, 2010, to begin on January 1, 2012 and set the new asset test levels to $17,000 for an individual and $34,000 for a couple. These amount would be indexed annually by the Consumer Price Index (CPI). CBO's estimate of the cost for this provision is bundled into an estimate of a set of provisions impacting the Medicare Savings Program and Low-Income Subsidy Programs.

The bill would also extend the QI group through December 2012. The federal government would continue to pay 100% of the cost of the QI group. State allocation limits would no longer apply. CBO estimates this provision would cost $1.5 billion over the FY2010-FY2019 period.

State Option to Disregard Certain Income in Providing Continued Medicaid Coverage for Certain Individuals with Extremely High Prescription Costs

Outpatient prescription drugs are an optional Medicaid benefit, but all states cover prescription drugs for most beneficiary groups. Under Medicaid law, states must cover certain categories of low-income individuals. These "categorically eligible" individuals include low-income pregnant women, children, families with dependent children, the elderly, and certain people with disabilities. States have the option to extend coverage to other individuals that meet these categorical requirements, but who have higher income levels. Federal law also gives states the option of allowing certain individuals with high medical expenses to qualify for Medicaid through so-called "spend-down" groups. Under these groups, people qualify only if their medical expenses (on such things as nursing home care, prescription drugs, etc.) deplete, or spend down, their income and assets to specified Medicaid thresholds.

For most beneficiaries and services, state Medicaid programs are allowed to establish "nominal" service-related cost-sharing requirements. Nominal amounts are defined in regulations and are generally between $0.50 and $3 (adjusted annually for medical inflation), depending on the cost of the service provided. As an alternative to these traditional, nominal cost-sharing rules, the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) provided states the option to increase beneficiary cost-sharing.[9] Total aggregate cost-sharing cannot exceed 5% of monthly or quarterly

[9] For individuals in families with income below 100% FPL, service-related cost-sharing cannot exceed nominal amounts. For individuals in families with income between 100% and 150% FPL, service-related cost-sharing cannot exceed 10% of the cost of the item or service. For individuals in families with income above 150% FPL, service-related (continued...)

family income. Certain groups and services are exempt from the nominal and the DRA cost-sharing rules.

Under H.R. 3962, states would have the option to disregard family income when re-determining eligibility for individuals with extremely high prescription drug costs, but individuals would need to otherwise qualify for Medicaid without the benefit of this special disregard. Individuals would be considered to have extremely high prescription drug costs for a 12-month period if (1) they have health insurance coverage, including prescription drug coverage, that has at least a maximum lifetime limit of $1 million; (2) they have exhausted all available prescription drug coverage; (3) their anticipated annual orphan drug costs will be in excess of $200,000; and (4) their annual family income does not exceed 75% of the amount incurred for such orphan drugs.[10]

States also would have the option to apply family income disregards in determining individuals' Medicaid eligibility for the extremely high prescription drug benefit at any level so long as the income disregard did not exceed $200,000 in 2009 or 2010 (adjusted for medical inflation in subsequent years). For otherwise eligible individuals with income exceeding this ceiling, states may disregard income equal to the cost of the orphan drugs used by the beneficiary. States would be required to at least apply Medicaid's nominal cost-sharing rules to these beneficiaries, and would have the option to apply additional cost-sharing up to DRA cost sharing rules. CBO estimates this provision would cost $0.5 billion over the FY2010-FY2019 period.

Medicaid Coverage for Citizens of Freely Associated States

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104-193) limited access of noncitizens (aliens) to certain federal benefits including eligibility for non-emergency Medicaid, food stamps, Supplemental Security Income (SSI), and TANF to only those categories of aliens considered "qualified aliens" (e.g., legal permanent residents, asylees, and refugees). Citizens of the Freely Associated States (i.e., citizens of the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau) are not considered qualified aliens under PRWORA. Prior to PRWORA, citizens of the Freely Associated States were not barred from Medicaid. In addition, under current law with some exceptions, qualified aliens arriving in the United States after August 22, 1996, are barred from full-Medicaid coverage for the first five years after entry. Coverage of such persons after the five-year bar is permitted at state option if such individuals meet other eligibility requirements.

H.R. 3962 would make citizens of the Freely Associated States eligible for full Medicaid (without regard to the five-year bar) if they are (1) lawfully residing in the United States, (2) lawfully residing in the territories and possessions of the United State in accordance with the Compacts of Free Association between the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau and at the options of the Governors of each such territory (as communicated in writing to the Secretary of HHS), and (3) are otherwise eligible for such coverage. CBO estimates this provision would cost $0.2 billion over the FY2010-FY2019 period.

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cost-sharing cannot exceed 20% of the cost of the item or service.

[10] Orphan drugs are prescription drugs designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 5 360bb) as a drug for a rare disease or condition.

Medicaid Coordination with Other Programs

Medicaid Coordination with Health Insurance Exchange

H.R. 3962 includes a provision that would require state Medicaid agencies to enter into a Medicaid memorandum of understanding (MOU) with the Health Choices Commissioner, acting in consultation with the Secretary, to coordinate implementation of the provisions on private health insurance, the Health Insurance Exchange, and health insurance premium credits with the Medicaid state plan to ensure the enrollment of Medicaid eligible individuals in acceptable coverage. Pursuant to this MOU, states would be required to accept without further determination the enrollment of traditional and non-traditional Medicaid eligible individuals (defined above) who are determined eligible by the Exchange. The state may conduct redeterminations of eligibility for these individuals consistent with the periodicity outlined in the MOU.

If the Commissioner determines that a state Medicaid agency has the capacity to make determinations of eligibility for health insurance affordablity credits, then the MOU would provide for the following: (1) the state Medicaid agency must conduct such determinations for any Exchange-eligible individual who requests such a determination; (2) in the case that a state Medicaid agency determines that an Exchange-eligible individual is not eligible for affordability credits, the agency must forward the information on the basis of which such determination was made to the Commissioner; and (3) the Commissioner must reimburse the state Medicaid agency for the costs of conducting such determinations. In the case of an individual that applies for health insurance affordablity credits but based on the MOU the state does not have the authority to make such an eligibility determination, the state would be required to refer the individual to the Commissioner for an eligibility determination.

In the case of a child born in the United States who at the time of birth is not otherwise covered under acceptable coverage, the child would be deemed to be a "non-traditional" Medicaid eligible and enrolled in Medicaid. For such children, the state would provide for a Medicaid eligibility determination not later than the date the child otherwise is covered under acceptable coverage (or, if earlier, the end of the month in which the 60-day period, beginning on the date of birth, ends). For such children who still do not have acceptable coverage at the end of the above defined period, the child would be deemed to be a traditional Medicaid eligible individual until such time as the child obtains acceptable coverage or the state otherwise determines the child to be eligible for the state Medicaid plan.

CBO's estimate of the cost for this provision is included in the estimate for expanding health insurance coverage, and is represented in the net cost of coverage provisions, estimated to be $891 billion over the FY2010-FY2019 period.

Medicaid Coordination with CLASS Program

H.R. 3962 would establish a publicly administered voluntary LTC insurance program within the Community Living Assistance and Supports (CLASS) provisions. The CLASS program would pay benefits to eligible persons who would require long-term care services. Such benefits would include cash payments set at a minimum of $50 a day, but amounts would vary based on the degree of the beneficiary's functional or cognitive impairment. Other benefits of the CLASS program would include advocacy services and advice and assistance counseling on accessing and coordinating LTC services. Under H.R. 3962, employed individuals aged 18 and older or

individuals who are non-working non-institutionalized spouses of workers could voluntarily enroll in the CLASS program.

Regarding Medicaid, H.R. 3962 would ensure that Medicaid comply with the CLASS program regulations concerning primary and secondary payers for those Medicaid eligible individuals who are also beneficiaries of the CLASS program. Specifically, the CLASS program would be the primary payer for LTC services for Medicaid enrollees and Medicaid would be the secondary payer. CLASS beneficiaries receiving institutional care and eligible for Medicaid would be able to retain 5% of the CLASS program daily or weekly applicable cash benefit (in addition to Medicaid's personal needs allowance). The remainder of the benefit would be applied to the facility's cost of providing the beneficiary's care. Medicaid would be required to provide secondary coverage of such care. For those receiving home- and community-based services, the state would receive 50% of a beneficiary's daily or weekly cash benefit from the CLASS program.

Not later than two years after enactment, H.R. 3962 would also require each state to assess the extent to which certain long-term care providers, public authorities created to provide personal care services to individuals eligible for Medicaid under the state plan, and nonprofit organizations, are serving or have the capacity to serve as fiscal agents for the CLASS program; help ensure an adequate supply of the workers for individuals receiving CLASS program benefits, including in rural and underserved areas; and ensure that the designation of certain entities in the CLASS program would not negatively alter or impede existing programs that provide for consumer controlled or self-directed home and community services, among other requirements. CBO's cost estimate for this provision in Medicaid is incorporated into its estimate for the CLASS provision in Division C (Public Health and Workforce Development) of H.R. 3962.

Outreach and Enrollment Facilitation

Expanded Outstationing

Under current law, a Medicaid state plan must provide for the receipt and initial processing of applications for medical assistance for low-income pregnant women, infants, and children under age 19 at outstation locations other than TANF offices, such as disproportionate share hospitals and Federally-qualified health centers (FQHCs). State eligibility workers assigned to outstation locations perform initial processing of Medicaid applications including taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete processing of the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews. States must also use applications which are other than those used for aid under TANF.

H.R. 3962 would require states to provide for receipt and initial processing of Medicaid applications at specified outstation locations for *all* Medicaid applicants, and would require state Medicaid programs to allow individuals applying for affordability credits (under subtitle C of title III of Division A) to apply for Medicaid coverage at Disproportionate Share Hospitals (DSH) hospitals, FQHCs, and locations apart from welfare offices.

CBO's estimate of the cost for this provision is included in the estimate for expanding health insurance coverage, and is represented in the net cost of coverage provisions, estimated to be $891 billion over the FY2010-FY2019 period.

Preserving Medicaid Coverage for Youth Upon Release from Public Institutions

In general, no federal matching funds are available for medical services delivered to inmates of public institutions. Such public institutions are the responsibility of a governmental unit or over which a governmental unit exercises administrative control. Federal rules do not require states to terminate Medicaid eligibility for inmates (individuals residing in a public institution), but research indicates that most states do so.

H.R. 3962 would require that states not terminate Medicaid eligibility for certain youth during periods of incarceration in a public institution. States would also be required to establish a process that ensures that no claims for federal matching funds be made for services delivered to youth while in a public institution and that such youth receive Medicaid services for which federal matching funds would be available. States must ensure that enrollment in Medicaid for such youth be completed before their release date. This provision would be applicable to an individual who (1) is 18 years of age or younger, (2) was enrolled in Medicaid under the state plan immediately before becoming an inmate of a public institution, (3) is 18 years of age or younger upon release from such institution, and (4) is eligible for Medicaid under the state plan at the time of his/her release. CBO estimates this provision would cost $0.6 billion over the FY2010-FY2019 period.

12-Month Continuous Coverage Under Certain CHIP Programs

Under CHIP, states may enroll targeted low-income children in a CHIP-financed expansion of Medicaid, create a new separate state CHIP program, or devise a combination of both approaches. States are required to re-determine CHIP eligibility at least every 12 months with respect to circumstances that may change and affect eligibility. Continuous eligibility allows a child to remain enrolled for a set period of time regardless of whether the child's circumstances change (e.g., the family's income rises above the eligibility threshold), thus making it easier for a child to stay enrolled. Not all states offer it, but among those that do, the period of continuous eligibility ranges from six months to 12 months. H.R. 3962 would require separate CHIP programs that cover children in families with annual income less than 200% of the federal poverty level to provide for 12 months of continuous coverage.

CBO's estimate of the cost for this provision is included in the estimate for expanding health insurance coverage, and is represented in the net cost of coverage provisions, estimated to be $891 billion over the FY2010-FY2019 period.

Preventing the Application under CHIP of Coverage Waiting Periods

Federal CHIP statute allows states to use a number of factors in determining eligibility for beneficiaries. However, states are not permitted to (1) extend coverage to children in families with higher family income without covering children with lower family income; (2) deny eligibility based on a preexisting medical condition; (3) apply a waiting period to targeted low-income pregnant woman who qualify for pregnancy-related assistance, or (4) apply a waiting period in the case of a child who is eligible for dental-only supplemental coverage.

H.R. 3962 would preclude states from applying a waiting period to children applying for child health assistance who are (1) under two years of age; (2) who lost health insurance coverage

under a group health plan or health insurance coverage offered through an employer due to (a) a loss of a job, (b) a reduction in work hours, (c) the elimination of an individual's retiree health benefits, or (d) the termination of an individual's health insurance coverage offered through an employer; or (3) the family of the child demonstrates that the cost of health insurance coverage (including the cost of premiums, co-payments, deductibles, and other cost sharing) exceeds 10% of the family income.

CBO's estimate of the cost for this provision is included in the estimate for expanding health insurance coverage, and is represented in the net cost of coverage provisions, estimated to be $891 billion over the FY2010-FY2019 period.

Outreach and Enrollment of Medicaid and CHIP Eligible Individuals.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) included provisions to facilitate access and enrollment in Medicaid and CHIP. Among the provisions related to outreach and enrollment, CHIPRA authorizes $100 million in outreach and enrollment grants above and beyond the regular CHIP allotments for fiscal years 2009 through 2013. Ten percent of the outreach and enrollment grants will be directed to a national enrollment campaign, and 10% will be targeted to outreach for Native American children. The remaining 80% will be distributed among state and local governments and to community-based organizations for purposes of conducting outreach campaigns with a particular focus on rural areas and underserved populations. Grant funds will also be targeted at proposals that address cultural and linguistic barriers to enrollment. Also as a part of the outreach-related provisions, CHIPRA requires state plans to describe the procedures used to reduce the administrative barriers to the enrollment of children and pregnant women in Medicaid and CHIP, and to ensure that such procedures are revised as often as the state determines is appropriate to reduce newly identified barriers to enrollment.

