Medicaid and the Children's Health Insurance Program (CHIP) Provisions in H.R. 3590, as Passed by the Senate

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Summary

This report summarizes key provisions applicable to Medicaid and the Children's Health Insurance Program (CHIP) in H.R. 3590, the Patient Protection and Affordable Care Act, as passed by the Senate on December 24, 2009. In general, the bill would expand health insurance coverage to many Americans who currently are uninsured, while attempting to reduce expenditures and offering mechanisms to increase care coordination, encourage more use of health prevention, and improve quality of care. The bill would reform the private health insurance market, impose a mandate for most legal U.S. residents to obtain health insurance, establish health insurance "Exchanges" that would subsidize health insurance coverage for eligible individuals; expand Medicaid eligibility; create programs to improve quality of care and encourage more use of preventive services; address healthcare workforce issues; and propose a number of other Medicaid and Medicare program and federal tax code changes.

Among the proposed Medicaid reforms, the bill would modify eligibility standards and methodologies, add several new mandatory and optional Medicaid benefits, expand Medicaid benefits, and increase CHIP funding. Beginning in 2014, or sooner at state option, nonelderly, non-pregnant individuals with income below 133% of the federal poverty level (FPL) would become eligible for Medicaid. New optional eligibility groups also would be added, such as non-elderly, non-pregnant individuals (childless adults) with income above 133% of poverty. The bill also would require states to maintain current coverage levels for individuals under Medicaid and CHIP. In addition, the bill would add several new mandatory Medicaid benefits including coverage of services in free standing birth clinics, and coverage of tobacco cessation services for pregnant women.

The bill would make a number of Medicaid and CHIP financing changes, such as reducing Medicaid disproportionate share hospital (DSH) payments, increasing prescription drug rebates and increasing certain pharmacy reimbursement, increasing federal spending for the Territories, providing special enhanced disaster recovery Medicaid funding, and requiring payment system reforms.

The bill includes provisions that would give states and other stakeholders new program integrity (PI)—waste, fraud and abuse—enforcement and monitoring tools as well as impose some new data reporting and oversight requirements on states and providers. Additional PI provisions affecting Medicaid and CHIP include requirements for states to implement a national correct coding initiative similar to the Medicare program, a broad new nursing home accountability initiative, and other new requirements to enhance PI that increase the uniformity of Medicare, Medicaid, and CHIP requirements.

The bill also offers opportunities for states and other stakeholders to use new demonstrations and grants to modify payment systems, introduce care delivery models, and improve care quality, which include a medical global payment system demonstration and school-based health center grants.

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Status of Legislation

This report summarizes key provisions applicable to Medicaid and the Children's Health Insurance Program (CHIP) in H.R. 3590, the Patient Protection and Affordable Care Act (PPACA), as passed by the Senate on December 24, 2009. The bill, a comprehensive health reform proposal, resulted from the merger of two separate Senate health reform bills, , the Affordable Health Choices Act, and S. 1796, America's Healthy Future Act of 2009. S. 1679 was ordered reported by the Senate Committee on Health, Education, Labor and Pensions (HELP), July 15, 2009, while S. 1796 was ordered reported by the Senate Committee on Finance, October 19, 2009. The Senate voted to take up S.Amdt. 2786 on November 21, 2009, after invoking cloture on the motion to proceed to consider the legislation. The Patient Protection and Affordable Care Act was passed by the Senate on December 24, 2009, as an amendment in the nature of a substitute to H.R. 3590, a homeowner tax credit bill that passed the House unanimously on October 8, 2009.

Congressional Budget Office and Joint Committee on Taxation Analysis

On March 11, 2010, the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) updated their estimate of the direct spending and revenue effects of H.R. 3590, the Patient Protection and Affordable Car Act (PPACA). The updated estimate reflects the bill as it was passed by the Senate on December 24, 2009.[1] The revised projection of PPACA assumes that federal deficits would be reduced by $118 billion over the 10-year period of 2010-2019[2] and, by 2019, would insure 94% of the non-elderly, legally present U.S. population. According to the CBO, the gross 10-year cost of the exchange subsidies ($449 billion), increased federal Medicaid and CHIP outlays ($386 billion), and tax credits for small employers ($40 billion) would total $875 billion. These costs would be partially offset by $251 billion over the 10-year budget window, from four sources: net revenues from the excise tax on high-premium insurance plans ($149 billion); penalty payments by uninsured individuals ($15 billion); penalty payments by employers whose workers received subsidies via the exchanges ($27 billion); and other budgetary effects, mostly on tax revenues, associated with the expansion of federally subsidized insurance ($60 billion). Taking into account these offsets, the net cost of the coverage provisions, according to the CBO analysis, would be $624 billion over 10 years.

[1] The March 11, 2010, estimate is available at http://cbo.gov/ftpdocs/113xx/doc11307/Reid_Letter_HR3590.pdf.

[2] The earlier estimate, dated December 19, 2009, can be found at http://cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers_Correction_Noted.pdf. That estimate assumed that federal deficits would be reduced by $132 billion over the same 10-year period. The more recent estimate incorporates a number of technical corrections, reflects an updated enactment date, includes a revised estimate of the impact of limiting contributions to flexible spending accounts, and includes the effect of amendments adopted by the Senate during its consideration of H.R. 3590 that were not reflected in the December 19, 2009, estimate. More detail on the revised estimate is provided in http://cbo.gov/ftpdocs/113xx/doc11307/Reid_Letter_HR3590.pdf.

Overview of the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act—herein referred to as the Senate bill—consists of 10 titles that cover the following general topics: Title I–health insurance; Title II–Medicaid, maternal and child health; Title III–Medicare, quality of care; Title IV–prevention and wellness; Title V–health workforce; Title VI–transparency, program integrity; Title VII–drugs and biologics; Title VIII–long-term care insurance; Title IX–revenues; and Title X-strengthening quality, affordable health care for all Americans.

This report summarizes key Medicaid and CHIP provisions in the bill. To help highlight the Senate bill's most important Medicaid and CHIP health reforms, applicable provisions were grouped into the following six major issue areas: eligibility, benefits, financing, program integrity, demonstrations and grant funding, and miscellaneous Medicaid and CHIP provisions.

The eligibility issue area may include the bill's most dramatic health reforms applicable to Medicaid, namely a coverage expansion for nonelderly, non-pregnant individuals with income up to 133% of the federal poverty level (FPL). This reform not only would expand eligibility to a group of individuals who were previously ineligible for Medicaid (low income childless adults), but also would raise Medicaid's mandatory income eligibility level for certain existing groups from 100% to 133% of the FPL. In addition, federal financial participation (FFP) would be increased for these new eligibility groups. Further, the bill would encourage states to improve outreach, streamline enrollment, and coordinate with the American Health Benefit Exchanges (Exchange).[3]

Other eligibility reforms would require states to maintain current Medicaid and CHIP coverage levels—through 2013 for adults and 2019 for children. The bill also would require states to maintain the current CHIP structure through FY2019, but would not provide federal CHIP appropriations beyond FY2013.

The benefit reforms proposed in the bill for Medicaid and CHIP, would add new mandatory and optional benefits. Mandatory benefit additions would include premium assistance for employer-sponsored health insurance, coverage of free standing birth clinics, and tobacco cessation services for pregnant woman. The bill also would authorize states to offer new optional benefits such as preventive services for adults, health homes, and a program to permit Medicaid beneficiaries first choice to remain in their community, rather than institutional care.

Under financing reforms, the bill would introduce measures to reduce the growth of Medicaid expenditures and would increase federal matching payments for eligibility expansion. Cost control reforms include proposed reductions in Medicaid disproportionate share hospital (DSH) payments, reduced expenditures for prescription drugs and payment reforms to reduce inappropriate hospital expenditures for health-care acquired conditions.

The bill would give states and other stakeholders new program integrity enforcement and monitoring tools as well as impose new data reporting and oversight requirements on states and

[3] For a description of the exchange, see CRS Report R40942, *Private Health Insurance Provisions in Senate-Passed H.R. 3590, the Patient Protection and Affordable Care Act* , by (name redacted) et al.

providers. Additional Medicaid and CHIP program integrity provisions would include requirements for states to implement initiatives used by the Medicare program, such as a national correct coding initiative and a recovery audit contract program. The bill also proposes a broad nursing home accountability initiative that would add a number of requirements to improve the transparency of information on facilities and chains as well as provide LTC consumers with information on the quality and performance of nursing homes.

The bill includes a number of demonstrations, pilot programs, and grants. These proposals would provide the Secretary of the Department of Health and Human Services (the Secretary) and state Medicaid and CHIP programs with opportunities to test models for improving the delivery, quality, and payment for services. Finally, the Senate bill would include a number of miscellaneous Medicaid and CHIP reforms. These proposals would add several offices within the Centers for Medicare and Medicaid Services (CMS) to work to better coordinate care across the Medicare and Medicaid/CHIP programs. One of these offices would be dedicated to improve coordination for beneficiaries eligible for both Medicare and Medicaid (dual eligibles) and another would add a Medicare and Medicaid innovation center, which may permit states to have more control over both Medicare and Medicaid expenditures for dual eligibles.

Unless otherwise indicated, the Secretary of the Department of Health and Human Services is referred to as "the Secretary" throughout this report.

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. State application of income counting rules result in expanding eligibility to higher-income individuals.

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 Supplemental Security Income (SSI) program. Three examples of groups that states may choose to cover under Medicaid include pregnant women and infants with family income between 133% FPL and 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

[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."

disabled, not pregnant and not parents of dependent children), for example, are generally not eligible for Medicaid, regardless of their income.

The measure would make several changes to Medicaid eligibility. Among the provisions that would impact eligibility, the bill would add two new mandatory eligibility groups, and several 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]

Medicaid and Health Insurance Reform

Medicaid Coverage for the Lowest Income Populations (§2001, §10201)

The measure would create a new mandatory Medicaid eligibility category for all non-elderly, non-pregnant individuals (e.g., childless adults, and certain parents) who are not entitled to or enrolled in Medicare Part A or enrolled in Medicare Part B, and are otherwise ineligible for Medicaid. For such individuals (hereafter referred to as "newly eligible" individuals), the proposal would establish 133% of FPL based on modified gross income (or MGI as described below), as the new mandatory minimum Medicaid income eligibility level. As a conforming measure, the bill also would change the mandatory Medicaid income eligibility level for children ages 6 to 19 from 100% FPL to 133% FPL (as applies to children under age 6). Thus, in 2014, most non-elderly citizens[6] up to 133% FPL would be eligible for Medicaid.

During the transitional period between April 1, 2011 and January 1, 2014, states would have the option to expand Medicaid to "newly eligible" individuals as long as the state does not extend coverage to (1) individuals with higher income before those with lower income, or (2) parents unless their child(ren) are enrolled in the state plan, a waiver, or in other health coverage. However, during the optional phase-in period, no additional federal financial assistance would be available for covering such individuals. Beginning in 2014, states would be *required* to extend Medicaid to the "newly eligible" group, and additional federal financial assistance would be provided to all states to share in the cost of covering such individuals. These financing arrangements are described in more detail under the Financing section of this report.

The bill would also allow states to make a "presumptive eligibility" determination (subject to guidance established by the Secretary) for "newly eligible" individuals or for individuals eligible for family coverage under Section 1931 of the Social Security Act (SSA),[7] if the state already allows for presumptive eligibility determinations for children, and pregnant women. That is, states may enroll such individuals for a limited period of time before completed Medicaid

[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.

[6] For more information about the treatment of noncitizens and the verification of individual's eligibility for premium credits under the various bills see CRS Report R40889, *Noncitizen Eligibility and Verification Issues in the Health Care Reform Legislation*, by (name redacted).

[7] Section 1931 of the Social Security Act, added in 1996, allows states to cover low income parents with incomes below Aid to Families with Dependent Children 1996 thresholds. States may provide coverage to parents with higher incomes by increasing asset and income limits and utilizing asset and income disregards.

applications are filed and processed, based on a preliminary determination by Medicaid providers of likely Medicaid eligibility. "Newly eligible" individuals must then formally apply for coverage within a certain timeframe to continue receiving this benefit. Under current law, such presumptive eligibility determinations can be made for children, pregnant women, and certain women with breast or cervical cancer.

Financial Eligibility Requirements for "Newly Eligible" Populations Determined Using Modified Gross Income (MGI) (§2001, §10201)

Certain income disregards (i.e., type of expenses such as child care costs or block of income disregards where a specified portion of family income is not counted), and assets or resource tests would no longer apply when assessing an individual's income to determine financial eligibility for Medicaid. Instead, income eligibility for an individual would be based on MGI, or in the case of an individual in a family greater than one, the household income of such family.[8] MGI and household income would also be used to determine applicable premium and cost sharing amounts under the state plan or waiver.

Financial Eligibility Requirements for Certain Populations Eligible Under Current Law (§2001, §2002, §10201)

Existing Medicaid income counting rules (rather than MGI) would continue to apply for determining eligibility for certain groups, including (1) individuals that are eligible for Medicaid through another federal or state assistance program (e.g., foster care children and individuals receiving SSI); (2) the elderly; (3) certain disabled individuals who qualify for Medicaid on the basis of being blind or disabled (or being treated as such) without regard to whether the individual is eligible for SSI; (4) the medically needy; and (5) enrollees in a Medicare Savings Program (e.g., Qualified Medicare Beneficiaries for which Medicaid pays the Medicare premiums, coinsurance and deductibles). In addition, MGI would not affect eligibility determinations through Express Lane (to determine whether a child has met Medicaid or CHIP eligibility requirements), for Medicare prescription drug low-income subsidies, or for determinations of eligibility for Medicaid long term care services (e.g., nursing facility services, a level of care in any institution equivalent to nursing facility services, home or community-based services furnished under the state plan or a waiver, and other related Medicare long-term care services). Any individual enrolled in Medicaid (under the state plan or a waiver) on January 1, 2014, who would be determined ineligible for medical assistance solely because of the application of the new MGI or household income counting rule would remain Medicaid eligible (and subject to the same premiums and cost-sharing as applied to the individual on that date) until the later of March 31, 2014, or his/her next Medicaid eligibility redetermination date.

Finally, state use of MGI and household income to determine income eligibility for Medicaid (and for any other purposes applicable under the state plan) would not affect or limit the application of (1) the state plan requirement to determine an individual's income when a Medicaid application is processed, or (2) Medicaid rules regarding sources of countable income.

[8] MGI and household income would also be used for determining the amount of premium credit assistance for the purchase of a qualified health benefits plan under state exchanges, described in Section 1401 of the bill. For more information on MGI and household income see CRS Report R40942, *Private Health Insurance Provisions in Senate-Passed H.R. 3590, the Patient Protection and Affordable Care Act* , by (name redacted) et al.

In general, these provisions would be effective as of January 1, 2014. For states who choose to transition to MGI earlier, these provisions would be effective when enacted by their individual state legislatures.

Medicaid Benefit Coverage for The New Mandatory Eligibility Group (§2001, §10201)

Medicaid standard benefits are identified in federal statute and regulations and include a wide range of medical care and services. Some Medicaid benefits are mandatory, meaning they must be made available by states to the majority of Medicaid populations (i.e., those classified as "categorically needy"), while other benefits may be covered at state option. As an alternative to providing all of the mandatory and selected optional benefits under traditional Medicaid, states have the option to enroll certain state-specified groups in benchmark and benchmark-equivalent benefit plans, as permitted under Section 1937 of the SSA. For more information on benchmark and benchmark-equivalent coverage, including the proposed changes to this coverage under the bill, see the Benefits section of this report.

"Newly eligible" individuals would receive either benchmark or benchmark-equivalent coverage consistent with the requirements of Section 1937 of the SSA, (excluding the "newly eligible" who meet the definition of currently exempted populations under Section 1937, such as blind or disabled persons, hospice patients, etc.).

Maintenance of Medicaid Income Eligibility (MOE) (§2001, §10201)

The measure includes a Medicaid eligibility maintenance of effort (MOE). States would not be eligible for Medicaid payments from the date of enactment through the date which the Secretary determines that an exchange (established by the state under Section 1311 of this bill) is fully operational if the eligibility standards, methodologies, or procedures under its state Medicaid plan (including any waivers) are more restrictive than the eligibility standards, methodologies, or procedures, under such plan (or waiver) that are in effect as of the date of enactment. The requirement to use MGI when determining Medicaid income eligibility (as described below) would not affect compliance with the MOE requirement. MOE would continue through September 30, 2019 for any child who is under age 19 (or such higher age as the state may have elected). States would be permitted to expand Medicaid eligibility or move populations covered under a waiver to state plan coverage at the same (or higher) eligibility level that applied under the waiver without affecting compliance with the Medicaid eligibility MOE requirements.

Between January 1, 2011 and December 31, 2013, a state would be exempt from the MOE requirement for optional non-pregnant, non-disabled adult populations whose income is above 133% FPL if the state certifies to the Secretary that the state is currently experiencing a budget deficit or projects to have a budget deficit in the following state fiscal year. The state may make such certification on or after December 31, 2010. For such states, the MOE exemption would apply from the date the state submits the certification to the Secretary through December 31, 2013.

States would be required to establish Medicaid income eligibility thresholds for state plan services (or waiver services) using MGI levels that are not less than the effective income eligibility levels applicable as of the date of enactment of H.R. 3590. To meet the MOE requirements during the transition to MGI and household income (described above), among other

requirements, states would be required to work with the Secretary to establish an equivalent income test that ensures that individuals eligible for Medicaid services as of the date of enactment do not lose coverage. The Secretary would be permitted to waive provisions of Medicaid or CHIP to ensure that states establish income and eligibility determination systems that protect beneficiaries.

Medicaid Coverage for Former Foster Care Children (§2004, §10201)

Except for children under age 19 and adults age 64 and older, age is generally not a factor in determining eligibility under Medicaid. Instead, youth age 19 or 20 may qualify for Medicaid coverage under several of the existing mandatory and optional eligibility pathways, three of which target individuals who were recently discharged from the child welfare system (i.e., Chafee Foster Care Independence Program (CFCIP)/Title IV-E, "Ribicoff" children, and youth participating in State Adoption Assistance Agreements).

The measure would add a new mandatory Medicaid eligibility group to include individuals who are (1) under 26 years of age; (2) not eligible or enrolled under existing Medicaid mandatory eligibility groups, or who are described in any of the existing Medicaid mandatory eligibility groups but have income that exceeds the upper income eligibility limit established under any such group; (3) were in foster care under the responsibility of the state on the date of attaining 18 years of age (or such higher age as the state has elected); and (4) were enrolled in the Medicaid state plan or under a waiver while in such foster care. The bill would also allow states to make "presumptive eligibility" determinations for these individuals. That is, states may enroll such individuals for a limited period of time before completed Medicaid applications are filed and processed, based on a preliminary determination by Medicaid providers of likely Medicaid eligibility. (Such individuals must then formally apply for coverage within a certain timeframe to continue receiving Medicaid.) The measure would also add this new group of foster care youth to those exempt from enrollment in Medicaid benchmark plans (even if such individuals also meet the definition of the "newly eligible" mandatory expansion population (described above)). Benchmark and benchmark equivalent plans are permitted as an alternative to regular Medicaid benefits under Section 1937 of the Social Security Act, and are nearly identical to those offered through CHIP. This provision would be effective as of January 1, 2014.

Protection for Recipients of Home- and Community-Based Services Against Spousal Impoverishment (§2404)

Generally, when a married individual applies to Medicaid, the combined income and assets of the couple are considered together to determine program eligibility. Medicaid law contains special rules; however, for situations in which one spouse applies for nursing home benefits under Medicaid and the other spouse does not apply for Medicaid coverage. Under these rules, referred to as spousal impoverishment protections, spouses remaining in the community do not have to meet the same stringent income and asset tests as their counterparts. By allowing them to retain higher amounts of income and assets, these protections are intended to better enable community spouses to continue residing in their homes or other community-based settings. These protections are also intended to prevent the impoverishment of those spouses who do not apply to Medicaid.

Under Medicaid law, states are required to apply spousal impoverishment protections to applicants for Medicaid nursing home care, yet are given the option to apply these protections to applicants for certain home and community-based services (e.g., waivers under Sections 1915(c)

and (d), and Section 1115 of SSA). In addition, Medicaid law prohibits states from applying spousal impoverishment protections to people who qualify for certain Medicaid-covered home and community-based services through an eligibility group known as the medically needy. The medically needy group allows for the enrollment in Medicaid of certain persons with exceptionally high medical expenses.

As spousal impoverishment rules apply only for the purposes of income and resource counting for eligibility (and for post-eligibility determination of income, not discussed here), they are not used when deciding which Medicaid-covered benefits would be offered to a particular beneficiary. Since the passage of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), some confusion has arisen about whether the new state home and community-based services (HCBS) state plan benefit (authorized under Section 1915(i) of SSA), is also an eligibility pathway into Medicaid. It is not. This HCBS plan benefit can only be made available to individuals who are already enrolled in Medicaid. As such, spousal impoverishment rules are not applied in determining whether a person may access this HCBS plan benefit.