H.R. 3962 would require the Secretary to issue guidance regarding standards and best practices (e.g., outstationing of eligibility workers, express lane eligibility, presumptive eligibility, continuous eligibility, and automatic renewal) to facilitate outreach and enrollment of eligible individuals in Medicaid and/or CHIP. Such guidance would be required to be issued not later than 12 months after date of enactment of this Act and must target vulnerable populations (e.g., unaccompanied homeless youth, victims of abuse or trauma, persons with mental health or substance related disorders, and individuals with HIV/AIDS). In implementing the requirements of this provision, the Secretary would be permitted to use such authorities as are available under law and may work with such entities as the Secretary deems appropriate to facilitate effective implementation of such programs. Not later than two years after the enactment of this Act and annually thereafter, the Secretary would be required to review and report to Congress on progress in implementing targeted outreach, application and enrollment assistance, and administrative simplification methods for such vulnerable and underserved populations. CBO estimates that this provision would have no effect on direct spending over the FY2010-FY2019 period.

Treatment of Certain Medicaid Brokers

States are permitted to seek federal reimbursement for the use of Medicaid managed care enrollment brokers when certain conditions are met (e.g., the broker is independent of the managed care entity and of any health care providers in a given state; no person who is an owner, employee, or consultant or has a contract with the broker has any direct or indirect financial

interest in the entity or health care provider). Enrollment brokers serve as a link between the Medicaid managed care delivery system and the Medicaid enrollee. Medicaid enrollment brokers (normally chosen as the result of a competitive bidding process) provide outreach, enrollment and education services to Medicaid consumers about available participating Medicaid managed care plans/entities in the state.

H.R. 3962 would require the Inspector General of the Department of Health and Human Services to rule that certain Medicaid brokers have established and maintain procedures to ensure the independence of their enrollment activities from the interests of any managed care entity or provider. CBO estimates this provision would have no effect on direct spending over the FY2010-FY2019 period.

Prohibitions on Federal Medicaid and CHIP Payment for Undocumented Aliens

Under current law, unauthorized aliens (i.e., illegal aliens, foreign nationals who are not lawfully present in the United States) are ineligible for Medicaid and CHIP. Such individuals who meet the categorical and residency eligibility requirements for Medicaid, but are ineligible due to immigration status, are only eligible for Medicaid coverage for emergency conditions (i.e., emergency Medicaid), which includes costs associated with labor and delivery for pregnant women. H.R. 3962 would specify that nothing would change the current prohibitions against federal Medicaid and CHIP payments on behalf of individuals who are not lawfully present in the United States. Since the provision reiterates current law, certain unauthorized aliens would still be eligible for emergency Medicaid services only, and providers could still obtain Medicaid reimbursement for such care. CBO estimates this provision would have no effect on direct spending over the FY2010-FY2019 period.

Benefits

Medicaid benefits are identified in federal statute and regulations and include a wide range of medical care and services. Some benefits are specific items, such as eyeglasses and prosthetic devices. Other benefits are defined in terms of specific types of providers (e.g., physicians, hospitals). Still other benefits define specific types of services (e.g., family planning services and supplies, pregnancy-related services) that may be delivered by any qualified medical provider that participates in Medicaid. Finally, additional benefits include premium payments for coverage provided through managed care arrangements and Medicare premium and cost-sharing support for persons dually eligible for both Medicare and Medicaid.

Medicaid's basic benefit rules require all states to provide certain "mandatory" services (e.g., inpatient hospital care, physician services, lab/x-ray services). The statute lists additional services that are considered optional (e.g., other licensed practitioners, rehabilitative services, nursing facility services for individuals under age 21) - that is, federal matching payments are available for optional services if states choose to include them in their Medicaid plans. States define the specific features of each mandatory and optional service to be provided under that plan within broad federal guidelines.

H.R. 3962 would make a number of changes to benefits under the Medicaid program. For example, this bill would add a new mandatory benefit for coverage of certain preventive services.

The bill would also add some optional Medicaid benefits (e.g., nurse home visitation services) and clarify the availability of certain existing optional services under current law (e.g., therapeutic foster care services, adult day health care). H.R. 3962 would also makes coverage of services provided by podiatrists and optometrists mandatory, rather than optional as under current law. These and other proposed benefit changes are described below.

New Mandatory Medicaid Benefits

Required Coverage of Preventive Services

Medicaid statute lists types of services covered under Medicaid, some of which are mandatory benefits, and others are optional. For beneficiaries under 21 years of age, states must cover a package of preventive services under the Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT). For eligible beneficiaries including adults, states are required to cover family planning services and supplies, and certain pregnancy-related services. Coverage may be required if, for example, a service meets another applicable requirement, such as physician's services. Otherwise, state coverage of screening and preventive services for adults is optional.

H.R. 3962 would require Medicaid state plans to cover, for all beneficiaries, preventive services that the Secretary determines are (1) services recommended with a grade of A or B by the Task Force on Clinical Preventive Services (established by this bill), or vaccines recommended by the Centers for Disease Control and Prevention (CDC), and (2) appropriate for Medicaid beneficiaries. This section would also amend Section 1928 of the Social Security Act (SSA) to clarify that vaccines covered under the Vaccines for Children (VFC) authority are those recommended by the CDC Director, rather than an advisory committee to the Director, and would also prohibit cost-sharing for the preventive services identified in this section, including cost-sharing otherwise permitted under traditional Medicaid and the optional alternative cost-sharing structure defined under DRA.

Except as provided in the general rule for changes requiring state legislation (described later in this report), this provision would apply to services furnished on or after July 1, 2010, without regard to whether related final regulations have been promulgated by that date. CBO estimates this provision would cost $10.7 billion over the FY2010-FY2019 period.

Mandatory Coverage of Podiatrists and Optometrists

Some standard Medicaid benefits are mandatory for most Medicaid groups (e.g., inpatient hospital services, physician services, family planning services and supplies, federally qualified health center services, nursing facility services for persons age 21 or older). Under Medicaid, physician services are those furnished by a physician as defined in the Medicare statute, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere. Other benefits are optional. Examples of optional benefits for most Medicaid groups that are offered by many states include prescribed drugs (covered by all states), other licensed practitioners (e.g., podiatrists, optometrists, chiropractors, psychologists), and nursing facility services for individuals under age 21 years.

H.R. 3962 would modify the definition of mandatory "physician services" under Medicaid to also include a doctor of podiatric medicine as defined in the Medicare statute, effective as of January

1, 2010. Similarly, the bill would make services provided by optometrists as defined in the Medicare statute a new mandatory benefit under Medicaid. This latter provision would take effect 90 days after enactment of this bill. CBO estimates these two provisions would cost $0.2 billion and $0.1 billion, respectively, over the FY2010-FY2019 period.

Continuing Requirement of Medicaid Coverage of Non-Emergency Transportation to Medically Necessary Services

Federal regulations (42 CFR 431.35) require state Medicaid plans to assure necessary transportation for recipients to and from providers, and describe the methods that the agency will use to meet those requirements. In late 2007, the Bush Administration issued a final rule (effective February 26, 2008) that would have eliminated Medicaid reimbursement for school-based administrative costs and costs of transportation to and from school. That rule modified the existing federal regulation on assurance of transportation, adding that for the purposes of this assurance, necessary transportation did not include transportation of school-age children between home and school.

Subsequent to the publication of this final rule, Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) imposed a moratorium on further action until June 30, 2008. This moratorium prevented the Centers for Medicare and Medicaid Services (CMS) from imposing restrictions contained in this rule that were more stringent than those applicable as of July 1, 2007. This moratorium was extended twice, first until April 1, 2009 (via Supplemental Appropriations Act, 2008, P.L. 110-252) and then until July 1, 2009 (via American Recovery and Reinvestment Act of 2009, P.L. 111-5). On June 29, 2009, the Obama Administration announced that it would rescind the final rule on school-based administration and transportation.[11]

H.R. 3962 would add non-emergency transportation to medically necessary services, consistent with 42 CFR 431.53 as in effect as of June 1, 2008 (when the Bush Administration final rule was not in effect), to the list of mandatory Medicaid benefits identified in federal statute that are available to Medicaid beneficiaries eligible under the state Medicaid plan. This provision would apply to such transportation services provided on or after the date of enactment. CBO estimates that the cost for this provision would be negligible (i.e., plus or minus $50 million).

Coverage of Federally Qualified Health Services (FQHCs)

"Services provided by federally qualified health centers" are a mandatory benefit under Medicaid for most Medicaid beneficiaries. For Medicaid purposes, H.R. 3962 would modify the definition of federally qualified health centers to include school-based health clinics (SBHC) that receive grants under a new SBHC grant program to be established by the Secretary under another provision of this bill in Division C. CBO estimates this provision would cost $1.0 billion over the FY2010-FY2019 period.

[11] For more information, see 74 *Federal Register* 31183.

Tobacco Cessation

Under federal Medicaid law, when prescription drug manufacturers enter into rebate agreements with the Secretary, states are required to cover all drug products offered for sale by these manufacturers, except products in 11 drug classes including smoking cessation products. Although prescription drugs are an optional Medicaid benefit, all states cover drugs for most beneficiaries. Under current law, Medicaid programs may cover tobacco cessation counseling services for pregnant women as an optional benefit. If the state covers tobacco cessation drugs when these are dispensed as part of that counseling states receive FFP for these expenditures. Under H.R. 3962, smoking cessation products would be removed from the list of excluded drugs, so that state Medicaid plans would be required to cover prescription and non-prescription FDA-approved smoking cessation products when these are covered by rebate agreements. CBO estimates this provision would cost $0.1 billion over the FY2010-FY2019 period.

New Optional Medicaid Benefits

Translation or Interpretation Services

Federal and state governments share in the cost of Medicaid benefits based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa). The federal matching rate for administrative expenditures is the same for all states and is generally 50%, but certain administrative functions have a higher federal matching rate. States have the option of covering language translation or interpretation services as a benefit, so Medicaid programs could receive federal financial participation for these services. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) provided a 75% matching rate for language translation or interpretation services in connection with the enrollment and retention of, and use of services under Medicaid by children of families for whom English is not the primary language.

Under H.R. 3962 , beginning January 1, 2010, states would receive the 75% matching rate for translation and interpretation services for other Medicaid beneficiaries, in addition to children of families whose primary language is not English. CBO estimates this provision would cost $0.3 billion over the FY2010-FY2019 period.

Optional Coverage for Free Standing Birth Center Services

While there is statutory authority under Medicaid to pay for services rendered by nurse midwives, there is no statutory authority to provide for direct payments to freestanding birthing centers for facility services. H.R. 3962 would add an optional benefit for freestanding birth center services and other ambulatory services offered by a freestanding birth center that are otherwise covered under the state Medicaid plan. The term "freestanding birth center services" would be defined as services furnished to an individual at a freestanding birth center, including by a licensed birth attendant. The term "freestanding birth center" would be defined as a health facility that is not a hospital and where childbirth is planned to occur away from the pregnant woman's residence. The term "licensed birth attendant" would be defined as an individual who is licensed or registered by the state to provide health care at childbirth and who provides such care within the scope of practice and which the individual is legally authorized to perform under state law (or state regulatory mechanism provided by state law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. This provision would

not change state law requirements applicable to licensed birth attendants, and would be effective for items and services furnished on or after the date of enactment of this Act. CBO estimates that the cost for this provision would be negligible (i.e., plus or minus $50 million).

Optional Therapeutic Foster Care (TFC) Services

In general, therapeutic foster care (TFC) temporarily places youths with serious emotional and behavioral issues with specially trained foster families. Although TFC programs vary, children/adolescents are placed for six to seven months in a structured environment where they are rewarded for positive social behavior and penalized for disruptive and aggressive behavior. TFC is not specifically addressed in Medicaid law, although it sometimes is considered a service under the rehabilitative services benefit, where states have the option to cover rehabilitative services, including medical or remedial services to reduce physical or mental disability and restoration of best possible functional level. There has been debate whether TFC should be considered a medical treatment and whether it should be paid for as a foster care benefit or a Medicaid rehabilitative service or other benefit.

CMS issued a controversial rehabilitative services proposed rule in August 2007, but a final rule was never implemented. The proposed rule would have prevented states from receiving federal financial participation (FFP) for TFC under rehabilitative services. Congress imposed a moratorium on implementation of the rehabilitative services rule, along with other administrative rules, until March 2009. The March moratorium was extended until July 1, 2009 by the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5). ARRA also included a sense of the Congress provision that CMS should not promulgate a final rule for rehabilitative services and other Medicaid regulations.

This provision in H.R. 3962 would clarify that states would have the option under Medicaid to cover TFC for Medicaid eligible children in out-of-home placements. TFC would be defined as a foster care program that provides certain services to parents (e.g., specialized training and consultation on management of troubled youth placed in their care) and children (e.g., structured activities to promote age-appropriate behaviors, crisis intervention, medication monitoring, and case management services). CBO estimates this provision would cost $0.6 billion over the FY2010-FY2019 period.

Adult Day Health Care Services

Adult day health care services often include coordinated services for adults in a community-based group setting, but services provided vary greatly depending on whether they follow a medical, social or combination model of care. Services are designed to provide social and some health services to adults who need supervised care in a safe place outside the home during the day.

Like TFC, adult day health care services are not specifically addressed in current Medicaid law, although these services often are considered rehabilitative services. There also has been disagreement about whether adult day health care services should be considered medical treatment and whether individuals using these services are receiving rehabilitative services or care that is more custodial or habilitative services. As noted under the discussion of TFC, CMS issued a proposed rehabilitative services rule in August of 2007. That rule sought to clarify the distinction between rehabilitative services that focus on restoration of individuals' functional levels and habilitative services designed to help people acquire new functional abilities.