The bill would make three major changes to current Medicaid law. First, states would be required to apply spousal impoverishment rules to applicants who apply to Medicaid to receive certain home and community-based services (i.e., authorized under Sections 1915(c), (d), and (i) and under Section 1115 of SSA). Second, states would be required to apply spousal impoverishment protections when determining eligibility for medically needy individuals applying for certain home and community-based services. These two changes would sunset after a five-year period beginning on January 1, 2014. Third, another provision in the bill would convert the HCBS state plan benefit option (Section 1915 (i)) into both a benefit and an eligibility pathway. Spousal impoverishment rules would apply to this new eligibility pathway. See the description of these provisions entitled “Removal of Barriers to Providing HCBS” in the Eligibility section of this report.

Optional Eligibility Expansions

Non-elderly, Non-pregnant Individuals with Family Income Above 133% of the FPL (§2001, §10201)

Beginning on January 1, 2014 the bill would create a new optional Medicaid eligibility category for all non-elderly, non-pregnant individuals (e.g., childless adults, and certain parents) who are otherwise ineligible for Medicaid, or enrolled in an existing Medicaid eligibility group. For such individuals, income would exceed 133% FPL (based on modified gross income), but would not exceed the maximum level established under the state plan or waiver. States would be permitted to phase in Medicaid coverage through a state plan amendment to these new optional eligible individuals based on income, as long as the state does not extend coverage to (1) individuals with higher income before those with lower income, or (2) parents unless their child is enrolled in the state plan, a waiver, or in other health coverage. Among other purposes, to support the transition to MGI, states may rely on this state plan option to meet the MOE requirements, as described above.

State Eligibility Option for Family Planning Services (§2303)

"Family planning services and supplies" is a mandatory Medicaid benefit for the majority of beneficiaries of childbearing age (including minors considered to be sexually active) who desire such services and supplies. States are permitted to provide family planning services under Medicaid for populations who are not otherwise eligible for traditional Medicaid (e.g., non-pregnant, non-disabled childless adults) through special waivers.

The bill would add a new optional categorically-needy eligibility group to Medicaid. This new group would be comprised of (1) non-pregnant individuals with income up to the highest level applicable to pregnant women covered under the Medicaid or CHIP state plan, and (2) at state option, individuals eligible under existing special waivers that provide family planning services and supplies. Benefits would be limited to family planning services and supplies and would also include related medical diagnosis and treatment services.

The bill would also allow states to make a "presumptive eligibility" determination for individuals eligible for such services through the new optional eligibility group. 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, unless such coverage includes family planning services and supplies. This provision would be effective upon enactment.

Removal of Barriers to Providing Home and Community-Based Services (§2402)

Under the DRA, Congress gave states the option to extend HCBS to Medicaid beneficiaries under the HCBS state plan option (Section 1915(i) of the Social Security Act) without requiring a Secretary-approved waiver for this purpose (under Sections 1915(c) or 1115 of the Social Security Act).

Eligibility

Although Medicaid law does not confer program eligibility through the home and community-based services state plan benefit option, federal law does impose certain limitations on the characteristics of beneficiaries who may obtain these services in a state. Specifically, this state plan option may only be extended to those Medicaid beneficiaries whose income does not exceed 150% of poverty and who meet a state's needs-based criteria. In addition, the needs-based criteria defined by states must be less stringent than the criteria the state uses to determine eligibility for institutional care in a nursing facility, intermediate care facility for the mentally retarded (ICF/MR), or hospital.

The bill would expand access to this benefit to persons with income below 300% of the SSI benefit rate and to persons who qualify for Medicaid HCBS waiver services (Sections 1915 (c), (d) or (e) of the SSA, or under Section 1115 Research and Demonstration waivers), because they require an institutional level-of-care. In addition, the bill would establish a new eligibility pathway into the program. States could allow people, beyond existing Medicaid beneficiaries, who meet these criteria to qualify for full benefit Medicaid as well as this HCBS state plan benefit.

Targeting

Under current law, states may cap enrollment numbers, select a broad or limited benefit package, define benefit eligibility expansively or narrowly, and extend coverage in geographic areas that are less than statewide. If actual enrollment exceeds states' projected enrollment, states may modify their needs-based criteria without having to obtain prior approval from the Secretary if the state: (1) provides at least 60 days notice to the Secretary and to the public of the proposed modification; (2) deems an individual receiving HCBS (on the basis of the most recent criteria in effect prior to the effective date of the change), to be eligible for such services for at least 12 months beginning on the date the individual first received medical assistance for such services; and (3) at a minimum, after the effective date of the change does not make the criteria more stringent than the criteria used to determine whether an individual requires the level-of-care provided in a hospital, nursing facility, or an intermediate care facility for the mentally retarded. States may use waiting lists to track those persons who would obtain services but for the cap.

The bill would no longer allow states to cap the number of persons eligible for this benefit. Rather, states could make adjustments to their needs-based criteria if their actual enrollment would exceed their projected enrollment. The provision would also remove states' existing ability to limit access to the benefit to 12 months for those persons who would become ineligible based on the new needs-based criteria. Under this bill, such individuals would continue to be eligible until such time as the individuals would no longer meet the state's pre-modified needs-based criteria.

In addition, states could elect to target the provision of HCBS to specific populations and to differ the type, amount, duration or scope of the benefits for each of these populations. Such elections would be for five-year periods (including an initial five-year period and five-year renewal periods). Enrollment and/or the provision of services could be phased-in, (as long as the phase-in is accomplished prior to the end of the initial five-year period). Further explanation of this provision can be found in the Benefits section of this report.

Outreach and Enrollment Facilitation

Streamlining Procedures for Enrollment Through a Health Insurance Exchange and Medicaid, CHIP, and Other Health Subsidy Programs (§1413)

Under the bill, the Secretary would be required to: (1) establish a system to ensure that individuals who apply for Exchange coverage and are found to be eligible for Medicaid or CHIP are enrolled in Medicaid or CHIP;[9] and (2) develop and distribute a standard application form for all state health subsidy programs. States would be permitted to develop and use their own application forms as long as they are consistent with those issued by the Secretary, and/or to use supplemental or alternative enrollment forms when household income is not used by the state in determining eligibility.

Applicants would be permitted to submit their forms online, by telephone, in person, or by mail to a state exchange, Medicaid, or the CHIP program. However, states would be required to develop a secure, electronic interface for health subsidy program eligibility determinations based on the

[9] For more information on how the Medicaid eligibility expansions included in the Senate bill interact with the premium credits and cost-sharing subsidies available for exchange coverage, see CRS Report R40935, *Health Insurance Premium Credits in Senate-Passed H.R. 3590*, by (name redacted) and (name redacted).

standard application form. States would also be required to verify eligibility data supplied by an applicant when determining eligibility for a health subsidy program in a manner consistent with specified standards (e.g., privacy, security, accuracy, and administrative efficiency). Finally, the Secretary would be required to ensure that applicants receive notice of eligibility for state health subsidy programs, or notice when they are determined ineligible because information on their application is inconsistent with electronic verification data, or is otherwise insufficient to determine eligibility. This provision would be effective January 1, 2014.

Enrollment Simplification and Coordination with State Health Insurance Exchanges (§2202)

As a condition of the Medicaid state plan and receipt of any federal financial assistance after January 1, 2014, the bill would require states to meet the following requirements:

(1) States would be required to establish procedures for:

- enabling individuals to apply for, or renew enrollment in, Medicaid or CHIP through an internet website allowing electronic signatures;
- enrolling individuals who are identified by an Exchange as being eligible for Medicaid or CHIP, without any further determination by the state;
- ensuring that individuals who apply for Medicaid and/or CHIP but are determined ineligible for either program are screened for enrollment eligibility in qualified plans offered through the Exchange, and if applicable, obtain premium assistance for such coverage without having to submit an additional or separate application;
- ensuring that the state Medicaid agency, CHIP agency, and the Exchange utilize a secure electronic interface that allows for eligibility determinations and enrollment in Medicaid, CHIP or premium assistance for a qualified plan as appropriate;
- ensuring that Medicaid and/or CHIP enrollees who are also enrolled in qualified health benefits plan through the Exchange are provided Medicaid medical assistance and/or CHIP child health assistance that is coordinated with the Exchange coverage, including services related to Early and Periodic Screening, Diagnostic and Treatment (EPSDT); and
- conduct outreach and enrollment of vulnerable populations such as unaccompanied homeless youth, racial and ethnic minorities, and individuals with HIV/AIDS;

(2) The state Medicaid and CHIP agencies may enter into an agreement with the Exchange under which each agency may determine whether a state resident is eligible for premium assistance for the purchase of a qualified health benefits plan under the Exchange, so long as the agreement meets specified requirements to reduce administrative costs, eligibility errors, and disruptions in coverage;

(3) The Medicaid and CHIP agency would be required to comply with the requirements for the system established under Section 1413 (relating to streamlined procedures for enrollment through an Exchange, Medicaid and CHIP); and

(4) The bill would require states to establish a website (not later than January 1, 2014) that links Medicaid to the state Exchange. The website would allow individuals who are Medicaid-eligible and eligible to receive premium assistance for the purchase of a qualified health benefits plan under the Exchange to compare benefits, premiums, and cost-sharing. In the case of a child, the website must allow individuals to compare benefits they would receive under Medicaid to the coverage available through an Exchange plan (including any supplemental Medicaid benefits that would be required so the Exchange coverage meets basic minimum standards established by the bill). The bill would not limit or modify the states' ability to assess an individual's eligibility for home and community-based services under the state plan or under a waiver.

Permitting Hospitals to Make Presumptive Eligibility Determinations for All Medicaid Eligible Populations (§2202)

Under current law, states may enroll certain groups (i.e., children, pregnant women, and certain women with breast and cervical cancer) for a limited period of time before completed Medicaid applications are filed and processed, based on a preliminary determination by a Medicaid provider of likely Medicaid eligibility. Such individuals must then formally apply for coverage within a certain timeframe to continue receiving Medicaid benefits. Presumptive eligibility begins on the date a qualified Medicaid provider determines that the applicant appears to meet eligibility criteria and ends on the earlier of (1) the date on which a formal determination is made regarding the individual's application for Medicaid, or (2) in the case of an individual who fails to apply for Medicaid following the presumptive eligibility determination, the last day of the month following the month in which presumptive eligibility begins.

The bill would allow states to permit all hospitals that participate in Medicaid to make presumptive eligibility determinations, based on a preliminary determination of likely Medicaid eligibility, for all Medicaid eligible populations. Such preliminary eligibility determinations would be subject to guidance established by the Secretary and would need to follow the same requirements as currently apply to presumptive eligibility (i.e., for children, pregnant women, and certain women with breast or cervical cancer) regardless of whether the state has opted to extend presumptive eligibility to any of these groups. States would be permitted to enroll such individuals for a limited period of time before completed Medicaid applications are filed and processed. Beneficiary claims submitted during the period of presumptive eligibility would not be included among those reviewed to determine if improper payments were made based on errors in the state agency's eligibility determinations. The provision would be effective on January 1, 2014.

Standards and Best Practices to Improve Enrollment of Vulnerable and Underserved Populations (§2201)

CHIPRA included provisions to facilitate outreach and enrollment in Medicaid and CHIP. CHIPRA appropriated $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 American Indian and Alaska Native 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. CHIPRA also requires state plans to describe the procedures used to

reduce the administrative barriers to 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.

The bill would require the Secretary to work with stakeholders to develop and issue guidance (that meets specified requirements) to states regarding standards and best practices to help improve enrollment of vulnerable populations in Medicaid and CHIP. Vulnerable populations include children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS. Such guidance would be required to be published no later than April 1, 2011. Not later than two years after enactment and annually thereafter, the Secretary would be required to review and report to Congress on state progress in implementing the standards and best practices identified in the guidance, and in increasing the enrollment of vulnerable populations under Medicaid and CHIP.

New Reporting Requirements (§2001, §10201)

The bill would require states to report on changes in Medicaid enrollment beginning January 2015, and every year thereafter. As a part of these reporting requirements, states must submit enrollment estimates of the total number of "newly enrolled" individuals by fiscal year disaggregated by: (1) children, (2) parents, (3) non-pregnant childless adults, (4) disabled individuals, (5) elderly individuals, and (6) such other categories or sub-categories of individuals eligible for Medicaid as the Secretary may require. States would also be required to report on their outreach and enrollment processes, and any other data reporting specified by the Secretary to monitor enrollment and retention in Medicaid. The Secretary would be required to submit a report to the appropriate Committees of Congress (beginning in April 2015 and every year thereafter) on total new enrollment in Medicaid by state, as well as recommendations for improving Medicaid enrollment.

Benefits

Medicaid standard benefits are identified in federal statute and regulations and include a wide range of acute and long-term care services and supplies. Additional benefits include premium payments for coverage provided through Medicaid managed care arrangements or for employer-sponsored insurance, and Medicare premium and cost-sharing support for persons dually eligible for both Medicare and Medicaid.

Modifications to DRA Benchmark and Benchmark-Equivalent Coverage (§2001(c))

As an alternative to traditional benefits, the Deficit Reduction Act (DRA) gave states the option to provide Medicaid to state-specified groups through enrollment in benchmark and benchmark-equivalent coverage similar to plans available under the Children's Health Insurance Program (CHIP). Benchmark plans include (1) the standard Blue Cross/Blue Shield preferred provider option under the Federal Employees Health Benefits Program (FEHBP), (2) the coverage generally available to state employees, and (3) the coverage offered by the largest commercial HMO in the state. Benchmark-equivalent plans must cover basic benefits (i.e., inpatient and

outpatient hospital services, physician services, lab/x-ray, well-child care including immunizations, and other appropriate preventive services designated by the Secretary), and must include at least 75% of the actuarial value of coverage under the selected benchmark plan for specific additional benefits (i.e., prescription drugs, mental health services, vision care and hearing services). Benchmark and benchmark-equivalent coverage must include Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services (whether provided by the issuer of such coverage or otherwise) as well as access to services provided by rural health clinics and federally qualified health centers.

The bill would modify benchmark and benchmark-equivalent benefit packages available under Medicaid. Such packages would be required to provide at least essential benefits as of January 1, 2014. Essential health benefits would include at least: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. For Medicaid benchmark-equivalent plans, prescription drugs and mental health services would be added to the list of basic services that must be covered under the plan. Also, for benchmark-equivalent coverage, states would be required to demonstrate that the coverage has an actuarial value of at least 75% for vision and hearing services only.

In the case of any benchmark benefit package or benchmark-equivalent coverage offered by an entity that is not a Medicaid managed care plan and that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan would be required to ensure that the financial requirements and treatment limitations applicable to such benefits comply with the mental health services parity requirements of Section 2705(a) of the Public Health Services Act in the same manner as such requirements apply to a group health plan. Coverage that provides EPSDT services would be deemed as meeting the mental health services parity requirement.

Premium Assistance (§2003, §10203(b))

The bill would also require states to offer premium assistance and wrap-around benefits (i.e., Medicaid covered services not included in employer plans) to Medicaid beneficiaries when it is cost-effective to do so (i.e., when beneficiary cost-sharing obligations in employer plans are less than the state's expected cost of providing Medicaid services directly). However, beneficiaries would not be required to apply for enrollment in employer plans, and individuals would be permitted to disenroll from such plans at any time. In addition, states would be required to pay premiums and cost sharing in excess of amounts permitted under current Medicaid program rules (i.e., nominal amounts specified in regulations and inflation adjusted over time, or higher amounts authorized in P.L. 109-171, the DRA). These provisions would be effective as if included in P.L. 111-3 (CHIPRA).

Birthing Centers (§2301)

The bill would also require Medicaid coverage of care provided in free-standing birthing centers. In addition, states would be required to separately pay providers administering prenatal, labor and delivery or postpartum care in freestanding birthing centers, such as nurse midwives and birth attendants, as deemed appropriate by the Secretary. This provision would be effective on the date

of enactment (except if state legislation is required, in which case additional time for compliance is permitted).

Smoking Cessation Services for Pregnant Women (§4107)

The bill would add counseling and pharmacotherapy to promote cessation of tobacco use by pregnant women as a mandatory benefit under Medicaid. Such coverage would include prescription and non-prescription tobacco cessation agents approved by the Food and Drug Administration (FDA). Services would be limited to those recommended for pregnant women in "Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline" (and if applicable, as subsequently modified), as well as other related tobacco cessation services designated by the Secretary. States would be allowed to continue to exclude coverage of agents to promote smoking cessation for other Medicaid beneficiaries, as permitted in current law. Cost-sharing for such counseling and pharmacotherapy for pregnant women would be prohibited. This provision would be effective on October 1, 2010.

Adult Preventive Care (§4106)

In current law, most Medicaid beneficiaries under age 21 are entitled to EPSDT services, which include well-child visits, immunizations, laboratory tests, as well as vision, dental, and hearing services at regular intervals. Under the bill, the current Medicaid option to provide "other diagnostic, screening, preventive, and rehabilitation services" would be expanded to include (1) any clinical preventive services recommended (i.e., assigned a grade of A or B) by the United States Preventive Services Task Force (USPSTF), and (2) adult immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration. States that elect to cover these services and vaccines, and also prohibit related cost-sharing, would receive the increased FMAP applicable to services provided to newly eligible mandatory individuals (established under this bill excluding the 95% cap on such FMAP), and an additional one percentage point increase in that FMAP would apply for these new adult preventive services, and for counseling and pharmacotherapy for cessation of tobacco use by pregnant women (also added by this bill and described above). The effective date of this provision would be January 1, 2013.

Scope of Coverage for Children Receiving Hospice Care (§2302)

States have the option to offer hospice services under Medicaid and nearly all states do so. Medicaid beneficiaries who elect to receive such services must waive the right to all other services related to the individual's diagnosis of a terminal illness or condition, including treatment. The bill would allow payment for services, as defined by the state, provided to Medicaid children, as defined by the state, who have voluntarily elected to receive hospice services, without foregoing coverage of and payment for other services that are related to the treatment of the children's condition for which a diagnosis of terminal illness has been made. This provision would also apply to CHIP, and would be effective upon enactment.

Community First Choice Option (§2401)

Personal care attendants provide assistance with activities of daily living (ADL) and/or instrumental activities of daily living (IADL) to individuals with a significant disability. 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 are permitted to cover personal care services, including personal care attendant services, under a variety of optional statutory authorities such as (1) the personal care state plan benefit; (2) self-directed personal care state plan benefit; (3) home and community-based services state plan benefit (Section 1915(i)); (4) HCBS Waiver (Sections 1915(c)(d)(e)); or (5) Research and Demonstration Waivers (Section 1115). Although states have significant flexibility to determine the amount and scope of these benefits, each statutory authority includes a unique set of rules limiting the way in which a state may extend this benefit to Medicaid beneficiaries.

The bill would allow states to offer HCBS under another statuary authority, and provide an increased match rate for five years. Beginning October 1, 2010, states could offer home and community-based attendant services as an optional benefit to Medicaid beneficiaries whose income does not exceed 150% of poverty level, or if greater, the income level applicable for an individual who has been determined to require the level of care offered in a hospital, nursing facility, or Intermediate Care Facility for the Mentally Retarded (ICF/MR), or an institution for mental disease. These services would include, among others, home and community-based attendant services and supports to assist eligible individuals in accomplishing ADLs, IADLs, and health-related tasks. Services would be delivered by qualified staff, including family members (as defined by the Secretary), and services would be managed, to the maximum extent possible, by the individual (or his or her representative).

To obtain approval from the Secretary to offer this benefit, states would be required to: (1) collaborate with a state-established Development and Implementation Council; (2) provide these services on a state-wide basis and in the most integrated setting as is deemed appropriate to meet the needs of the individual; (3) maintain or exceed the preceding fiscal year's level of state Medicaid expenditures for individuals with disabilities or elderly individuals; and (4) establish and maintain a comprehensive, continuous quality assurance system; among other requirements.

States that choose this option would be eligible for an enhanced federal match rate of an additional six percentage points for reimbursable expenses in the program. The option would sunset after five years. No later than December 31, 2015, the Secretary would be required to submit to Congress a final report on the findings of an evaluation of the community-based attendant services and supports. This provision would be effective on October 1, 2010.

State Option to Provide Health Homes for Enrollees with Chronic Conditions (§2703)

A health home, also referred to as medical home, provides patients with access to a primary care medical provider, and is thought to ultimately improve patient health outcomes. 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. Physician-guided, patient-centered 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. In practice, medical homes are physicians offices that, in exchange for a fee, provide care coordination and management to patients.

This section of the bill would establish a new Medicaid state plan option, beginning January 1, 2011, under which certain Medicaid enrollees with chronic conditions could designate a health home, as defined by the Secretary.