Under a 1989 law, CMS was forbidden from taking adverse action against states that were approved to cover habilitative services until regulations were issued specifying the types of day habilitation services that states could cover under Medicaid. The proposed rehabilitation services rule would have withdrawn prior approval of habilitative services in states grandfathered under the 1989 law. Congress imposed a moratorium on further administrative action on the rehabilitative services rule, along with other administrative rules, until April 1, 2009. Subsequently, ARRA included a Sense of the Congress provision that CMS should not promulgate a final rule for rehabilitative services.

H.R. 3962 would prohibit the Secretary from denying federal reimbursement for adult day health care services, day activity and health services, or adult medical day care services, as defined under a state Medicaid plan approved before 1995. The Secretary also would be prohibited from withdrawing federal approval (by regulation or otherwise) for rehabilitative services under a state Medicaid plan. This provision would apply to services provided beginning October 1, 2008. CBO estimates this provision would have no effect on direct spending over the FY2010-FY2019 period.

Other Benefit Modifications

Inclusion of Public Health Clinics Under the Vaccines for Children Program

Section 1928 of the SSA authorizes the VFC program, under which Medicaid assumes the costs for providing certain low-income children with recommended vaccinations. Medicaid law further defines children who are eligible for vaccines as those who are eligible for Medicaid; who are uninsured; and who receive vaccines purchased through the program and administered at a FQHC or rural health clinic, and do not have health insurance coverage for vaccines, or who are Indians.

H.R. 3962 would add public health clinics to the list of providers that may administer vaccines to eligible children under the VFC program. CBO estimates this provision would cost $0.5 billion over the FY2010-FY2019 period.

Financing

Medicaid financing is shared by the federal government and the states. The federal share for most Medicaid expenses for benefits is determined by the federal medical assistance percentage (FMAP). FMAP is based on a formula that provides higher reimbursement to states with lower per capita income relative to the national average (and vice versa). FMAPs have a statutory minimum of 50% and maximum of 83%, although some Medicaid services receive a higher federal match rate. FY2009 FMAPs ranged from a high of 75.8% in Mississippi to a low of 50.0% in 13 other states. In February of this year, with passage of ARRA, states received temporary enhanced FMAP rates for nine quarters beginning with the first quarter of FY2009 and running through the first quarter of FY2011.

State expenditures to administer their Medicaid programs are matched by federal funding at the 50% matching funding rate. Federal matching rates for administrative expenditures are the same for all states, although some activities are matched at higher rates. Within broad federal guidelines, states generally control Medicaid spending levels by tailoring eligibility, covered services, cost-sharing and premiums paid by beneficiaries, provider reimbursement rates, and

other program components to achieve their budget and policy goals. To receive payment for the federal share of Medicaid expenditures, states submit quarterly expenditure reports to the Centers for Medicare and Medicaid Services (CMS).

The Medicaid financing provisions in H.R. 3962 generally can be considered technical changes or refinements that would reduce federal and state health care expenditures. The proposed changes would affect Medicaid purchases of prescription drugs, disproportionate share hospital (DSH) payments, and graduate medical education (GME) payments. Some of the Medicaid financing provisions in H.R. 3962, discussed in this section, appear in two Subtitles. Division B, Title VII—Medicaid and CHIP, Subtitle A—Medicaid and Health Reform contains a DSH financing provision, and Subtitle E—Financing, contains provisions on prescription drugs and GME.

Payments to States

Disproportionate Share Hospital Payments

Medicaid statute requires that states make disproportionate share (DSH) adjustments to the payment rates of hospitals treating large numbers of uninsured individuals and Medicaid beneficiaries. Federal statute specifies a formula for determining DSH allotments for each state. (However, Tennessee and Hawaii have special statutory arrangements relating to their state DSH allotments.) States must define, in their state Medicaid plan, hospitals qualifying as DSH hospitals and DSH payment formulas, taking into account certain federal criteria.[12] For FY1998-FY2002, state-by-state DSH allotments were specified in federal statute. A number of changes to these allotments occurred after that time.

H.R. 3962 would require the Secretary to provide a report to Congress (due January 1, 2016), on the extent to which, based on the impact of provisions included in the bill aimed at reducing the number of uninsured, there is a continued role for Medicaid DSH payments. In preparing this report, the Secretary would be required to consult with community-based networks serving low-income beneficiaries. The report would be required to include recommendations regarding (1) the appropriate targeting of Medicaid DSH funds within states, (2) the distribution of Medicaid DSH funds among states, taking into account the ratio of the amount of DSH funds allocated to a state to the number of uninsured individuals in the state, and (3) a new methodology for reducing DSH allotments (described below). Also, the Secretary would be required to coordinate the Medicaid DSH report with the report on Medicare DSH (as delineated in another part of this bill).

Aggregate reductions in DSH allotments would equal $1.5 billion in FY2017, $2.5 billion in FY2018, and $6.0 billion in FY2019. (CBO's score also shows a $10 billion reduction in DSH payments over the FY2010-FY2019 period.) To achieve these aggregate reductions among states for each of these fiscal years, the Secretary would be required to impose the largest percentage reduction on states that (1) have the lowest percentages of uninsured individuals (as determined through audited hospital cost reports) during the most recent year for which such data are available, or (2) do not target their DSH payments to hospitals with high volumes of Medicaid patients (i.e., hospitals with a Medicaid inpatient utilization rate that is at least one standard deviation above the mean Medicaid utilization rate among hospitals receiving Medicaid payments in the state), and hospitals that have high levels of uncompensated care (excluding bad debt).

[12] For more information on Medicaid DSH, see CRS Report 97-483, *Medicaid Disproportionate Share Payments*.

The provision also specifies that no hospital may be considered to be a DSH hospital (or as an essential access hospital under the TennCare program in Tennessee) unless the hospital (1) provides services to beneficiaries without discrimination based on race, color, national origin, creed, source of payment, status as a Medicaid beneficiary, or any other ground unrelated to such beneficiary's need for services or the availability of the services in the hospital, and (2) makes arrangements for, and accepts, reimbursement under Medicaid for services provided to Medicaid beneficiaries. The provision related to the definition of a DSH hospital would apply to Medicaid expenditures made on or after July 1, 2010.

Graduate Medical Education (GME)

Most states make Medicaid payments to help cover the costs of training new doctors in teaching hospitals and other teaching programs. There is no formal federal reporting mechanism to document Medicaid GME payments made by states. In 2005, total state and federal Medicaid payments for GME were estimated to be nearly $3.2 billion.[13] On average, Medicaid GME payments were estimated to represent 7% of total Medicaid inpatient hospital expenditures.[14] In May 2007, CMS issued a proposed rule that would have eliminated federal reimbursement for GME under Medicaid.[15] Subsequent federal laws have placed a moratorium on further action on this rule. Most recently, ARRA included a Sense of the Senate provision that the Secretary should not promulgate a final GME payment rule. In its May 11, 2009, unified agenda for forthcoming regulatory action, HHS indicated that final action is "to be determined" on the proposed Medicaid GME rule.

H.R. 3962 would explicitly authorize GME payments under Medicaid, whether the GME occurred in or outside of a hospital. To increase transparency and enable GME funds to be monitored, states would be required to provide timely information to the Secretary on annual GME payments. States would be required to report total GME payments and how these payments were used including (1) the institutions and programs eligible for receiving the funding, (2) the manner in which such payments are calculated, (3) the types and fields of education being supported, (4) the workforce or other goals to which the funding is being applied, (5) state progress in meeting workforce or other state GME funding goals, and (6) other information the Secretary determines will assist states in supporting other types and fields of education and workforce goals. In addition, H.R. 3962 also would require that the information reported to the Secretary is provided to an Advisory Committee on Health Workforce Evaluation and Assessment, and the Secretary and this advisory committee would independently review the state information. The Secretary also would be required to issue rules before December 31, 2011 on program goals for Medicaid GME payments, and requirements for use of GME funds. Finally, the bill would add a state option to make hospital GME payments under Medicaid, consistent with the other provisions of this section of the bill. These provisions would be effective upon enactment of H.R. 3962, and nothing in this section of the bill would affect payments made before such date under a state Medicaid plan for GME. CBO estimates this provision would have no effect on direct spending over the FY2010-FY2019 period.

[13] For comparison, Medicare spent about $8.4 billion on GME in 2007. State support for GME may also include appropriations to state-operated medical schools or residency programs.

[14] For more information, see CRS Report RS22842, *Medicaid and Graduate Medical Education*, by (name redacted) and (name redacted).

[15] For more information on the status of the GME and other regulations issued by CMS, see CRS Report RL34764, *Medicaid Regulatory Issues*, by (name redacted) and (name redacted).

Extension of the Delay in the Elimination of Managed Care Organization Provider Tax

States' ability to use provider-specific taxes to fund Medicaid is limited. If a state establishes provider-specific taxes to fund the state share of program costs, federal matching dollars will not be available unless the tax program meets three rules: (1) the taxes collected cannot exceed 25% of the state (non-federal) share of Medicaid expenditures, (2) the state cannot provide a guarantee to the providers that the taxes will be returned to them, and (3) the tax must be broad-based (i.e., the tax is uniformly applied to all providers within the provider class). Per DRA, the Medicaid managed care organization (MCO) provider class includes all MCOs. That is, to qualify for federal matching dollars, a state's provider tax must apply to both Medicaid and non-Medicaid MCOs. This provision was effective upon enactment of DRA (as of February 8, 2006), except in states with taxes based on the Medicaid provider tax class defined in prior law that was in place as of December 8, 2005. In that prior law, MCOs were classified as a separate class of providers for the purposes of determining if a tax was broad-based, and was limited to only Medicaid providers (not all MCOs including non-Medicaid MCOs). In those states, this exception to the DRA MCO provider tax rule was to be effective on October 1, 2009.

H.R. 3962 would postpone the effective date from October 1, 2009 to October 1, 2010 for those states with provider taxes based on the prior Medicaid provider tax classification (described above) that was in place as of December 8, 2005. This change would be effective as if included in DRA. CBO estimates this provision would cost $0.4 billion over the FY2010-FY2019 period.

Optional Coverage of Nurse Home Visitation Services

States can seek federal reimbursement at the 50% matching rate typically available for administrative activities for home visitation services under Medicaid administrative case management. These administrative activities are defined as activities necessary for the proper and efficient operation of the state Medicaid plan (e.g., outreach, eligibility determinations, utilization review, and prior authorization).

Under EPSDT benefits, a mandatory service for individuals under age 21, states can seek Medicaid reimbursement for care coordination and/or case management provided through home visitation services. Such EPSDT-related home visitation may be covered as an administrative cost (reimbursed at the 50% administrative matching rate), or as medical assistance (reimbursed at the state's regular FMAP rate) in the case of medically necessary case management.

H.R. 3962 would give states a new option to cover certain nurse home-visitation services for first-time pregnant women or children under age two. CBO estimates this provision would cost $0.8 billion over the FY2010-FY2019 period.

Technical Corrections: Medicaid Medical Assistance Payments

Medicaid medical assistance refers to payment for part or all of the cost of care and services covered under a state's Medicaid program on behalf of individuals eligible for benefits. H.R. 3962 would make a technical correction to the definition of Medicaid medical assistance to include payment for part or all of the cost of care and services, or the care and services themselves, or both covered under a state's Medicaid program on behalf of individuals eligible

for benefits. CBO estimates this provision would have no effect on direct spending during the FY2010-FY2019 period.

Extension of ARRA Increase in FMAP

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 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%. 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 also are subject to federal spending caps). Under the Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L. 108-27), all states and the District of Columbia 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.

The American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) adjusted FMAP rates for the states, the District of Columbia, and the Territories. The recession adjustment period began with the first quarter of FY2009 and continues through the first quarter of FY2011. Under ARRA, all states are held harmless from any decline in their regular FMAPs, the states and the District of Columbia receive an across-the-board FMAP increase of 6.2 percentage points, and qualifying states receive an additional unemployment-related increase. States were subject to certain requirements to receive the temporary FMAP increase. ARRA allows each territory a one-time choice between an FMAP increase of 6.2 percentage points and a 15% increase in its spending cap, or its regular FMAP rate and a 30% increase in its spending cap. Each of the five territories elected the 30% increase in their spending caps. The ARRA enhanced FMAP rates expire December 31, 2010.

H.R. 3962 would extend the ARRA recession adjustment period for the 50 states and DC from the first quarter of FY2011, through the third quarter of FY2011 (i.e., June 2011). In the case of the five territories, the ARRA 30% increase in the cap on Medicaid payments would not apply for calendar quarters beginning on or after October 1, 2010, however, H.R. 3962 includes another provision (described below) that would increase Medicaid spending caps in the territories for each of FY2011 through FY2019. CBO estimates this provision would cost $23.5 billion in FY2011.

Payments to Providers

Reimbursement Rates for Primary Care Services

Under current law, state Medicaid plans must provide methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care, and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care is available to the general population in the geographic area. Additional requirements regarding payment rates under Medicaid apply to inpatient hospital and long-term care facility services. However, within these guidelines, states have considerable flexibility to set provider reimbursement rates independent of any national baseline or reference.

Under H.R. 3962, states would be required to set Medicaid payments for primary care services (i.e., evaluation and management or E & M services defined under Medicare as of December 31, 2009 and as subsequently modified by the Secretary) relative to 2010 Medicare payment rates. For Medicaid purposes, two adjustments would be made to these Medicare payment rates. First, Medicare payments rates for E & M services would be increased by 1.25% in 2010, and in each subsequent year (rather than basing the increase on the conversion factor update used for the Medicare program). For 2010, Medicaid payments to physicians and other health care professionals would equal 80% of the adjusted Medicare E & M service payments. In 2011, the Medicaid rate would equal 90% of the updated 2010 rate. For 2012 and subsequent years, the Medicaid payment for E & M services would equal 100% of the updated Medicare rate. With respect to Medicaid managed care, the provision also would require that, in the case of E & M services, these payment rates would apply, regardless of the manner in which such payments are made, including in the form of capitation or partial capitation (e.g., payments made on a "per member per month" basis, rather than for each specific unit of service delivered).