Individuals with chronic conditions would be eligible for this option. Chronic conditions would include a mental health condition, a substance abuse disorder, asthma, diabetes, heart disease, and a Body Mass Index over 25 (overweight). To be eligible, the patient would have, at a minimum, (1) at least two chronic conditions; (2) one chronic condition and be at risk of having a second chronic condition; or (3) one serious and persistent mental health condition. Higher eligibility requirements, however, could be established by the Secretary.

To assemble their health home, patients would designate providers, teams of health care professionals operating with providers, or health teams. A designated provider could be a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, pediatrician, gynecologist, obstetrician or other qualified entity, as determined by the state and approved by the Secretary. To be qualified, the provider must offer services including comprehensive care management, care coordination, health promotion, transitional care, patient and family support, referral to community and social support services, and use of health information technology. In all cases, the Secretary would establish the standards for qualification.

The health home state option would be funded though a federal/state matching program. The states would receive assistance according to the Federal Medical Assistance Percentage (FMAP) after the first eight fiscal year quarters. States would be reimbursed for payments by the federal government at a 90% FMAP for the first eight fiscal quarters. States could use a variety of payment schedules to reimburse providers. In addition, the state plan must provide referrals from hospitals to providers; coordination across substance abuse, mental health, and other services; various monitoring arrangements; and reports on the quality of the health home option.

Beginning January 1, 2011, the Secretary may award planning grants to the states for developing their health home programs. Each state must match the federal contribution using its normal matching rate. The total payments made to the states would not exceed $25 million.

The Secretary would be required to evaluate this program by an independent entity. The evaluation would focus on whether the program reduced hospital admissions, emergency room visits, and admissions to skilled nursing facilities. The evaluation would first be presented to the Secretary and then to Congress by January 1, 2017. By January 1, 2014, however, the Secretary must survey the states that have participated in this program, and report to Congress on a variety of topics including the program's effects on hospital admission rates, chronic disease management, coordination of care for individuals with chronic conditions, assessment of quality improvements, estimates of cost savings, and other topics.

Changes to Existing Medicaid Benefits

Removal of Barriers to Providing Home and Community-Based Services (§2402)

Under the DRA, Congress gave states the option to extend HCBS to Medicaid beneficiaries under the HCBS state plan option (Section 1915(i) of the SSA) without requiring a Secretary-approved waiver for this purpose (under Sections 1915(c) or 1115 of the SSA).

Under current law, the HCBS state plan option allows states to offer home and community-based services from a list of services contained in statute. The bill would expand that list of services to include state-selected services, other than room and board, that are approved by the Secretary.

Current law also allows states to use this benefit option to offer a single benefit package to a single target population. The bill would allow states to offer different packages of services to different target groups of beneficiaries—those who would qualify because they meet the state's needs-based criteria and those who would qualify because they would otherwise be eligible for waiver services. A further explanation of this provision can be found in the Eligibility section of this report.

Clarification of The Definition of Medical Assistance (§2304)

The term "medical assistance" means payment of part or all of the cost of care and services identified in federal statute. This term is repeated throughout Title XIX, Grants to States for Medical Assistance Programs, of the SSA. The bill would clarify that "medical assistance" encompasses both payment for services provided and the services themselves. This provision would be effective upon enactment.

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 rates are 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 a 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 2009, with passage of the American Recovery and Reinvestment Act of 2009 (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 (December 31, 2010).

State expenditures to administer Medicaid programs are generally matched by federal funding at 50%. Federal matching rates for administrative expenditures are the same for all states, although some activities are matched at higher rates.

Payments to States

Additional Federal Financial Assistance Under the bill (§2001, §10201)

Federal Funding for Existing Eligibility Groups

Under the measure, states would continue to receive federal financial assistance as determined by FMAP. For existing eligibility groups, from January 1, 2014 through December 13, 2016, states that meet certain requirements would receive an increase in their regular FMAP rate in the amount of .5 percentage points. States eligible for the .5 percentage point FMAP increase would include (1) "expansion states" (as defined below); (2) states that the Secretary determines would not receive additional federal matching funds for "newly eligible" individuals based on the criteria described below; and (3) the state that is determined to be the state with the highest percentage of its population insured during 2008, based on the Current Population Survey, i.e. Massachusetts.

From January 1, 2014 through September 30, 2019, states that meet certain requirements would receive an increase in their regular FMAP rate of 2.2 percentage points with respect to amounts expended for medical assistance for individuals who are not "newly eligible" (as defined below). States eligible for the 2.2 percentage point FMAP would include: (1) "expansion states" (as defined below); (2) states that the Secretary determines would not receive additional federal matching funds for "newly eligible" individuals based on the criteria described below; and (3) states that have not been granted Secretary approval to divert a portion of such state's Disproportionate Share Hospitals (DSH) allotment for the purpose of providing medical assistance or other health benefits coverage under a waiver in effect on July 2009. The FMAP increase described in this provision would not apply to: (1) Disproportionate Share Hospital payments; (2) payments under CHIP; and (3) payments under Medicaid that are based on the CHIP enhanced FMAP rate.

In the case of the territories (e.g., Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands) the FMAP would be increased by 0.075 percentage point. This increase in the FMAP rate would not be permitted to apply to: (1) Disproportionate Share Hospital payments; (2) payments under Title IV (foster care); (3) payments under CHIP; and (4) payments under Medicaid that are based on the CHIP enhanced FMAP rate.

Federal Funding for Timeline for "Newly Eligible" Populations

The cost of providing benchmark or benchmark-equivalent coverage to the "newly eligible" individuals (defined for the purposes of this subsection below) would be matched by the federal government at higher rates as specified below. However, in the case of a state that requires a political subdivision within the state to contribute the non-federal share of expenditures, such state would not be eligible for an increase in its FMAP (under this provision or under the FMAP increases provided under the American Recovery and Reinvestment Act of 2009) if it requires that political subdivisions pay a greater percentage of the non-federal share of expenditures, or a greater percentage of the non-federal share of payments under their DSH payment program than amounts that would have been required as of December 31, 2009. Voluntary contributions would not be considered as "required" contributions. **Table 1** summarizes the additional federal financial assistance that would be available under the bill and a timeline associated with the implementation of the mandatory eligibility expansion.

For the purposes of this financing provision:

- "Newly eligible" individuals would be defined as non-elderly, non-pregnant individuals with family income below 133% FPL who (1) are not under the age of 19 (or such higher age as the state may have elected), and (2) are not eligible under the state plan (or a waiver) for full Medicaid state plan benefits or for Medicaid benchmark or benchmark-equivalent coverage, or are eligible but not enrolled (or are on a waiting list) in such coverage as of December 1, 2009.
- Full Medicaid state plan benefits would be defined as medical assistance that includes all services of the same amount, duration, and scope, or is determined by the Secretary to be substantially equivalent to the Medicaid state plan services available to categorically eligible mandatory coverage groups.
- "Expansion states" would be defined as a state with health benefits coverage (that includes inpatient hospital services) for parents and non-pregnant childless adults whose income is at least 100% FPL. Such health benefits coverage may not be based on employer coverage or employment. While health benefits coverage may be less comprehensive than Medicaid, the bill would require such coverage to be more than (1) premium assistance, (2) hospital-only benefits, (3) a high deductible health plan, or (4) alternative benefits under a demonstration program authorized under Section 1938 (health opportunity accounts); and
- "Non-expansion states" would be defined as states that, as of the date of enactment of H.R. 3590, offer minimal or no coverage of the "newly-eligible" population, or that offer health benefits coverage to only parents or only non-pregnant childless adults.

Table 1. Federal Finding Timeline for Mandatory Expansion to "Newly Eligible" Populations and Current Law Eligible Populations

Calendar Year	H.R. 3590 Requirement
2013	No additional federal matching funds for "newly eligible" populations or those populations eligible for Medicaid under current law.
2014	Expansion mandate begins for "newly eligible" populations (enhanced federal match rate for individuals eligible under current law also begins as described above), and new mandatory enrollment procedures begin.
	Benchmark or benchmark equivalent coverage for "newly eligible" would be fully financed by the federal government (i.e., the applicable federal medical assistance percentage would be 100%).
2015	Mandatory enrollment reporting of "newly enrolled" individuals (described above) begins.
	Benchmark or benchmark equivalent coverage for "newly eligible" would be fully financed by the federal government (i.e., the applicable federal medical assistance percentage would be 100%).
2016	Benchmark or benchmark equivalent coverage for "newly eligible" would be fully financed by the federal government (i.e., the applicable federal medical assistance percentage would be 100%).

Calendar Year	H.R. 3590 Requirement	
2017	For "expansion states"(defined above) the FMAP percentage point increase over the state's regular FMAP rate for "newly eligible" populations would equal 30.3 with a ceiling of 95%.	For "non-expansion states"(defined above) the FMAP percentage point increase over the state's regular FMAP rate for "newly eligible" populations would equal 34.3 with a ceiling of 95%.
	Benchmark or benchmark equivalent coverage for "newly eligibles" in the state of Nebraska only would be fully financed by the federal government (i.e., the applicable federal medical assistance percentage would be 100%), and would not apply to: (1) Disproportionate Share Hospital payments; (2) payments under CHIP; and (3) payments under Medicaid that are based on the CHIP enhanced FMAP rate.	
2018	For "expansion states" (defined above) the FMAP percentage point increase over the state's regular FMAP rate for "newly eligible" would equal 31.3 with a ceiling of 95%.	For "non-expansion states"(defined above) the FMAP percentage point increase over the state's regular FMAP rate for "newly eligible" would equal 33.3 with a ceiling of 95%.
	Benchmark or benchmark equivalent coverage for "newly eligibles" in the state of Nebraska only would be fully financed by the federal government (i.e., the applicable federal medical assistance percentage would be 100%), and would not apply to: (1) Disproportionate Share Hospital payments; (2) payments under CHIP; and (3) payments under Medicaid that are based on the CHIP enhanced FMAP rate.	
2019 (and beyond)	Beginning January 1, 2019 (and succeeding fiscal years), for amounts expended by the states for medical assistance on "newly eligible" individuals with family income less than 133% FPL, the FMAP would be increased by 32.3 percentage points with a ceiling of 95% for all states except the state of Nebraska. For Nebraska, benchmark or benchmark equivalent coverage for "newly eligibles" would be fully financed by the federal government (i.e., the applicable federal medical assistance percentage would be 100%), and would not apply to: (1) Disproportionate Share Hospital payments; (2) payments under CHIP; and (3) payments under Medicaid that are based on the CHIP enhanced FMAP rate.	

Source: CRS analysis of the financing provisions in §2001 and §10201 of H.R. 3590.

Notes: "Newly eligible" individuals would be defined as non-elderly, non-pregnant individuals with family income below 133% FPL who are (1) not under the age of 19 (or such higher age as the state may have elected) and (2) are not eligible under the state plan (or a waiver) for full Medicaid state plan benefits or for Medicaid benchmark or benchmark-equivalent coverage, or are eligible but not enrolled (or are on a waiting list) in such coverage as of December 1, 2009.

Full Medicaid state plan benefits would be defined as medical assistance that (1) includes all services of the same amount, duration, and scope, or is determined by the Secretary to be substantially equivalent to the Medicaid state plan services available to categorically eligible mandatory coverage groups.

"Expansion states" would be defined as a state with health benefits coverage (that includes inpatient hospital services) for parents and non-pregnant childless adults whose income is at least 100% FPL. Such health benefits coverage may not be based on employer coverage or employment. While health benefits coverage may be less comprehensive than Medicaid, the bill would require such coverage to be more than (1) premium assistance, (2) hospital-only benefits, (3) a high deductible health plan, or (4) alternative benefits under a demonstration program authorized under Section 1938 (health opportunity accounts); and

"Non-expansion states" would be defined as states that, as of the date of enactment of H.R. 3590, offer minimal or no coverage of the "newly-eligible" population, or that offer health benefits coverage to only parents or only non-pregnant childless adults.

The Children's Health Insurance Program (CHIP)

CHIP provides health care coverage to low-income, uninsured children in families with income above Medicaid income standards. States may also extend CHIP to pregnant women when certain conditions are met. In designing their CHIP programs, states may choose to expand Medicaid, create a stand-alone program, or use a combined approach. As with Medicaid, states have the flexibility under CHIP to disregard amounts or types of income and expenses, effectively expanding eligibility to higher-income individuals. Federal CHIP appropriations are currently provided through FY2013.

Like Medicaid, CHIP is a joint federal-state program. For each dollar of state spending, the federal government makes a matching payment drawn from CHIP allotments. A state's share of program spending for Medicaid is equal to 100% minus FMAP. But for CHIP, the federal share is higher. That is, the enhanced FMAP (E-FMAP) for CHIP lowers the state's share of CHIP expenditures by 30% compared to the regular Medicaid FMAP. Although uncommon, certain types of CHIP expenditures are reimbursed at a rate different than the E-FMAP, and certain types of Medicaid expenditures are reimbursed at the E-FMAP rate. For FY2009, prior to increases in FMAP as a result of American Recovery and Reinvestment Act of 2009 (ARRA), the E-FMAP for CHIP ranged from 65% to 83.09%.

Beneficiary cost-sharing varies depending upon how a state designs its CHIP program. For CHIP Medicaid expansions, nominal amounts may apply as specified under the Medicaid program. For CHIP stand-alone programs, higher amounts may apply based on income level. In both cases, preventive services are exempt from all cost-sharing, and aggregate cost-sharing for all individuals is capped at 5% of family income.

The bill would make a number of changes to CHIP for future years. These changes are described below.

Additional Federal Financing Participation for CHIP (§2101, §10203(c))

This bill would maintain the current CHIP structure, and provide CHIP appropriations through FY2015. In the event that future federal allotments would be insufficient to provide coverage to all eligible CHIP children, states would be required to establish procedures to ensure that such children receive coverage through state-established Exchanges, and would be ineligible for coverage under CHIP. Under the bill, states would receive a 23 percentage point increase in the CHIP match rate (E-FMAP), subject to a cap of 100% for FY2014 through FY2019 (although no CHIP appropriations would be provided for FY2016 through FY2019). The 23 percentage point increase would not apply to certain expenditures (i.e., translation services, CHIP-enrolled children above 300% FPL outside New Jersey and New York, expenditures for administration of citizenship documentation/verification, expenditures for administration of payment error rate measurement or PERM, and Medicaid coverage of certain breast or cervical cancer patients).

Upon enactment, states would be required to maintain income eligibility levels for CHIP through September 30, 2019 as a condition of receiving payments under Medicaid (notwithstanding the lack of corresponding federal appropriations for FY2016 through FY2019). Specifically, with the exception of waiting lists for enrolling children in CHIP or enrolling CHIP-eligible children in certified exchange plans (see below), states could *not* implement eligibility standards, methodologies, or procedures that are *more* restrictive than those in place on the date of

enactment. However, states could expand their current income eligibility levels—that is, states could enact *less* restrictive standards, methodologies or procedures.

After September 30, 2015, states may also enroll children eligible for CHIP in a qualified health plan that has been certified by the Secretary. With respect to such certification, not later than April 1, 2015, for each state, the Secretary would be required to review the benefits offered for children and the associated cost-sharing for qualified health plans offered through the Exchange, and must certify that such plans have been determined to be at least comparable to the benefits and cost-sharing protections provided under the state CHIP plan. In the event that CHIP allotments are insufficient to provide coverage of all children eligible for CHIP, states would be required to establish procedures to ensure that such children are screened for eligibility for Medicaid (under the state plan or a state waiver), and if found eligible, enrolled in Medicaid. In the case of children who, as a result of such screening, are determined to not be eligible for Medicaid, the state would be required to establish procedures to ensure that those children are enrolled in a qualified health plan that has been certified by the Secretary (as described above) and is offered through an Exchange established by the state.

The Medicaid and CHIP enrollment bonuses included in CHIPRA (P.L. 111-3) would not apply beyond the current authorization period; bonus payments would not be available after FY2013.

Beginning January 1, 2014, states would be required to use modified gross income (MGI) and household income (as defined for premium credits eligibility in an exchange) to determine Medicaid and CHIP eligibility, premiums and cost-sharing. States would be required to treat as CHIP children those children determined to be ineligible for Medicaid due to the new provision eliminating income disregards based on expense or type of income. In addition, the CHIP benefit package and cost-sharing rules would continue as under current law.

Finally, a new Medicaid section added by this bill regarding Medicaid programs' coordination with state health insurance exchanges would also apply to CHIP programs.

Distribution of CHIP Allotments Among States (§2101, §10203(d))

Currently, the allotment of the annual federal CHIP appropriation among the states is determined by a formula set in law.

For FY2009, federal CHIP allotments for states was to be the largest of three state-specific amounts: (1) the state's FY2008 federal CHIP spending, multiplied by a growth factor; (2) the state's FY2008 federal CHIP allotment, multiplied by a growth factor; and (3) the state's own projections of federal CHIP spending for FY2009, submitted by states to the Secretary of Health and Human Services (HHS) as of February 2009. The largest of these three amounts was to be increased by 10% and serve as the state's FY2009 federal CHIP allotment, as long as the national appropriation was adequate to cover all the states' and territories' FY2009 allotments. If not, allotments were to be reduced proportionally.

For the FY2009 allotment formula, the growth factor, called the "allotment increase factor," was the product of (a) 1 plus the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for 2009 over 2008, and (b) 1.01 plus the percentage change in the child population in each state (except for the territories, for which the national amount is used) from July 1, 2008, to July 1, 2009, based on the most recent published estimates of the Census Bureau. For future fiscal years, the growth factor is calculated in the same way, but uses

updated projected per capita spending in the National Health Expenditures for each such fiscal year, and the percentage change in the child population in each state (except for the territories, for which the national amount is used) from July 1 of the previous calendar year, to July 1 of the applicable calendar year, based on the most recent published estimates of the Census Bureau.

For FY2010, the allotment for a state (or territory) will be calculated as the sum of the following four amounts, if applicable, multiplied by the applicable growth factor (described below) for the year: (1) the FY2009 CHIP allotment; (2) FY2006 unspent allotments redistributed to and spent by shortfall states in FY2009; (3) spending of funds provided to shortfall states in the first half of FY2009; and (4) spending of Contingency Fund payments (described below) in FY2009, although there may be none.

For FY2011 and FY2013, the allotment for a state (or territory) will be "rebased," based on prior year spending. This will be done by multiplying the state's growth factor for the year by the new base, which will be the prior year's federal CHIP spending.

For FY2012, the allotment for a state (or territory) will be calculated as the FY2011 allotment and any FY2011 Contingency Fund spending, multiplied by the state's growth factor for the year.

The proposal would carry the current law CHIP allotment formula forward through FY2015.

For FY2013, federal CHIP allotments for a state (or territory) would be "rebased," based on prior year spending, and subject to the new appropriation amounts made available under this bill. Rebasing would be done by multiplying the state's growth factor for the year (as updated based on the formula described in current law) by the new base, which would be the prior year's federal CHIP spending.

For FY2014, the allotment for a state (or territory) would be calculated as the FY2013 allotment and any FY2013 Contingency Fund spending, multiplied by the state's growth factor for the year subject to the new appropriation amounts made available under this bill.

For FY2015, federal CHIP allotments for a state (or territory) would be "rebased," based on prior year spending, and subject to the new appropriation amounts made available under this bill. Rebasing would be done by multiplying the state's growth factor for the year (as updated based on the formula described in current law) by the new base, which would be the prior year's federal CHIP spending.

As per current law, the Child Enrollment Contingency Fund (created under CHIPRA) was established to prevent states from experiencing shortfalls of federal CHIP funds. This fund receives an appropriation separate from the national CHIP allotment amounts. For FY2009, its appropriation would be 20% of the CHIP available national allotment. For FY2010 through FY2013, the appropriation would be such sums as are necessary for making payments to eligible states for the fiscal year, as long as the annual payments did not exceed 20% of that fiscal year's CHIP available national allotment. Direct payments from the Contingency Fund can be made to shortfall states for the federal share of expenditures for CHIP children above a target enrollment level.

The proposal would extend the authority for the Child Enrollment Contingency Fund through FY2015. For FY2013 through FY2015, the appropriation for the Fund would be such sums as are necessary for making payments to eligible states for the fiscal year, as long as the annual

payments did not exceed 20% of that fiscal year's CHIP available national allotment. Direct payments from the Contingency Fund can be made to shortfall states for each of fiscal year 2013 through fiscal year 2015 for the federal share of expenditures for CHIP children above a target enrollment level.

Finally, the current CHIP statute permits 11 early expansion "qualifying states" to draw some CHIP funds for Medicaid children above 150% of poverty level, although with an additional limit in the amount besides just their available federal CHIP funds (that is, no more than 20% from each original allotment could be spent on these Medicaid children). CHIPRA continued this spending for Medicaid children above 133% of poverty level, and without the 20% limitation through FY2013.