For services furnished as of January 1, 2010 up to 2015, the federal government would fully finance the portion of such payments by which the new minimum payment rates specified above exceed payment rates in effect as of June 16, 2009. The federal government would pay 91% of such payments beginning in 2015. CBO estimates this provision would cost $57.0 billion over the FY2010-FY2019 period.

Assuring Adequate Payment Levels for Services

The state Medicaid plan must provide methods and procedures (1) relating to the utilization of and the payment for care and services available under the plan as necessary to safeguard against unnecessary utilization, and (2) to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

H.R. 3962 would require that state Medicaid plans be considered out of compliance with these statutory requirements unless certain conditions are met. Beginning in 2011, states would be required to submit annually to the Secretary a state Medicaid plan amendment (SPA) that details payment rates for that year and specified additional data (i.e., how Medicaid managed care payments take into account provider payment rates) that would assist in the evaluation of states' compliance with this requirement. If the Secretary disapproves the state's SPA, states would be required to submit a revised amendment that complies with these requirements. This provision would take effect on the date of enactment of this bill. CBO estimates this provision would have no effect on direct spending over the FY2010-FY2019 period.

Nursing Facility Supplemental Payment Program

Until 1980, state Medicaid programs were required to follow Medicare reimbursement principles in paying nursing facilities. Under the Medicare rules in effect at that time, this meant that states were required to use a retrospective reasonable cost system. States continued to have to assure that rates provided access to care. Payment amounts were determined after services were rendered and were based on the actual costs incurred by the provider in furnishing those services. In what is known as the "Boren amendment," the Omnibus Reconciliation Act of 1980 (P.L. 96-499)

repealed this requirement for nursing facility services, freeing states to establish new methodologies of their own.

The new rules specified that payment rates for hospitals and nursing facilities had to be "reasonable and adequate" to meet the costs of "efficiently and economically operated" facilities. Nearly all states responded to the new flexibility by shifting from retrospective to prospective payment systems for nursing facility services. Under prospective payment systems, rates may be set in advance and may not be related to the actual costs providers incur in furnishing services; or the state may set ceilings and pay the lesser of actual costs.

Out of any funds not otherwise appropriated, H.R. 3962 would appropriate to the Secretary $6 billion to reimburse nursing facilities certified by both Medicare and Medicaid (i.e., dually-certified) for Medicaid underpayments that occurred in cost reporting periods ending during a year (beginning no earlier than 2010) that is covered by the latest available Medicare cost report. Funds would be made available for obligation in the following years: $1.5 billion in 2010, $1.5 billion in 2011, $1.5 billion in 2012 and $1.5 billion in 2013. Any funds that remain available after all eligible dually-certified facilities are reimbursed for quality care furnished to Medicaid-eligible individuals would be deposited into the Medicaid Improvement Fund. The Secretary would be prohibited from requiring state matching funds for these payments.

Under H.R. 3962, payment amounts for eligible dually-certified facilities (in which the combined Medicare and Medicaid share of resident days is not less than 75% of the total resident days and the share of Medicaid patient days is not less than 60% of the combined Medicare and Medicaid share of resident days) for a year would be determined by the Secretary as reported on the facility's latest available Medicare cost report. Payments would be made directly by the Secretary to the nursing facility and could not exceed the payment deficit, as defined by the amount of Medicaid reimbursement for the provision of covered services that is significantly less (as determined by the Secretary) than the allowable costs incurred by the facility. Certain facilities, such as those in the highest quartile of costs per day, would be excluded. The Secretary would be prohibited from spending more than 0.75% of the amount made available in any year on administering this payment program.

As determined by the Secretary, eligible facilities would be required to provide quality care to Medicaid beneficiaries and dually-enrolled facilities could not have been cited for any immediate jeopardy deficiencies in the most recent state compliance survey. Eligible facilities also would have had to maintain an appropriate staffing level, among other restrictions.

Additional limitations and requirements would apply and no administrative or judicial review of the determination of a facility's eligibility for payments or its payment amounts would be allowed. Annual reports would be submitted to the congressional committees of jurisdiction.

CBO estimates this provision would cost $6.0 billion over the FY2010-FY2019 period.

Prescription Drugs

Outpatient prescription drugs are an optional Medicaid benefit, but all states cover prescription drugs for most beneficiary groups. States purchase prescription drugs from drug manufacturers on behalf of Medicaid beneficiaries and receive matching federal payments for a portion of these purchases, just as they do for other medical services. Medicaid law requires drug manufacturers to ensure that Medicaid receives their "best price." The best price provisions require prescription

drug manufacturers, who wish to sell any products to Medicaid beneficiaries, to enter into rebate agreements with the Secretary on behalf of states. Under these agreements, drug manufacturers must provide state Medicaid programs with rebates for the drugs purchased for Medicaid beneficiaries.[16] In exchange for entering into rebate agreements, state Medicaid programs must cover all drugs (except certain statutorily excluded drug classes) marketed by those manufacturers. In 2004 CMS estimated that 550 manufacturers participated in the Medicaid drug rebate program.[17]

For each prescription drug purchased by Medicaid, participating drug manufacturers must report two market prices to CMS—the average manufacturer price (AMP), which is the average price that drugmakers receive for sales to retail pharmacies and mail-order establishments, and the lowest transaction price, or "best price," that manufacturers receive from sales to certain private buyers of a drug. Those prices, which serve as reference points for determining manufacturers' rebate obligations, must be reported for each formulation and dosage of each prescription drug purchased on behalf of Medicaid beneficiaries.

H.R. 3962 includes three Medicaid prescription drug provisions, described below. CBO estimates that the combined effects of these provisions (and one expanding the list of entities eligible for discounted drug prices under the Section 340B program in the Public Health Service Act) would save $24.6 billion over the FY2010-FY2019 period.

Payments to Pharmacists

Medicaid law also requires the Secretary to establish an upper limit on the federal share of payments for prescription drug acquisition costs. These limits, referred to as federal upper payment limits (FULs) when applied to multiple source drugs, are intended to encourage substitution of lower-cost generic equivalents for more costly brand-name drugs. FULs apply to aggregate state expenditures for each drug. CMS calculates FULs and periodically publishes these prices. Under DRA, new FULs issued after January 2007 were to equal 250% of the AMP of the least costly therapeutic equivalent (excluding prompt pay discounts). Manufacturers are required to report AMP to CMS.

National pharmacy associations legally challenged the DRA FUL changes that were published in a proposed rule CMS issued in 2007. The court issued an injunction on December 19, 2007 which prohibited CMS from setting FULs for Medicaid covered generic drugs based on AMP, and from disclosing AMP data except within the Department of Health and Human Services or to the Department of Justice. The court's 2007 injunction was for an indefinite period and remains in place.

Congress also imposed a moratorium on the use AMPs to set FULs until October 1, 2009 when the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275)

[16] Federal law exempts selected purchases from Medicaid's rebate agreements, such as drugs dispensed by Medicaid managed care organizations (when prescription drugs are included in the capitation agreement), inpatient drugs, and drugs dispensed in physicians' or dentists' offices. Some states exclude or carve out drug benefits from their Medicaid managed care organization contracts, in which case, managed care beneficiaries receive their prescribed drugs through the fee-for-service delivery system, and states can claim manufacturer rebates for these purchases.

[17] Testimony of Dennis Smith, Director, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, before the Energy and Commerce Committee, Subcommittee on Oversight and Investigations, December 7, 2004.

became law in 2008. In the interim, FULs were based on the pre-DRA methodology of 150% of the lowest published price (i.e., wholesale acquisition cost, average wholesale price or direct price) for each dosage and strength of generic drug products. In general, these prices are significantly higher than AMPs. MIPPA authority to use the pre-DRA FUL methodology expired October 1, 2009, so that CMS will not be able to set new FULs without further legislative action and or the removal of the court injunction.

Under H.R. 3962, the Secretary would be required to calculate FULs at 130% of the weighted average (determined on the basis of utilization) of monthly AMPs and also would clarify that the definition of AMP excludes certain discounts and other payments.[18] H.R. 3962 also would require drug manufacturers to report within 30 days after the close of a rebate period, the manufacturer's total number of units used in calculating monthly AMPs for each covered drug. The Secretary would have authority to expedite the promulgation of regulations to clarify upper payment limit and AMP requirements and these regulations could be effective on an interim basis before a public comment period. Through December 31, 2010, states would receive federal financial participation (FFP) for multiple source drug purchases under upper limits in effect on December 31, 2006.

Prescription Drug Rebates

For brand-name prescription drugs, there are two components to drug manufacturers' rebate obligations—the basic rebate and an additional rebate. The basic rebate is the greater of either 15.1% of AMP or the difference between AMP and best price. An additional rebate may also apply depending on how quickly the manufacturer raises a drug's price to private purchasers. No additional rebate is owed if the drug's current AMP does not exceed its inflation-adjusted base period level; if a drug's AMP exceeds inflation adjusted levels, then an additional rebate is owed that is equal to the excess amount. Currently, modifications to existing drugs—new dosages or formulations, such as extended release versions, sometimes referred to as product line extensions—generally are considered new products for purposes of reporting AMPs to the Secretary. As a result, drug makers can avoid incurring additional rebate obligations by making slight alterations to existing products. When new products are released, manufacturers can set their base period AMP to any price, so they are able to set new higher prices that will not incur Medicaid's additional rebates.

H.R. 3962 would alter the Medicaid rebate for certain extended release versions of single source drugs. Effective for drugs purchased after December 31, 2009, the rebate for extended release line extensions of single source or innovator multiple source prescription drugs that are oral solid dosage forms would be the greater of either the basic rebate or a new rebate calculation. The new rebate would be the product of (1) the AMP for the extended release formulation (in oral solid

[18] The proposed exclusions would include (1) customary prompt pay discounts paid to wholesalers; (2) bona fide service fees paid by manufacturers; (3) reimbursement from manufacturers for recalled, damaged, expired, or otherwise unsalable returned goods, including reimbursement for the cost of goods as well as handling and processing, reverse logistics, and drug destruction; (4) sales, rebates, discounts, or price concessions, paid to pharmacy benefit managers, managed care organizations (MCOs), health maintenance organizations, insurers, mail order pharmacies not open to all members of the public, or long-term care providers, that are not passed through to retail pharmacies; (5) direct sales, rebates, discounts, or other price concessions to hospitals, clinics, or physicians unless the drugs are for inhalation, infusion, or injection or the Secretary determines under HHS procedures (which would not be subject to judicial review) that it was necessary to include the price concessions to calculate an accurate AMP for these drugs; or (6) rebates, discounts, and other price concessions required under Medicare Part D.

dosage form) of the single source or innovator multiple source drug; (2) the highest additional rebate (calculated as a percentage of AMP) for any strength of the original single source or multiple source innovator drug; and (3) and the total number of units (as reported by a state) of each dosage form and strength of the extended release formulation that was purchased by a state during the rebate period. In addition, beginning January 1, 2010, H.R. 3962 would increase the basic minimum rebate for single source and multiple source prescription drugs purchased under Medicaid rebate agreements from 15.1% to 23.1%. For rebate periods beginning January 1, 2010, the Secretary would be required to reduce quarterly Medicaid matching payments to states by the amounts attributable to federal share of the increased minimum rebate. The reduction in state matching payments would be considered an overpayment and not be subject to reconsideration.

Extension of Prescription Drug Discounts to Enrollees of Medicaid Managed Care Organizations

States use a variety of service delivery mechanisms to provide medical and related services to Medicaid beneficiaries. Service delivery mechanisms range from full-risk capitation agreements with managed care organizations (MCOs) to fee-for-service (FFS).[19] Under full-risk capitation agreements, MCOs are paid a fixed amount for all the care Medicaid beneficiaries receive, and are responsible for all costs that exceed the fixed capitation payments. Full-risk contracts cover all medical and related services, including prescription drugs.

Drug manufacturers pay states rebates for Medicaid drug purchases, although certain purchases are excluded from the Medicaid drug rebates. Drug purchases excluded from the rebate agreements include drugs dispensed by Medicaid MCOs (when prescription drugs are included in the capitation agreement), inpatient drugs, and drugs dispensed in physicians' or dentists' offices. Some states exclude or carve out drug benefits from their Medicaid MCO contracts, in which case managed care beneficiaries receive their prescribed drugs through the FFS delivery system, and states can claim manufacturer rebates for these purchases.

H.R. 3962 would require prescription drug manufacturers to pay rebates on drugs purchased for beneficiaries covered under Medicaid managed care contracts,[20] similar to the rebates required in the FFS component of Medicaid. To help the Secretary monitor prescription drug rebates, H.R. 3962 also would require states to report quarterly their total dollar amount and volume of rebates received from prescription drug manufacturers for Medicaid beneficiaries enrolled in managed care. Drug purchases under the 340B program discount program would be excluded from rebate requirements for Medicaid MCOs. The reporting requirements would apply to prescription drugs dispensed beginning on July 1, 2010.

[19] Approximately 38% of Medicaid beneficiaries, primarily children and non-disabled adults, receive services under full risk capitation contracts.

[20] Where the health plans are responsible for prescription drugs under the managed care contracts.

Reports on Medicaid Financing

Report on Medicaid Payments

Under current law, there are no federal requirements for states to report on a regular basis the details regarding their Medicaid payment rates to participating providers. H.R. 3962 would require new annual state reports on Medicaid payments. Each year, states would be required to provide the Administrator of CMS specific data on payment rates to providers under the state Medicaid plan, including (1) final rates, (2) the methods used to determine such rates, (3) justification for those rates, and (4) an explanation of the process by which providers, beneficiaries, and other state residents have an opportunity to review and comment on such information before such rates are made final by the state. CBO estimates this provision would have no effect on direct spending during the FY2010-FY2019 period.

Assuring Transparency of Information

H.R. 3962 would require that, beginning on October 1, 2010, states must establish and maintain laws to require disclosure of information on hospital charges and quality and to make such information available to the public and the Secretary. These state laws must (1) require reporting to the state by each hospital in the state information on (a) charges for the most common inpatient and outpatient hospital services, (b) Medicare and Medicaid reimbursement amount for such services, and (c) if the hospitals allow for or provide reduced charges for individuals based on financial need, the factors used to determine reductions in charges; (2) provide notice to individuals of the availability of information on charges; (3) provide timely access to such information, including through an Internet website; and (4) provide for timely access to quality of care information at each hospital made publicly available. States with an existing program may certify to the Secretary that its program satisfies the requirements of this section. States that, as of this Act's date of enactment, do not meet these requirements would have two years from such date to make necessary modifications to come into compliance. CBO estimates this provision would have no effect on direct spending during the FY2010-FY2019 period.

Review of the Federal Matching Rate Formula Under Medicaid

The federal and state governments' share in the cost of Medicaid is based on a formula that provides higher federal matching payments to states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes). This formula, called the federal medical assistance percentage (FMAP), provides a minimum matching rate of 50% and a maximum matching rate of 83%. The federal matching rate for administrative services is the same for all states and is generally 50%, but certain administrative functions have a higher federal matching rate (for example 75% for operating a state Medicaid fraud control unit; 90% for start-up costs associated with creating a Medicaid Management Information System).

H.R. 3962 would require GAO to study federal matching payments made to state Medicaid programs to make recommendations on the FMAP formula to Congress. By February 15, 2011, GAO would be required to submit a report based on this study assessing the effect on the federal government, states, providers, and beneficiaries of making the following changes to the FMAP formula: (1) removing the 50% floor or 83% ceiling, or both and (2) revising the current FMAP formula to better reflect state fiscal capacity, state efforts to finance health and long-term care services, and to better adjust for national or regional economic downturns. In addition and also

due by February 2011, GAO would be required to submit a report to Congress on Medicaid's administration by HHS, state Medicaid agencies, and local government agencies. GAO's study of Medicaid administration would address (1) the extent to which federal funding of each administrative function is being used effectively and efficiently, and (2) the administrative functions funded with federal dollars and the expenditure amounts for each function. CBO estimates this provision would have no effect on direct spending during the FY2010-FY2019 period.

Medicaid and CHIP Payment Access Commission

The Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3) established a new Federal commission called the Medicaid and CHIP Payment and Access Commission, or MACPAC. This commission will review program policies under both Medicaid and CHIP affecting children's access to benefits, including (1) payment policies, such as the process for updating fees for different types of providers, payment methodologies, and the impact of these factors on access and quality of care; (2) the interaction of Medicaid and CHIP payment policies with health care delivery generally; and (3) other policies, including those relating to transportation and language barriers. The commission will make recommendations to Congress concerning such payment and access policies.

Beginning in 2010, the commission is required to submit an annual report to Congress containing the results of these reviews and MACPAC's recommendations regarding these policies. Also beginning in 2010, the commission is required to submit annual reports to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the U.S. and in the market for health care services.

MACPAC must also create an early warning system to identify provider shortage areas or other problems that threaten access to care or the health care status of Medicaid and CHIP beneficiaries.

H.R. 3962 would require MACPAC to submit two new reports to Congress on: (1) the adequacy of nursing facility payment policies under Medicaid; and (2) the adequacy of Medicaid payment policies for pediatric subspecialists and the adequacy of patient access to such providers under Medicaid. The provision would also broaden the scope of MACPAC to review policies that affect low-income children (required by current law) as well as other eligible individuals' access to Medicaid benefits; change current law report deadlines to 2011 (instead of 2010); and require MACPAC to examine the impact of the implementation of the Affordable Health Care for America Act on the access to needed health care and services by low-income individuals and families under Medicaid and CHIP. The bill would authorize to be appropriated $11.8 million for the purpose of carrying out the requirements of this provision. Such funds would be made available until expended. CBO estimates this provision would have no effect on direct spending during the FY2010-FY2019 period.

Waste, Fraud, and Abuse

States are required to create a state plan for their Medicaid programs that is subject to approval by CMS. This comprehensive document describes nearly all aspects of each state's Medicaid program including administrative activities, eligibility, enrollment, covered benefits, provider

credentialing, provider reimbursement, quality assurance, beneficiary cost sharing, and many more program elements. In creating their Medicaid plans, states must conform to federal rules and guidance. Whenever states make changes to their Medicaid program, they must update their state plans by submitting a state plan amendment, which is also subject to review and approval by CMS. As part of the Medicaid plan, states establish participation requirements and reimbursement rules for different providers and suppliers that deliver services to Medicaid beneficiaries, subject to federal rules. These requirements include reporting and monitoring waste, fraud, and abuse.

In general, initiatives designed to combat fraud, waste, and abuse are considered program integrity activities. This includes processes directed at reducing improper payments, as well as activities to prevent, detect, investigate, and ultimately prosecute health care fraud and abuse. More specifically, program integrity ensures that correct payments are paid to legitimate providers for appropriate and reasonable services for eligible beneficiaries. Medicaid and CHIP[21] program integrity are often limited to issues of fraud and abuse by providers (as well as beneficiaries) and efforts to curtail these problems.[22]

The federal government pays a share of every state's spending on Medicaid services and program administration, including expenditures for the reduction of waste, fraud, and abuse. The federal share for most Medicaid service costs is determined by a state's FMAP. The federal match for administrative expenditures does not vary by state and is generally 50%, but certain administrative functions have a higher federal match, including two program integrity expenditures: operation of required Medicaid Management Information Systems (MMIS) and operation of state Medicaid Fraud Control Units (MFCU). Operation of MFCUs and MMIS activities are matched at 75%, although the federal match is 90% for certain startup expenses. Thus, the federal government provides the majority of Medicaid spending to combat fraud and abuse.

Congress provided new dedicated Medicaid program integrity funding in DRA when it established a Medicaid Integrity Program (MIP) with an appropriation reaching $75 million annually for audits, identification of overpayments, education with respect to payment integrity and quality of care, and other purposes. Congress also provided in DRA an additional $25 million annually for five years beginning in FY2006 for Medicaid activities of the HHS Office of Inspector General (OIG), and an annual appropriation reaching $60 million to expand the Medicare-Medicaid data match project (referred to as Medi-Medi) that analyzes claims from both programs together in order to detect aberrant billing patterns.[23]

Improper payments are one measure of fraud and abuse activities under Medicaid. Under the Improper Payments Information Act of 2002 (IPIA, P.L. 107-300), federal agencies were required to identify programs that are susceptible to significant improper payments, estimate the amount of overpayments, and report annually to Congress on those figures and on the steps being taken to

[21] Medicaid and CHIP program integrity are generally parallel. CHIP statute references many of the Medicaid authorities, including administrative activities, such as program integrity.

[22] For more information on Medicaid program integrity issues, see CRS Report RS22101, *State Medicaid Program Administration: A Brief Overview*

[23] The Medi-Medi program is designed to identify fraudulent or improper billing practices that affect both Medicare and Medicaid programs. By matching data across both programs, CMS investigates atypical billing patterns that may not be evident when analyzing the data from each program separately. When problems are identified, CMS works with the states to initiate payment recovery actions. CMS currently has Medi-Medi projects in 10 states and plans to expand the program nationwide.

reduce such payments. In compliance with IPIA provisions, the Department of Health and Human Services estimated FY2008 Medicaid composite error rates at 10.5%, or $32.7 billion in improper payments of which the federal share was $18.6 billion, and, for CHIP, the rate was 14.7%, or $1.2 billion, with a federal share of $0.8 billion.[24]

Measures of improper payment measures focus on payments made in error, not the cause of those improper payments. Thus, improper payment measures provide no measure of fraud, which most often is undetected. Improper payment measures provide estimates of program losses in general. The National Health Care Anti-Fraud Association estimates that the losses to health insurers, including Medicaid, attributable to health care fraud are in the range of 3% to 10% of paid claims.[25]

Health-Care Acquired Conditions

Subject to federal rules, states generally establish their own payment policies, rates, and reimbursement methodologies for Medicaid providers, including inpatient facilities such as hospitals, nursing facilities, and intermediate care facilities for the mentally retarded. Federal regulations require that Medicaid provider rates be sufficient to enlist enough providers so that covered services are available at least to the same extent that comparable care and services are available to the general population within a given geographic area.

In Medicare, hospitals are reimbursed under a prospective payment system (PPS), where each admission is classified into a Medicare severity adjusted diagnosis-related group (MS-DRG) based on the patient's diagnosis and procedures performed. Each MS-DRG has a predetermined reimbursement amount. In general, a hospital is paid the same amount for an MS-DRG regardless of how long patients stay in the hospital or what is required to treat the patient. In some situations under Medicare's PPS, patients with certain complicating conditions could be reclassified into different MS-DRGs for which the hospital would receive a higher payment.

To avoid additional hospital payments for complications that were acquired during patients' admissions, DRA required the Secretary to initiate a hospital-acquired condition (HAC) program for Medicare.[26] Starting October 1, 2007 (FY2008), CMS required hospitals to report whether Medicare patients had certain conditions when they were admitted. Beginning October 1, 2008 (FY2009), if the HACs identified by the Secretary are coded as present at admission, the conditions would not be considered to be acquired during the patient's hospital stay, and the case could receive additional MS-DRG payment. In addition to the HAC policy, in January 2009,

[24] Among all federal programs reporting in FY2008, Medicaid had the highest estimated dollar value of reported improper payments, but CMS reported that the most common causes of Medicaid improper payments resulting from its medical and data processing reviews included insufficient or lack of documentation (which accounted for 90 percent of the errors), pricing errors, and non-covered services. For more discussion of improper payments, see Government Accountability Office (GAO) Testimony to the Senate Subcommittee on Federal Financial Management on April 22, 2009 at http://hsgac.senate.gov/public/_files/NewTestimonyDaly20094220.pdf.

[25] http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_centr&wpscode=TheProblemOfHCFraud.

[26] In creating the HAC program, the Secretary was to select conditions that (1) were high cost, high volume, or both; (2) were identified as complicating conditions or major complicating conditions; and (3) were reasonably preventable through the application of evidenced-based guidelines.

CMS issued three national coverage determinations that precluded Medicare from paying any amount for certain serious preventable medical care errors.[27]

For Medicaid, CMS issued guidance to states in July 2008 to appropriately align Medicaid inpatient hospital payment policies with Medicare's HAC payment policies.[28] In the guidance, CMS indicated that for patients eligible for both Medicare and Medicaid (dual eligibles), hospitals that were denied payment under Medicare might attempt to bill Medicaid for HACs as the secondary payer. CMS instructed state Medicaid agencies to deny Medicaid payments when dual eligible beneficiaries had HACs during an inpatient stay. In its guidance, CMS also encouraged Medicaid agencies to implement policies that would deny payment when other (non-dual eligible) Medicaid beneficiaries had HACs during a hospitalization. CMS identified several Medicaid authorities that could be used to justify payment denials for HACs, but unlike Medicare, DRA did not specifically apply the HAC initiative to Medicaid.

H.R. 3962 would require state Medicaid and CHIP programs to deny hospital payments for HACs as well as for certain serious preventable errors in medical care (never events) determined as non-covered by the Medicare program. In addition, states would have permission to identify other health-care acquired conditions for non-payment under Medicaid. States would be required to have these programs in place for hospital discharges that occur on or after January 1, 2010. CBO estimates that the cost for this provision would be negligible (i.e., plus or minus $50 million).

Evaluations and Reports Required Under Medicaid Integrity Program

Under DRA's Medicaid Integrity Program (MIP) provision, the Secretary has the authority to contract with entities to (1) conduct program integrity activities including reviewing actions of individuals and entities that furnish services under Medicaid to determine if waste, fraud, or abuse has occurred or is likely to occur; (2) audit claims for payment of services provided under a Medicaid state plan (including cost reports, consulting contracts, and risk contracts); (3) identify federal overpayments to individuals or entities; and (4) educate providers, managed care entities, and beneficiaries on program integrity and quality of care. The law established conditions that restrict entities eligible to provide MIP services and create requirements for the Secretary to follow in contracting with eligible entities.

The Secretary was required to establish a five-fiscal year comprehensive plan for ensuring Medicaid program integrity. DRA's MIP provisions also required CMS to hire an additional 100 full-time equivalent employees who would be dedicated to Medicaid program integrity activities. The Secretary also was required to submit to Congress a report, identifying how MIP funds were spent and what MIP expenditures achieved, within 180 days of the close of each fiscal year (beginning in FY2006).

H.R. 3962 would require eligible entities (MIP contractors) to issue assurances to the Secretary that they will conduct periodic evaluations of the effectiveness of their MIP contract activities, and submit to the Secretary annual reports documenting these evaluations. This reporting

[27] These preventable errors are sometimes called "never events." Never events include surgery on the wrong body part or mismatched blood transfusions, which can cause serious injury or death to beneficiaries, and result in increased costs to the Medicare program to treat the consequences of the error.

[28] See State Medicaid Director Letter, SMDL #08-004, July 31, 2008 at http://www.cms.hhs.gov/SMDL/downloads/SMD073108.pdf

requirement would be effective for each contract year beginning with 2011. CBO estimates this provision would have no effect on direct spending during the FY2010-FY2019 period.

Require Providers and Suppliers to Adopt Programs to Reduce Waste, Fraud, and Abuse

Medicaid statute delegates the administration of the Medicaid program to the states. There is considerable variation in how states administer their provider enrollment processes. State Medicaid agencies determine whether a provider or supplier is eligible to participate in the Medicaid program by providing for written agreements with providers and suppliers. Written agreements require that providers and suppliers maintain specific records, disclose certain ownership information, and grant access to federal and state auditors to books and records. States establish policies for provider and supplier re-enrollment, although federal rules must be met for certain providers, such as nursing facilities and intermediate care facilities for the mentally retarded (ICF/MRs), which must have passed survey and certification inspection (at least every 15 months) before they can be re-enrolled as Medicaid providers or suppliers.