The provision would extend the authority for qualifying states to use CHIP allotments for spending on Medicaid children above 133% of poverty, and without the 20% limitation through FY2015.

Extension of Funding for CHIP Through FY2015 and Other Related Provisions (§10203(a), §10203(b), and §10203(d))

Revisions to the Child Health Quality Measurement Initiative

Section 1139A of the Social Security Act established a child health quality measurement initiative for both Medicaid and CHIP. Among several requirements, this initiative includes the establishment of a pediatric quality measurement program that will engage in a number of activities. In general, the purpose of this program is to improve and strengthen core child health quality measures, expand on existing pediatric quality measures used by public and private health care purchasers and advance the development of new and emerging quality measures, and increase the portfolio of evidence-based, consensus pediatric quality measures available to public and private purchasers of children's health services, providers and consumers.

Under the bill, the Secretary is required to establish by regulation the criteria for certifying health plans as qualified health plans. A number of criteria for such certification are outlined, including, for example, plans must at a minimum utilize a uniform enrollment form for both qualified individuals and employers for enrolling in qualified health plans offered through the Exchange, and utilize a standard format for presenting health plan benefit options. The provision would add another criteria for plans seeking certification to report to the Secretary at least annually (and in a manner specified by the Secretary) the pediatric quality reporting measures established under Section 1139A of the Social Security Act.

Participation in, and Premium Assistance for, Employer-Sponsored Health Plans

Under current law, when certain conditions are met, states can require Medicaid beneficiaries to enroll in employer-sponsored health plans. One of those conditions is that such coverage is "cost-effective" meaning that the reduction in expenditures under Medicaid for an individual enrolled in a group health plan is likely to be greater than the additional expenditures for premiums and cost-sharing required.

In CHIP, states may receive federal matching payments for the purchase of family coverage under a group health plan or health insurance that includes CHIP children, if such coverage is cost-effective relative to (1) the amount of expenditures under the state CHIP plan (including administrative costs) that the state would have made to provide comparable coverage of the children or families involved (as applicable), or (2) the amount of expenditures that the state would have made under CHIP (including administrative expenses) for providing coverage under the plan for all such children or families. In addition, the coverage must not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage.

When certain conditions are met under Medicaid, states may offer premium assistance subsidies for qualified employer-sponsored coverage for Medicaid beneficiaries under age 19 (and to the parents of such individuals) who have access to such coverage.

Under the Senate bill, several provisions would be effective as if included in CHIPRA (P.L. 111-3). First, the provision would apply the cost-effectiveness definition used in CHIP to the coverage of Medicaid beneficiaries in employer-sponsored group health plans, and for the current premium assistance option for children under Medicaid.

Another provision in the bill would have required states to offer a premium assistance subsidy for qualified employer-sponsored coverage to all Medicaid beneficiaries under age 19 (along with their parents) who have access to such coverage that otherwise meets specified requirements. A separate provision (subsequently added by the Title X of the bill) would make that requirement null, void and of no effect. That is, premium assistance subsidies for qualified employer-sponsored coverage to Medicaid beneficiaries under 19 (and their parents) would remain a state option, not a requirement.

Also under current law, states may offer a premium assistance subsidy for qualified employer-sponsored coverage to all targeted low-income children in CHIP who have access to such coverage that meets certain requirements. No subsidy shall be provided to a CHIP child unless that child (or the child's parent) voluntarily elects to receive such a subsidy. States may not require such an election as a condition of receiving CHIP benefits.

In addition, premium assistance subsidies for qualified employer-sponsored coverage must be deemed to meet the cost-effectiveness requirement described above.

The provision would require that the premium assistance subsidy for qualified employer-sponsored coverage for CHIP children can occur if the offering is cost-effective [i.e., the coverage is cost-effective relative to (1) the amount of expenditures under the state CHIP plan (including administrative costs) that the state would have made to provide comparable coverage of the children or families involved (as applicable), or to (2) the amount of expenditures that the state would have made under CHIP (including administrative expenses) for providing coverage under the plan for all such children or families].

The bill would also strike the current law provision that deems compliance with the cost-effectiveness test for premium assistance subsidies for qualified employer-sponsored coverage.

Definition of CHIP Eligible Children

Section 2110(b) of the Social Security Act defines "targeted low-income child" for CHIP purposes. Generally, such children are not otherwise insured, and live in families with income above Medicaid applicable levels, up to 50 percentage points above that level. (Some states have set higher income standards via waiver authority or by disregarding "blocks of income" in determining financial eligibility, for example). The law also defines two groups of children as being ineligible for CHIP: (1) children who are inmates of public institutions or are patients in an institution for mental disease, and (2) children in families for whom a member is eligible for health benefits coverage under a state health benefits plan through the family member's employment with a public agency in the state.

The provision would make two exceptions to the CHIP exclusion of children of employees of a state public agency. First, children of state employees may be enrolled in CHIP if the amount of annual agency expenditures made on behalf of an employee enrolled in a state health plan that includes dependent coverage (for the most recent state fiscal year) is not less than the amount of such expenditures made by the agency for state fiscal year 1997, increased by the percentage increase in the medical care component of the Consumer Price Index for such preceding year. Second, children of state employees may be enrolled in CHIP if the state determines, on a case-by-case basis, that the annual aggregate amount of premiums and cost-sharing applicable to the family of the child would exceed 5% of the family's income for the year involved.

CHIP Annual Allotments

Federal statute provides yearly total allotments for CHIP. Specific annual amounts are appropriated for fiscal years starting with FY1998 ($4.295 billion) through FY2012 ($14.982 billion). For FY2013 only, two semi-annual allotments will be available. For the period October 1, 2012 through March 31, 2013, $2.85 billion is available, and for the period April 1, 2013 through September 30, 2013, another $2.85 billion is available. In addition, a "one-time appropriation" of $11.706 billion was added to the half-year amounts provided for FY2013. These provisions for FY2013 were intended to annually reduce by the "one-time appropriation" the amount of allotments assumed by the Congressional Budget Office (CBO) for fiscal years after FY2013.

The provision would strike the current law language that provides semi-annual allotments for FY2013, and would replace that language with an appropriation of $17.406 billion for FY2013. The provision would also provide an appropriation of $19.147 billion for FY2014, and would establish two semi-annual allotments for FY2015. For the period October 1, 2014 through March 31, 2015, $2.85 billion would be made available, and for the period April 1, 2015 through September 30, 2015, another $2.85 billion would be made available. The bill would also modify this section of the CHIP statute to provide a one-time appropriation of $15.361 billion to be added to the half year amounts provided for FY2015.

CHIPRA authorized $100 million in outreach and enrollment grants above and beyond the regular CHIP allotments for FY2009 through FY2013. Ten percent of the allocation 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.

The provision would expand the time period for the outreach and enrollment grants through FY2015. This provision would also change the appropriation level to $140 million for FY2009 through FY2015.

Technical Corrections to the CHIP Statute (§2102)

CHIPRA was signed into law on February 4, 2009, to extend and improve CHIP (e.g., to provide federal CHIP allotments to states from FY2009 through FY2013), and for other purposes. The American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) was signed into law on February 17, 2009, making supplemental appropriations for job preservation and creation, infrastructure investment, energy efficiency and science, assistance to the unemployed, and state and local fiscal stabilization, for fiscal year ending September 30, 2009, and for other purposes.

The proposal would make corrections to selected provisions in CHIPRA and ARRA, including, for example (1) makes an adjustment to the FY2010 CHIP allotments for certain previously approved Medicaid expansion programs; (2) clarifies a reference to certain lawfully residing immigrants in CHIP statute; (3) deletes a reference to CHIP funds set aside for coverage of certain Medicaid non-pregnant childless adult waivers when those funds are not expended by September 30, 2011 (this block grant was not included in the final version of P.L. 111-3); (4) makes adjustments to the Current Population Survey (CPS) to improve estimates used to identify high performing states (those with the lowest percentage of uninsured, low-income children) for CHIP purposes; and (5) stipulates that the alternative premiums and cost-sharing provision in Medicaid would not supersede or prevent the application of premium and cost-sharing protections for American Indians under Medicaid and CHIP as established in P.L. 111-5. All of these changes would be effective as if they were included in the enactment of P.L. 111-3 and P.L. 111-5.

Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes (§10202)

Under Medicaid, states make available a broad range of institutional and home and community-based services to certain Medicaid enrollees. States are required to offer some of these services, while states are not required to offer others. For those services that are offered, states define them differently, using criteria that places limits on the amount, duration, and scope of the benefits. States may also restrict benefits to persons who demonstrate medical necessity for the benefit. Under Medicaid, institutional services are generally defined as care provided in nursing facilities, Intermediate Care Facilities for People with Mental Retardation (ICFs/MR), inpatient hospital services and nursing facility services for persons aged 65 and older in institutions for mental diseases. Home and community-based services are generally defined as long-term care services offered under Medicaid's home health state plan benefit, personal care state plan benefit, case management or targeted case management benefit, respiratory care benefit for persons who are ventilator-dependent, Program of All-inclusive Care for the Elderly (PACE), transportation benefit, home and community-based services state plan option, and Medicaid home and community-based 1915(c) and (d) waivers.

This bill would establish a state balancing incentive payment program that would allow states that spend less than 50% of their long-term care services on non-institutional care to receive additional federal matching funds for these benefits for fiscal years 2012 through 2015.

To receive incentive payments, a state would be required to submit an application that includes a proposed budget detailing the state's plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports during the balancing incentive period and to achieve the target spending percentage applicable to the state through required structural changes in furnishing the services. For states proposing to expand the Section 1915(i) benefit, the application would also include a description of the state's election to increase the eligibility level above 150% of the FPL to a percentage that would not exceed 300% of the SSI benefit rate. Regarding a state's structural changes, the application would also include a description of the new or expanded offerings of such services that the state would provide and the projected costs of such services.

States would be required to meet certain target-spending percentages. If the state's spending on home and community based services in FY2009 is less than 25%, its target spending percentage for October 1, 2015 would be 25%. For any other state the target spending percentage would be 50%.

The bill would increase a state's FMAP by 5 percentage points on eligible medical assistance payments for states meeting the 25% target; all other participating states' FMAP would be increased by 2 percentage points for eligible payments. The balancing incentive period would begin October 1, 2011 and end on September 30, 2015.