OIG has issued a series of compliance guidance documents since 1998 for providers participating in federal health care programs to assist in preventing fraud, waste, and abuse. The purpose of the documents is to encourage health care providers to adopt compliance programs and internal control measures to monitor their adherence to applicable rules, regulations, and requirements. The adoption of these programs is not mandatory. There is no current law explicitly directing health care providers to adopt compliance programs.

States would be required under H.R. 3962 to ensure that providers and suppliers (other than physicians or nursing facilities) that provide services under state Medicaid plans implement compliance programs. In addition, H.R. 3962 would require states to enforce determinations made by the Secretary of a significant risk of fraud by a category of providers or suppliers and carry out enforcement activities as required by the Secretary. CBO estimates this provision would have no effect on direct spending during the FY2010-FY2019 period.

Overpayments

Under current Medicaid law, when states discover that overpayments have been made to individuals or other entities, they have 60 days to recover or attempt to recover the overpayment before an adjustment is made to their federal matching payment. Adjustments in federal payments are made at the end of the 60 days, whether or not recovery is made. When states are unable to recover overpayments because the debts were discharged in bankruptcy or were otherwise uncollectable, federal matching payments would not be adjusted. Beginning with enactment, H.R. 3962 would extend the period for states to repay overpayments to one year when the overpayment is due to fraud. CBO estimates this provision would cost $0.1 billion during the FY2010-FY2019 period.

Managed Care Organizations

Medical loss ratio is the share of total premium revenue spent on medical claims. Medigap insurance policies are private supplemental health care policies that Medicare beneficiaries can purchase to help cover some items, services, and cost sharing not covered under Medicare. Medigap plans are required to have a minimum medical loss ratio of 65% for individual policies

and 75% for group policies. In addition, some states impose medical loss ratios or related requirements on insurers in the individual and/or small group health insurance markets. As of June 2008, minimum ratios required by states ranged from 55% to 80%.

States are prohibited from making payments to Medicaid managed care organizations (MMCO) that are paid on a prepaid capitation or other risk basis unless the managed care organizations fulfill certain requirements. For instance, MMCOs are required to maintain sufficient patient encounter data to identify the physician who delivered services to Medicaid beneficiaries.

H.R. 3962 would require that no federal Medicaid and CHIP payments be made to states for expenditures incurred for services provided by certain Medicaid managed care organizations that are paid on a prepaid capitation or other risk basis (e.g., health maintenance organizations, provider sponsored organizations, other public or private organizations that meet certain requirements for written policies and procedures with respect to adult enrollees) unless the contract between the state and the entity has a medical loss ratio, as determined in accordance with a methodology specified by the Secretary, that is at least 85%. This provision also would require MMCOs to maintain and report to states patient encounter data at a frequency and level of detail to be specified by the Secretary. CBO estimates this provision would have no effect on direct spending during the FY2010-FY2019 period.

Termination of Provider Participation under Medicaid and CHIP if Terminated Under Medicare or Other State Plan or Child Health Plan

Subject to certain specified exceptions, the Secretary is required to exclude from Medicare or Medicaid program participation providers that (1) have been convicted of a criminal offense related to the delivery of an item or service under Medicare or under any state health care program, (2) have been convicted, under federal or state law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service, (3) have been convicted of a felony conviction related to health care fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct, or (4) have been convicted of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

The Secretary also may exclude from Medicare or Medicaid participation providers or individuals involved in acts specifically prohibited, such as program-related convictions, license revocation, failure to supply information, and default on loan or scholarship obligations. CMS must promptly notify the Inspector General of the receipt of any application for participation that identifies any principal of a provider that has engaged in prohibited activities.

Subject to certain specified exceptions, when Medicare provider reimbursement is precluded as a result of the termination of provider participation for reasons such as those listed above, H.R. 3962 would require states to terminate federal financial participation for such providers under Medicaid and CHIP effective for services provided on or after January 1, 2011. CBO estimates this provision would have no effect on direct spending during the FY2010-FY2019 period.

Medicaid and CHIP Exclusion from Participation Relating to Certain Ownership, Control, and Management Affiliations

Under current law, states are required to exclude providers from Medicaid and CHIP participation for reasons specified in statute (e.g., the provider is involved in criminal acts related to the program) for a specified period of time as directed by the Secretary.

H.R. 3962 would require Medicaid and CHIP state agencies to exclude individuals or entities from participating in Medicaid or CHIP if such providers own, control, or manage entities that (1) have unpaid overpayments under Medicaid or CHIP or have been determined by the Secretary or the Medicaid or CHIP state agencies to be delinquent during the specified period; (2) are suspended, excluded, or terminated from participation under Medicaid or for such period; or (3) are affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid or CHIP participation. CBO estimates this provision would have no effect on direct spending during the FY2010-FY2019 period.

Requirement to Report Expanded Set of Data Elements Under MMIS to Detect Fraud and Abuse

States are required to operate an automated claims processing and information retrieval system or Medicaid Management Information System (MMIS) to administer their state plans. MMIS systems must meet a number of requirements. For example, they must (1) be compatible with Medicare claims processing and information systems, (2) provide for electronic transmission of claims data, (3) be capable of providing timely and accurate data, (4) be consistent with Medicaid Statistical Information Systems data formats, (5) meet other specifications as required by the Secretary.

H.R. 3962 would require states to submit new MMIS data as determined necessary by the Secretary for the detection of waste, fraud, and abuse under Medicaid. Such new data elements would be required on or after July 1, 2010. CBO estimates this provision would have no effect on direct spending during the FY2010-FY2019 period.

Billing Agents, Clearinghouses, or Other Alternate Payees Required to Register Under Medicaid

As a condition of participation, certification, or recertification under Medicaid, the Secretary requires participating providers to supply (to the Secretary or the state Medicaid agency) information on the identity of each person with ownership or control interests in the entity or subcontractor that is equal to five percent or more of such entity. Disclosing entities include providers of service, independent clinical laboratories, renal disease facilities, managed care organizations or a health maintenance organizations, entities (other than individual practitioners or groups of practitioners) that furnish or arrange for services, carriers or other agencies or organizations that act as fiscal intermediaries or agents for service providers. Medicare laws require the Secretary to establish a process for the enrollment of providers of services and suppliers.

H.R. 3962 would require Medicaid agents, clearinghouses, or other alternate payees that submit claims on behalf of health care providers to register with the state and the Secretary in a form and manner that is consistent with the Medicare process for the enrollment of providers of services

and supplies. Entities that fail to register would be denied federal financial participation (Medicaid matching payments). CBO estimates this provision would have no effect on direct spending during the FY2010-FY2019 period.

Denial of Payments for Litigation-Related Misconduct

States are required to deny Medicaid federal assistance payments in a number of circumstances specified in statue. Examples include, reimbursement of a nursing facility for payment of legal expenses associated with actions initiated by the facility that are dismissed because there was no basis for legal action; or reimbursement of a state for roads, bridges, stadiums, or other items not covered in a state Medicaid plan.

Under H.R. 3962, the Secretary would be required to deny payment for any amount expended on litigation in which a court imposes sanctions on a state, its employees, or its counsel for litigation-related misconduct, or for payment of legal expenses associated with any action in which a court imposes sanctions on a managed care entity for litigation-related misconduct. This provision would apply to amounts expended on or after January 1, 2010. CBO estimates this provision would have no effect on direct spending during the FY2010-FY2019 period.

Mandatory State Use of National Correct Coding Initiative

CMS processes Part B Medicare claims which include payments for physician, laboratory, and radiology claims. In 1996, to help ensure correct payment for reimbursement claims, CMS implemented the correct coding initiative (CCI). Under CCI, CMS' contractors use automated pre-payment edits to review Medicare claims submitted by Part B providers. Medicare contractors use software to scan claims and apply CCI edits designed to detect anomalies that indicate a claim has incorrect information. For example, CCI edits can detect claims with duplicate services delivered to the same beneficiary on the same date of service. In addition, comparing medical billing codes CCI software can identify when medical procedure were billed erroneously as service bundles (when individual services are grouped together, but cheaper comprehensive codes are available to describe the same services) or in other cases when services should have been billed individually, but were grouped as bundled services.

H.R. 3962 would require that Medicaid claims submitted for federal reimbursement on or after October 1, 2010, would incorporate methodologies compatible with Medicare's National Correct Coding Initiative or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment. By September 1, 2010, the Secretary would be required to identify CCI methodologies (or methodologies of any successor initiative) that are compatible to claims filed under Medicaid, and identify those methodologies that should be incorporated into claims files under Medicaid with respect to items or services for which states provide medical assistance under Medicaid and no national correct coding methodologies have been established under such initiative with respect to Medicare. The Secretary also would be required to notify states of the CCI methodologies (or successor initiative) that were identified and how states should incorporate those methodologies into their Medicaid claims processing systems. The Secretary would be required to submit a report to Congress that includes the notice given to states about the CCI methodologies (or successor initiatives) and analysis that supports the identification of CCI methodologies to be applied to Medicaid claims. CBO estimates this provision would save $0.3 billion over the FY2010-FY2019 period.

Payments to the Territories

Payments to Territories

In the 50 states and the District of Columbia (hereafter referred to as the states), Medicaid is an individual entitlement. There are no limits on federal payments for Medicaid provided that the state contributes its share of the matching funds. By contrast, Medicaid programs in the five territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands) are subject to annual federal spending caps that are set in statue. The Congress has increased the levels of federal Medicaid funding in the territories in recent years. For FY2008 and subsequent fiscal years, the total annual cap on federal funding for the Medicaid programs in the territories is calculated by increasing the FY2007 ceiling for inflation. All five territories typically exhaust their caps prior to the end of the fiscal year. Once the cap is reached, the territories assume the full costs of Medicaid services, or in some instances may suspend services or cease payments to providers until the next fiscal year.

The federal share for most Medicaid service costs is determined by the FMAP, which is based on a formula that provides higher reimbursement to states with lower per capita income relative to the national average (and vice versa). FMAPs have a statutory minimum of 50% and maximum of 83%. In the territories, the FMAP is typically set at 50%. Most recently, ARRA allows each territory to choose between an FMAP increase of 6.2 percentage points along with a 15% increase in its spending cap, or its regular FMAP along with a 30% increase in its spending cap for the period between the first quarter of FY2009 through the first quarter of FY2011. All five territories made the one time choice for the 30% increase in their spending caps.

The Medicaid programs in American Samoa and the Northern Mariana Islands have operated under a Section 1902(j) waiver since 1983 and 1989, respectively. Section 1902(j) refers to the section of the Social Security Act under which authority is granted to waive certain Medicaid program rules. Under a Section 1902(j) waiver, the only Medicaid requirements that may not be waived are: (1) the 50% FMAP, (2) the capped Medicaid allotments for American Samoa and the Northern Mariana Islands, and (3) the requirement that payment may not be made for services that are not described in Section 1905(a) of the Social Security Act.

Under H.R. 3962, for FY2011 through FY2019, the provision would increase the existing spending caps in the territories that are otherwise determined under current law by the following amounts (in $ millions):

Fiscal Year	Puerto Rico	Virgin Islands	Guam	Northern Mariana Islands	American Samoa
2011	$727.6	$34	$34	$13.5	$22
2012	$775	$37	$37	$14.5	$23.7
2013	$850	$40	$40	$15.5	$24.7
2014	$925	$43	$43	$16.5	$25.7
2015	$1,000	$46	$46	$17.5	$26.7
2016	$1,075	$49	$49	$18.5	$27.7
2017	$1,150	$52	$52	$19.5	$28.7
2018	$1,225	$55	$55	$21	$29.7
2019	$1,396	$58	$58	$22	$30.7

The provision would require that the Secretary submit a report not later than October 1, 2013, that details a transition plan to modify the existing Medicaid programs and outline actions the Secretary and the governments of each territory must take to achieve full parity in Medicaid financing with the states by FY2020. The report would be required to include FMAP rates for each territory if the formula applicable to the states were applied. The report would also be required to include any recommendations that the Secretary may have as to whether the mandatory ceiling amounts for each territory provided in Section 1108 of the Social Security Act should be increased any time before FY2020 due to any factors that the Secretary deems relevant. The Secretary would also be required to include information about per capita income data that could be used to calculate FMAP percentages for each territory, and information on how such data differ from the per capita income data used to promulgate FMAPs for the states, as well as recommendations on how the FMAP would be calculated for the territories beginning in FY2020 to ensure parity with the states.

The Secretary would be required to submit subsequent reports to Congress in 2015, 2017, and 2019 detailing the progress that the Secretary and the governments of each territory have made in fulfilling the actions outlined to achieve Medicaid parity in the financing transition plan for the territories (described above).

For fiscal years 2011 through 2019, FMAP rates for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa would be set at the highest FMAP applicable to any of the states for the fiscal year involved, taking into account the application of relevant provisions of ARRA to such states for calendar quarters during such fiscal years for which such subsections apply.

Finally, the provision would extend the waiver authority provided under Section 1902(j) to all of the territories beginning with FY2011. In addition, the Secretary would be required to provide nonmonetary technical assistance (i.e., without additional funding) to the territories in upgrading their existing computer systems in order to meet reporting requirements necessary to implement the financing parity provisions (described above).

CBO estimates this provision would cost $9.3 billion over the FY2010-FY2019 period.

Demonstrations and Pilot Programs

Medical Home Pilot Program

In theory, a medical home would provide participants with access to a personal primary care physician, or specialist, with an office care team who would coordinate and facilitate care and provide guidance, insight, and advice to help the patients obtain physician-guided, patient-centered care. Integrated health care is expected to enhance patient adherence to recommended treatment and avoid (1) hospitalizations, unnecessary office visits, tests, and procedures; (2) use of expensive technology or biologicals when less expensive tests or treatments are equally effective; and (3) patient safety risks inherent in inconsistent treatment decisions.

Section 204 of the Tax Relief and Health Care Act of 2006 (TRCHA, P.L. 109-432) mandated a three-year Medicare medical home demonstration project, which began in 2008. The demonstration is being conducted in up to eight states and pays medical practices for providing continuous and coordinated family-centered care management to Medicare beneficiaries with

multiple chronic illnesses (such as severe asthma, complex diabetes, cardiovascular disease, rheumatologic disorder) or prolonged illnesses that require regular medical monitoring, advising or treatment. The demonstration aims to enroll 400 practices as medical homes and is scheduled to end in 2012, with a final evaluation due by December 2013.[31] No similar demonstration or program is currently being conducted under the Medicaid program.

Like Medicare, Medicaid has limited experience with medical home pilots or programs. While there have never been national or regional medical home demonstrations or pilots under Medicaid, some federal programs designed to help fund health information technology (HIT) infrastructure have provided support for the creation of medical homes in Medicaid. First, Medicaid Transformation Grants, established by DRA (P.L. 109-171), have been used by some states to provide funding for medical homes. Eight of the forty-two grants awarded in FY2007 and FY2008 were used to develop information technology infrastructure for medical home programs. Second, the Medicaid Information Technology Architecture (MITA) initiative has provided some state Medicaid agencies with federal matching funds to enhance Medicaid Management Information Systems (MMIS) capacity (P.L. 92-603). It is believed that a more flexible and fully interoperable MMIS would facilitate the creation of medical homes in Medicaid. Under the MITA initiative, states are eligible to receive a 90% federal match for the purchase/implementation of an MMIS system, and a 75% match for its maintenance. Despite the funding from MITA and the Transformation Grants, most medical home activity in Medicaid has been state-initiated and state-funded. The National Academy for State Health Policy conducted an environmental scan in June 2009 which identified 34 medical home programs, or efforts, in 31 states. Each of these seeks to establish medical homes for Medicaid or CHIP beneficiaries.

H.R. 3962 would require the Secretary to establish a five-year Medicaid medical home pilot program for Medicaid eligible individuals, including medically fragile children and high-risk pregnant women. In establishing medical home pilot projects, states with Secretary-approved applications would be required to apply either an Independent Patient-Centered Medical Home model or a Community-Based Medical Home Model. Under an Independent Patient-Centered Medical Home, payments would be made to physician-directed or nurse-practitioner directed practices for the provision of services, such as care coordination, population disease management, and teaching self-care skills for managing chronic illness, to high need beneficiaries. Under a Community-Based Medical Home Model, payments would be made to certain nonprofit community-based or state-based organizations, or a state, which provide services under the supervision of or in close collaboration with the primary care or principal care physician, nurse practitioner, or physician assistant designated by the beneficiary. Such services would include teaching self-care skills for managing chronic illnesses; transitional care services; care plan setting; nutritional counseling; among others. The pilot would increase the matching percentage for administrative expenditures up to 90% for the first two years of the pilot, and 75% for the next three years. The Secretary would be required to submit to Congress a report on the evaluation of this pilot. The additional federal financial participation resulting from the implementation of this project could not exceed in the aggregate $1,235 million over the five-year period. CBO estimates this provision would cost $0.5 billion over the FY2010-FY2019 period.

Accountable Care Organization Pilot Program

Under H.R. 3962, the Secretary would be required to establish an accountable care pilot program under Medicaid, and would apply one or more of the models for the Medicare program also included in this bill. Among several activities, the Medicare accountable care organizations (ACOs) would encourage the redesign of care processes, reward high-quality, efficient physician

practices, and test certain payment incentive models. Qualifying ACOs would include certain physician groups, and could also include hospitals or other providers and suppliers that would share in any incentive payments. Among a number of criteria, these ACOs would have to meet certain reporting requirements and contribute to a best practices network or website to share strategies on quality improvement, care coordination and efficiency. The Medicaid ACO project would be limited to a period of five years. The Secretary would be authorized to increase federal matching rates for administrative services performed by ACOs up to 90% for the first two years and up to 75% for the remaining three years of the project. In addition, the Secretary would be required to evaluate the payment incentive model to determine its impact on beneficiaries, providers, suppliers and the overall program. An evaluation report would be required to be submitted to Congress and made available to the public. CBO estimates this provision would save $0.1 billion over the FY2010-FY2019 period.

Demonstration Project for Stabilization of Emergency Medical Conditions by Institutions for Mental Diseases.

Medicaid does not reimburse for treatment provided to patients receiving care in institutions for mental disease (IMD), except to those patients under age 21 receiving inpatient psychiatric care and individuals age 65 and over. IMDs are defined under Medicaid statute as hospitals, nursing facilities, or other institutions of more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. Federal law requires that hospital-based IMDs which have emergency departments provide a medical screening examination to individuals for whom an examination or treatment for a medical condition is requested. In such cases, the hospital-based IMD must provide for an appropriate medical screening examination to determine whether or not a medical emergency exists. If a medical emergency exists, then the hospital-based IMD must provide, within the staff and facilities available at the hospital, for further medical examination and treatment as may be required to stabilize the medical condition, or to transfer the individual to another medical facility, subject to certain limitations.

Under H.R. 3962 the Secretary would be required to establish a three-year Medicaid demonstration project in which eligible states would be required to reimburse certain IMDs for services provided to Medicaid eligibles between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency medical condition. To be defined as having an emergency medical condition, an individual would have to express suicidal or homicidal thoughts or gestures, if determined dangerous to self or others.

The Secretary would be required to establish a mechanism for in-stay review to determine whether or not the patient has been stabilized. This mechanism would commence before the third day of the inpatient stay. The term “stabilized” means that the emergency medical condition no longer exists with respect to the individual and that the individual is no longer dangerous to self or others.

Eligible states would be selected by the Secretary based on geographic diversity and would manage the provision of these benefits under the project through utilization review, authorization or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health.

Up to $75 million would be appropriated for FY2010. Such funds would remain available for obligation for three years through December 31, 2012. The Secretary would be required to allocate funds, on a quarterly basis, based on their availability and the FMAP formula.

Finally, the Secretary would be required to submit annual reports to Congress on the progress of the demonstration project as well as a final report that includes an evaluation of the demonstration's impact on the functioning of the health and mental health service system and on Medicaid enrollees. In addition, the final report would be required to contain information pertaining to whether the demonstration project resulted in increased access to inpatient mental health services under Medicaid, whether average lengths of stays for individuals admitted under the demonstration project were longer or shorter as compared to individuals otherwise admitted in comparison sites, and a state-by-state analysis of whether the project reduced emergency room visits or lengths of stay for eligibles, among other requirements. Further, the final report would be required to include a recommendation regarding whether the demonstration project should be continued after December 31, 2012, and expanded on a national basis. CBO estimates this provision would cost $0.1 billion over the FY2010-FY2019 period.

American Indians and Alaska Natives

Division D of the H.R. 3962, the "Indian Health Care Improvement Act Amendments of 2009," contains a number of sections related to improving American Indian and Alaska Natives' access to the Medicaid and CHIP programs. This section includes a summary of the Medicaid and CHIP-related sections of Division D.

The Indian Health Service (IHS), an agency in HHS, provides health care for eligible American Indians/Alaska Natives through a system of programs and facilities located on or near Indian reservations and in certain urban areas.[29] IHS may provide services directly, or Indian tribes (ITs) or tribal organizations (TOs) can operate IHS-services themselves through self-determination contracts and self-governance compacts negotiated with IHS.[30] Urban Indian Organizations (UIOs) also provide IHS-services using grants and contracts from IHS. IHS, and tribally-operated facilities are eligible to receive reimbursements from SSA programs including Medicaid and CHIP.[31] UIOs may also be eligible to receive reimbursements from Medicaid and CHIP. For Medicaid, services received through IHS facilities, whether operated by the IHS, a IT or a TO, the federal government pays the entire cost of covered services; that is, there is no state share for such services delivered by such providers.

In recent years, there have been efforts to expand American Indian and Alaska Native enrollment in the Medicaid and CHIP programs. For example, the Children's Health Insurance Programs Reauthorization Act (CHIPRA, P.L. 111-3)[32] and American Recovery and Reinvestment Act

[29] Additional information about IHS can be found in CRS Report RL33022, *Indian Health Service: Health Care Delivery, Status, Funding, and Legislative Issues*, by (name redacted).

[30] Authorized by P.L. 93-638, act of January 4, 1975, 88 Stat. 2203, as amended; 25 U.S.C. 450 et seq.

[31] IHS received this authority through the Indian Health Care Improvement Act §3, P.L. 94-437, act of September 30, 1976, as amended (25 U.S.C. 1602) and P.L. 105-33.

[32] CRS Report R40130, *The Children's Health Insurance Program Reauthorization Act of 2009*, by (name redac ted) et al.

(ARRA, P.L. 111-5)[33] amended Medicaid and CHIP statutes as they apply to American Indians and Alaska Natives to require states to increase outreach, facilitate enrollment, and eliminate cost sharing for eligible American Indians and Alaska Natives in Medicaid and CHIP. H.R. 3962 would amend the Indian Health Care Improvement Act[34] to include cross references to the CHIPRA and ARRA amendments that relate to American Indians and Alaska Natives in Medicaid and CHIP. These cross references are not discussed below because they do not change the Medicaid or CHIP programs as they affect American Indians and Alaska Natives.

CBO did not provide separate cost/savings estimates for the individual provisions described below. However, CBO did estimate that Division D would cost $0.2 billion in total over the FY2010-FY2019 period.

Definition

H.R. 3962 would define a number of Indian terms as they are defined in Section 4 of the Indian Health Care Improvement Act as amended by this bill. These terms include IHS, IT, TOs, and UIOs, Indian Health Programs (IHPs) and Tribal Health Programs (THPs). IHPs include programs operated by IHS, ITs, TOs, and THPs include programs operated by ITs and TOs. These definitions would apply for all of the SSA including Titles XI, XVIII, XIX and XXI.

Payments Under Medicaid and CHIP[35]

H.R. 3962 would require that payments received by an IHP or UIO from Medicaid or CHIP not be considered in appropriations for Indian health care services. It would also prohibit the Secretary from providing services to Indians with coverage under Medicaid or CHIP in preference to those Indians without such coverage. In addition, H.R. 3962 designates IHPs and UIOs as the payor of last resort for services provided to eligible American Indians and Alaska Natives, including services covered by Medicaid and CHIP.

H.R. 3962 would also require that Medicaid payments to IHS facilities be placed in a special fund to be held by the Secretary, and would require the Secretary to ensure that each IHS service unit receives 100% of the reimbursed amounts to which the service unit's facilities are entitled. Amounts in the special fund are to be used by a facility first (to the extent provided in appropriations acts) to improve IHS facilities so they can comply with the applicable conditions and requirements of the Medicaid program; if the reimbursed amounts are in excess of the amount necessary to make such improvements, the facility is required to use the funds, after consulting with the tribes being served by the service unit, to increase the facility's capacity to provide services or to increase the quality or accessibility of its services. CHIP funds are not required to be placed in the special fund.

H.R. 3962 would also authorize THPs to elect to directly bill and receive payments from Medicaid or CHIP. It would exclude THPs that directly bill these programs from making payments into, or receiving payments from, the special fund discussed above. THPs would be

[33] CRS Report R40223, *American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5): Title V, Medicaid Provisions*, coordinated by (name redacted).

[34] P.L. 94-437, act of September 30, 1976, as amended; 25 U.S.C. 1602 and P.L. 105-33.

[35] This division refers to the SCHIP program. The report will refer to this program as CHIP, because the program was renamed in the Children's Health Insurance Programs Reauthorization Act (CHIPRA) (P.L. 111-3).

required to use reimbursements received from Medicaid and CHIP in the same manner as discussed above for IHS facilities. THPs electing to directly bill Medicaid and CHIP would be subject to the auditing requirements applicable to whichever programs it chooses to bill directly. H.R. 3962 would authorize the Secretary to terminate direct billing for THPs that are not compliant with direct billing requirements.

Expanded Payment

H.R. 3962 would expand payments under Medicaid and CHIP for services provided by IHPs. It would provide that IHPs would be eligible for payments for all items and services provided under a state plan or under a waiver, if the IHP meets the requirements that are generally applicable to other types of providers (i.e., non-IHPs) that provide these services. It would also authorize the Secretary to enter into an agreement with a state for the purpose of reimbursing that state for Medicaid/CHIP services provided by an IHP or UIO directly, through referral, or under contract or other arrangements between an IHP/UIO and another entity. The section would also amend SSA Section 1911(d), which contains a cross-reference on direct billing for IHPs and would add a new SSA Section 1911(c) that cross-references the special fund for improvement of IHS facilities that is described above and a new SSA Section 1911(d) that cross-references direct billing.

H.R. 3962 would also amend SSA Sec. 2105 to permit CHIP payments to be made to ITs, TOs and UIOs explicitly. Currently, CHIP payments cannot be made to health care programs where other federal payments are made with the exception of IHS-operated or funded facilities.

Outreach and Enrollment

H.R. 3962 would require the Secretary to make grants or enter into contracts with tribes and tribal organizations for programs on or near reservations and trust lands, including using electronics and telecommunications, to assist individual Indians to enroll in Medicare, Medicaid, and CHIP, and pay premiums and cost sharing required by the programs. Payment of premiums and cost sharing may be based on need as determined by the tribe or tribal organization. H.R. 3962 would direct the Secretary to place conditions as deemed necessary on the contracts and grants, including requirements to determine Indian Medicaid, Medicare, and CHIP populations, educate Indians about the programs' benefits, provide transportation to enrollment sites, and develop and implement methods to improve Indian participation in the programs. H.R. 3962 would also apply the enrollment, premium, and cost-sharing assistance program to UIOs, and would set requirements for agreements with such organizations. In addition, H.R. 3962 would also require the Secretary, acting through CMS, to consult with states, IHS, ITs, TOs, and UIOs on developing and disseminating best practices to facilitate agreements between the states and Indian entities regarding enrollment and retention of Indians in Medicare, Medicaid, and CHIP. H.R. 3962 also contains cross-references to sections in the SSA for provisions on agreements for collecting, preparing, and submitting applications for Medicaid and CHIP and relevant SSA sections for targeted CHIP assistance for enrolling low-income Indian children.

H.R. 3962 would also amend SSA Sec. 2102 to increase Medicaid and CHIP outreach and enrollment for American Indians and Alaska Natives. Specifically, state CHIP plans would be required to describe how the state would ensure that payments are made to IHPs providing CHIP benefits in the state.

Studies and Reports

H.R. 3962 would require the Secretary to conduct three studies related to SSA programs and submit reports to Congress based on these studies. The studies/reports that would be required are as follows:

- A study to determine the feasibility of treating the Navajo Nation[36] as a state for Medicaid purposes, for Indians living within the Navajo Nation's boundaries. The Secretary would be required to consider the feasibility of certain options—including allowing an Indian entity to operate as a state Medicaid program for Indians living within the boundaries of Navajo Nation—and to report the results of the study to specified committees of Congress not later than three years after enactment. The report would be required to include certain specified elements such as a summary of consultation between the relevant states, the Secretary, and Navajo Nation, projected costs or savings, and the legislative actions necessary to address the establishment of such an entity if it is determined feasible.
- An annual report to Congress, beginning January 1, 2011, covering the enrollment and health status of Indians receiving items or services under the health benefit programs funded under the SSA during the preceding year. The report must contain certain specified information including the number of Indians enrolled in or receiving items or services under each SSA program and under programs funded by IHS; the health status of these Indians, disaggregated by diseases or conditions; the status of IHP and UIO facilities' compliance with the applicable terms and conditions under Medicare, Medicaid, and CHIP, and the progress being made by such facilities toward achievement and maintenance of compliance; and other information as the Secretary determines appropriate. The Secretary would be required to act through the administrator of CMS and the director of IHS in submitting this report.
- A study to identify barriers to interstate coordination of enrollment and coverage of Medicaid- and CHIP-enrolled children who frequently change their state of residence or may be temporarily outside their state of residence for a variety of reasons (e.g., educational needs, family migration, or emergency evacuations). The study must also include an examination of enrollment and coverage coordination issues faced by Medicaid- and CHIP-enrolled Indian children temporarily residing in an out-of-state boarding school or peripheral dormitory funded by the Bureau of Indian Affairs. The Secretary, in consultation with state Medicaid and CHIP directors, would be required to submit a report to Congress, not later than 18 months after enactment, that contains recommendations for legislative and administrative actions to address the enrollment and coverage coordination barriers identified in the study.

[36] The Navajo reservation contains parts of Arizona, Utah, and New Mexico.

Miscellaneous

Improved Coordination and Protection for Dual Eligibles

H.R. 3962 would require the Secretary to establish an identifiable program or office within CMS to improve coordination between Medicare and Medicaid and protection for dual eligible beneficiaries (individuals eligible for both Medicare and Medicaid). CMS' dual eligible office or program would be required to (1) review Medicare and Medicaid enrollment, benefits, service delivery, and payment, policies as well as grievance and appeals processes for Medicare Parts A and B, Medicare Advantage, and Medicaid; (2) identify areas where improved coordination and protection could improve care and reduce costs; (3) issue guidance to states on improving coordination and protection for duals.

In addition, under this provision of H.R. 3962, the new dual eligible beneficiary coordination office or program would be responsible for simplifying dual eligibles' access to benefits and services under Medicare and Medicaid; improving the care continuity for duals as well as their safe and effective care transitions; harmonizing regulatory conflicts between Medicare and Medicaid; and reducing the total cost and improving quality for services provided to duals under Medicare and Medicaid. The Secretary's responsibilities for implementing the CMS office or program for coordination and protection for dual eligibles would include the following:

(1) examination of Medicare and Medicaid payment systems to develop strategies to foster more integrated and higher quality care;

(2) development of methods to facilitate dual eligibles' access to post-acute and community-based services and to identify actions to improve coordination of community-based care;

(3) a study of enrollment in Medicare Savings Program or MSP (for both Medicare and Medicaid) to identify methods to more efficiently and effectively reach and enroll dual eligibles;

(4) an assessment of communication strategies aimed at dual eligibles, including the Medicare website, 1-800-MEDICARE, and the Medicare handbook;

(5) research and evaluation of areas where service utilization, quality, and access to cost sharing protection could be improved and an assessment of factors relating to enrollee satisfaction with services and delivery;

(6) collection and dissemination to the public of data and a database that describes eligibility, benefits, and cost-sharing assistance available to dual eligibles by state;

(7) support for coordination of state and federal contracting oversight for dual eligible coordination programs;

(8) support for state Medicaid agencies by providing technical assistance for Medicaid and Medicare coordination initiatives to improve integration of acute and long-term care services for duals;

(9) monitoring total combined Medicare and Medicaid program expenditures in serving dual eligibles and making recommendations to optimize total quality and cost performance across both programs; and

(10) coordination of Medicare Advantage plan activities under Medicare and Medicaid.

The office or program of dual eligible coordination and protection also would be required to work with relevant state agencies and appropriate quality measurement entities to improve and

coordinate Medicare and Medicaid reporting requirements. The office or program of dual eligible coordination and protection also would seek to minimize duplicate reporting requirements and identify ways to combine assessment requirements. The office also would strive to identify quality metrics and assessment requirements that facilitate quality comparisons across FFS Medicare, Medicare Advantage, FFS Medicaid, and Medicaid managed care. The Secretary would be required to seek endorsement by the quality metrics contractor described under Sec. 1890 (a) of H.R. 3962. Further the office or program of dual eligible coordination and protection would be required to consult with relevant dual eligible stakeholders. Finally, within one year of enactment of H.R. 3962 and every three subsequent years the Secretary would be required to submit a report to Congress documenting progress of the office or program of dual eligible coordination and protection. CBO estimates this provision would have no effect on direct spending during the FY2010-FY2019 period.

Application of the Medicaid Improvement Fund

Under the Supplemental Appropriations Act (P.L. 110-252), Congress directed the Secretary of HHS to establish a Medicaid Improvement Fund (MIF) that is available to the Secretary to improve the management of the Medicaid program with regard to Agency oversight of contracts and contractors, and the evaluation of demonstration projects. MIF funds are authorized and appropriated in the amount of $100 million for FY2014, and $150 million for each of fiscal years 2015 through 2018, and are available in addition to payments that would otherwise be made for such activities. H.R. 3962 would strike MIF funding amounts authorized and appropriated for the period between FY2014 through 2018, and would specify that funds available for expenditures from the MIF would be in an amount as appropriated or otherwise made available by law. CBO estimates this provision would save $0.7 billion during the FY2010-FY2019 period.

Sense of the Congress Regarding Community First Choice Option to Provide Medicaid Coverage of Community-Based Attendant Services and Supports

A Personal Care Attendant is a person who provides personal care to an individual with a significant disability by providing assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs generally refer to eating, bathing and showering, using the toilet, dressing, walking across a small room, and transferring (getting in or out of a bed or chair). IADLs include preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone, among others. Under current law, states have the option to cover personal care services, including personal care attendant services, under a variety of optional state plan benefits. These are the state plan: (1) personal care benefit; (2) self-directed personal care benefit; and (3) the home and community-based services benefit. State also have the option to offer personal care under certain waiver authorities, including section 1915(c) home and community-based waivers, and section 1115 Research and Demonstration waivers. Although states have significant flexibility to determine the amount and scope of these benefits, each statutory authority includes a unique set of rules defining and limiting the way in which a state may extend this benefit to Medicaid beneficiaries.

H.R. 3962 states that it is the sense of the Congress that states would be allowed to elect under their Medicaid programs a Community First Choice Option under which (1) coverage of community-based attendant services and supports furnished in home and communities would be available, at an individual's option, to individuals who would otherwise qualify for Medicaid institutional coverage; (2) such supports and services would include assistance to individuals with

disabilities with activities of daily living, instrumental activities of daily living, and health-related tasks; (3) the FMAP for such services and supports would be enhanced; (4) states, consistent with minimum federal standards, would ensure the quality of such supports and services; and (5) states would collect and provide data to the Secretary on the cost, effectiveness and quality of supports and services provided through state options. CBO estimates this provision would have no effect on direct spending over the FY2010-FY2019 period.

Technical Corrections

Medicare Savings Programs (MSP) and Part D low-income subsidy (LIS) Programs

Federal assistance is provided to certain low-income persons to help them meet Medicare Part D premium and cost-sharing charges. To qualify for the Part D low-income subsidy (LIS), Medicare beneficiaries must have resources (assets) no greater than the income and resource limits established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). Individuals may qualify for the full subsidy in two ways: (1) if they are eligible for Medicaid or one of the Medicare Savings Programs (MSP; Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI)), or are recipients of Supplemental Security Income benefits, they are deemed automatically eligible; or (2) if they apply for the benefit through their state Medicaid agency or through the Social Security Administration (SSA) and are determined to have an annual income below 135% of the federal poverty level and to have resources below a certain limit.

The Commissioner of Social Security is required to conduct outreach efforts to identify persons potentially eligible for assistance under the MSP and the LIS programs and to notify such persons of the availability of assistance. Outreach efforts are to be coordinated with the states.

MIPPA extended the outreach requirements for the Commissioner of Social Security. Beginning January 1, 2010, the Commissioner is required, with the applicants' consent, to transmit data from the LIS application to the appropriate state Medicaid agency. The transmittal initiates an application of the individual for MSP benefits. states are required to accept data transmitted under this provision and to act on the data in the same manner and in accordance with the same deadlines as if the data constituted an initiation of an MSP application submitted directly by the individual. The date of the individual's application for LIS from which the summary data was derived constitutes the application date for MSP. Under Medicaid rules, states are required to process Medicaid applications, including MSP applications, with reasonable promptness.

H.R. 3962 would clarify that for the purpose of a state's obligation to furnish medical assistance (Medicaid-financed coverage) with reasonable promptness and for the purpose of determining when medical assistance is to be made available, the date of the electronic transmission of low-income subsidy program data to the state Medicaid Agency would constitute the date of filing for benefits under the MSP. In addition, for the purpose of determining when medical assistance will be made available, the state would be required to consider the date of the individual's application for the LIS to constitute the date of filing for benefits under the MSP. With respect to Medicaid spending, CBO estimates this provision would cost $2.0 billion over the FY2010-FY2019 period. (Effects on Medicare spending for this provision were estimated by CBO to be $11.8 billion over the same period.)

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

CHIPRA restated prior law that federal funding for individuals who are not legal residents is not allowed, and that the law provides for the disallowance of federal funding of erroneous expenditures under Medicaid and CHIP. H.R. 3962 would make a technical correction to one sentence in CHIPRA by replacing the reference to "legal residents" with the phrase "lawfully residing in the United States." Thus, the new wording would be "Nothing in this Act allows federal payment for individuals who are not lawfully residing in the United States." CBO estimated this provision would have no effect on direct spending over the FY2010-FY2019 period.

Section 1115 Waivers

Approved Section 1115 waivers are deemed to be part of a state's Medicaid (or CHIP) state plan for purposes of federal reimbursement. The provision would clarify that Medicaid coverage offered under the Special Terms and Conditions (STCs) of a Section 1115 demonstration waiver approved by the Secretary (e.g., benefit coverage, cost sharing rules, special financing arrangements, eligible populations, etc.) would be considered part of the Medicaid state plan. Medicaid program rules not explicitly listed in the waiver STCs would still apply. CBO estimated this provision would have no effect on direct spending over the FY2010-FY2019 period.

Quality Measures for Maternity and Adult Health Services Under Medicaid and CHIP

CHIPRA, the reauthorization of CHIP, included several provisions designed to improve the quality of care for children under Medicaid and CHIP. The law directed to Secretary to develop (1) child health quality measures, (2) a standardized format for reporting information, and (3) procedures to encourage states to voluntarily report on the quality of pediatric care in these two programs. Examples of these initiatives included grants and contracts to develop, test, update and disseminate evidence-based measures, and demonstrations to evaluate promising ideas for improving the quality of children's health care under Medicaid and CHIP.

H.R. 3962 would require the Secretary to develop and publish measures on the quality of maternity care under Medicaid and CHIP. The Secretary would also be required to publish a standardized reporting format for these measures, to be used by participating managed care entities, providers and practitioners in reporting such measures to the Secretary. The bill would also require the Secretary to develop quality measures for services provided to adult Medicaid and CHIP beneficiaries ages of 21 and 64 (that are not part of the set of quality measures for the delivery of health care services in the U.S. established under a separate provision in this bill). These measures would also be published, along with a standardized reporting format for use by participating providers. In developing these quality measures, the Secretary would be required to consult with certain academic institutions with related health quality measurement expertise, and to obtain input from stakeholders. The development of these measures must be coordinated with the development of the child health quality measures established in CHIPRA. Starting in 2013, and annually thereafter, the Secretary would be required to submit a report to Congress on the availability of reliable data relating to the quality of maternity care and services provided to adults ages 21 to 64 under Medicaid and CHIP, and recommendations for improving such quality of care under both programs. A total of $40 million would be appropriated for these activities for

the five year period beginning with FY2010, to remain available until expended. CBO estimates that the cost for this provision would be negligible (i.e., plus or minus $50 million).

Rule for Changes Requiring State Legislation

H.R. 3962 would provide that a state plan for medical assistance under Title XIX, if considered by the Secretary to require state legislation in order for the plan to meet an additional requirement imposed by an amendment made in this title, must not be regarded as failing to be in compliance solely on the basis of failure to meet the requirement prior to the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of the enactment of this Act. For states with a two-year legislative session, each year of its session would be required to be deemed a separate regular session of the state legislature. CBO estimates this provision would have no effect on direct spending over the FY2010-FY2019 period.

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