Disproportionate Share Hospital Payments (§2551, §10201(e))

Medicaid statute requires states to pay disproportionate share (DSH) adjustments to hospitals serving large numbers of uninsured individuals and Medicaid beneficiaries. The law also specifies a formula for determining DSH allotments for each state (however, unique arrangements apply to certain states that largely operate their Medicaid programs under special waivers). States must define, in their state Medicaid plans, hospitals qualifying as DSH hospitals and DSH payment formulas, taking into account certain federal criteria. A number of changes to state DSH allotments have occurred over time.

Special rules apply to "low DSH states," comprised of states in which total DSH payments for FY2000 were less than 3% of the state's total Medicaid spending on benefits. DSH allotments for such states were raised for FY2004 through FY2008 to an amount that was 16% above the prior year's amount. For each year beginning with FY2009, the allotment for low DSH states, as well as all other states, will be equal to the prior year amount increased by the change in the consumer price index for all urban consumers (CPI-U). States cannot obtain federal matching payments for DSH that exceed the state's DSH allotment.[10]

Under the bill, state DSH allotments would remain intact as under current law until a state level is reached. The level would be initially reached the first fiscal year after FY2012 for which a state's uninsured rate, as measured by the Census Bureau's American Community Survey, decreases by at least 45%, compared to an initial uninsured rate for FY2009. Once the level is reached, reductions in DSH allotments would depend on a state's status as a low DSH state and spending patterns over a base 5-year period (FY2004 through FY2008).

[10] See Section 5002 of the American Recovery and Reinvestment Act of 2009 (ARRA) provision on DSH.

First, for low DSH states that have not spent more than 99.90% of their DSH allotments on average for the base 5-year period (as of September 30, 2009), DSH allotments would be decreased by 25%. Second, for low DSH states that have spent more than 99.90% of their DSH allotments on average for the base 5-year period, DSH allotments would be decreased by 17.5%. Third, for all other states that have not spent more than 99.90% of their DSH allotments on average for the base 5-year period, DSH allotments would be decreased by 50%. Fourth, for all other states that have spent more than 99.90% of their DSH allotments on average for the base 5-year period, DSH allotments would be decreased by 35%.

For subsequent fiscal years, if a state's uninsurance rate decreases further, the state's DSH allotment would be further reduced again depending on a state's status as a low DSH state and its spending patterns over the base 5-year period. First, for low DSH states that have not spent more than 99.90% of DSH allotments on average for the base 5-year period (as of September 30, 2009), DSH allotments would be decreased by a percentage equal to the product of the percentage reduction in the uncovered individuals in the preceding year and 27.5%. Second, for low DSH states that have spent more than 99.90% of DSH allotments on average for the base 5-year period, DSH allotments would be decreased by a percentage equal to the product of the percentage reduction in the uncovered individuals in the preceding year and 20%. Third, for all other states that have not spent more than 99.90% of DSH allotment on average for the base 5-year period, DSH allotments would be decreased by a percentage equal to the product of the percentage reduction in the uncovered individuals in the preceding year and 55%. Fourth, for all other states that have spent more than 99.90% of DSH allotments on average for the base 5-year period, DSH allotments would be decreased by a percentage equal to the product of the percentage reduction in the uncovered individuals in the preceding year and 40%. For FY2013 forward, in no case would a state's DSH allotment be less than 50% of the state's FY2012 allotment, increased by the percentage change in the CPI-U for each previous year occurring before the fiscal year. In addition, these provisions would not apply to Hawaii.

These percentage reductions would not apply to certain state waivers using DSH funds to provide Medicaid or other health benefits coverage in effect in July 2009.

Under current law, some states that operate their Medicaid programs through waivers (i.e., Tennessee and Hawaii) have special statutory arrangements relating to their specific DSH allotments. Tennessee's allotment amount was set at $30 million for each of fiscal years 2009 through 2011, and one-quarter of that amount for the first quarter of FY2012. Hawaii's DSH allotment is set at $10 million for each of fiscal years 2009 through 2011, with an additional $2.5 million for the first quarter of FY2012.

Under the bill, for the last three quarters of FY2012, Hawaii's DSH allotment would be $7.5 million. For FY2013 forward, Hawaii's annual DSH allotment would be increased in the same manner applicable to low DSH states (i.e., adjusted by the percentage change in the CPI-U from year to year). The provision also prohibits the Secretary from imposing a limit on payments made to hospitals under Hawaii's QUEST Section 1115 demonstration project, except to the extent necessary to ensure that a hospital does not receive payments in excess of its hospital specific cap, or that payments do not exceed the amount that the Secretary determines is equal to the federal share of DSH within the budget neutrality provision of the QUEST demonstration project.

Special FMAP Adjustment for States Recovering From a Major Disaster (§2006)

In recent years, the fiscal situation of the states has focused attention on the size of the state's share of Medicaid expenditures, as well as changes in the federal share of those expenditures. For instance, 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. Medicaid FMAPs for the last two quarters of FY2003 and the first three quarters of FY2004 were held harmless from annual declines and were increased by an additional 2.95 percentage points, as long as states met certain other requirements.

During the most recent recession, Congress provided states additional economic stimulus funding, including enhanced FMAP rates, when it passed ARRA in February 2009. ARRA provided enhanced FMAP rates for states, the District of Columbia, and the Territories for the recession period which began with the first quarter of FY2009 and will continue through the first quarter of FY2011 (December 31, 2010). Under ARRA, all states are held harmless from declines in their normal FMAP rates beginning with FY2008 and continuing through the recession period. 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. ARRA allowed each territory a one time choice 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. All of the territories chose the 30% increase in spending caps.

In addition, DRA included provisions to exclude certain Hurricane Katrina evacuees and their incomes from FMAP calculations, prevent Alaska's FY2006-FY2007 FMAPs from falling below the state's FY2005 level, and provide $2 billion to help pay for (among other things) the state share of certain Katrina-related Medicaid and CHIP costs. Other provisions, that would have temporarily increased FMAPs for states affected by Hurricane Katrina, limited FY2006 FMAP reductions for all states, and disregarded certain employer contributions toward pensions from the calculation of Medicaid FMAPs, were debated but not included in the final bill.

Under the bill, states recovering from a major disaster, which occurred within the last seven years (beginning with the effective date of January 1, 2011), could receive a special FMAP adjustment percentage. To qualify for the special disaster recovery adjustment, states would need to meet the following two criteria: (1) the President would have had to have declared a state a major disaster under Sec. 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (P.L. 100-77) and every county or parish would have had to have been determined to warrant individual public assistance from the federal government[11]; and (2) there was at least a three percentage point difference between the state's normal fiscal year FMAP rate and the previous fiscal year's FMAP rate where the previous fiscal year's rate was adjusted in the first year only for the hold harmless component of ARRA's temporary enhanced FMAP adjustment. In the second and succeeding years, there also would need to be at least a three percentage point difference between the state's normal fiscal year FMAP and the previous fiscal year's FMAP, but the previous year's FMAP rate would not receive an adjustment for ARRA's hold harmless provision.

[11] The Federal Emergency Management Association (FEMA) makes the determination of which counties or parishes within a state warrant individual public assistance from the federal government.

The special disaster recovery FMAP adjustment for the first qualifying fiscal year would be 50% of the difference between the state's normal FMAP rate and the rate for the previous fiscal year where the previous year's FMAP would be adjusted for ARRA's hold harmless provision. For the second or any succeeding fiscal years, where states have met the criteria to qualify for the special disaster recovery FMAP rate, a state's FMAP rate would be 25% of the difference between the state's normal FMAP rate and the rate for the previous fiscal year including the disaster recovery enhancement, but excluding the ARRA hold harmless adjustment.

For FY2011, seven states would meet the criteria for the President to have declared the state a major disaster under Sec. 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act and every county or parish was determined to warrant individual public assistance from the federal government. However, only Louisiana also had at least a three percentage point difference between the state's normal fiscal year FMAP rate and the previous fiscal year's FMAP rate (including ARRA's hold harmless adjustment). In the future, other states may qualify for the special disaster relief FMAP increase if they meet both requirements. This provision would be effective January 1, 2011.

Payments to The Territories (§2005, §10201)

Five territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands) operate Medicaid programs under rules that differ from those applicable to the states and the District of Columbia (hereafter referred to as the states for the purposes of this provision). The territories are not required to cover the same eligibility groups, and they use different financial standards (income and asset tests) in determining eligibility compared to the states. For example, states must cover certain mandatory groups such as pregnant women, children, and qualified Medicare beneficiaries, but for the territories, these groups are optional. In addition, Medicaid programs in the territories are subject to annual federal spending caps. 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. Finally, the FMAP for all the territories is set at 50%.

The bill would increase spending caps for the territories by 30% for the second, third and fourth quarters of FY2011, and for each full fiscal year thereafter. The measure also would increase the applicable FMAP by five percentage points—to 55%—beginning January 1, 2011 and for each full fiscal year thereafter. Beginning in fiscal year 2014, payments made to the territories for medical assistance for "newly eligible" individuals would not count towards territories' applicable Medicaid spending caps. In the case of the territories, the provision defines "newly eligible" individuals as non-pregnant childless adults who are eligible under the new Medicaid mandatory eligibility group and whose modified gross income or household income does not exceed the income eligibility level in effect for parents under each such commonwealth or territory's state plan or waiver as of the date of enactment of the bill.

Payments to Providers for Health-Care Acquired Conditions (§2702, §10303)

Medicare uses a prospective payment system (PPS) to reimburse hospitals for inpatient care. Medicare's PPS classifies each hospital admission into severity adjusted diagnosis-related groups (MS-DRG) based on the patient's diagnosis and procedures performed.

To appropriately align Medicare's hospital payment policies with quality of care, the DRA required the Secretary to initiate a hospital-acquired condition (HAC) program.[12] Beginning October 1, 2008, when Medicare patients were admitted with certain HACs identified by the Secretary, then the presence of these conditions at admission would allow the hospital to receive an additional MS-DRG payment if these conditions affected the patient's treatment. However, if a patient did not have one of the HACs at admission, but acquired one during their stay, then the hospital could not receive an additional MS-DRG payment. In addition to the HAC policy, CMS issued three national coverage determinations in January 2009 that prohibited Medicare from reimbursing hospitals for certain serious preventable medical care errors. [13]

For Medicaid in July 2008, CMS issued guidance to help states appropriately align Medicaid inpatient hospital payment policies with Medicare's HAC payment policies.[14] CMS instructed state Medicaid agencies to implement policies to avoid payment liability when dual eligible beneficiaries had HACs. CMS also encouraged Medicaid agencies to implement policies to deny payment when other Medicaid beneficiaries developed complications during hospitalizations. CMS directed states to several Medicaid authorities to appropriately deny payment for HACs. However, DRA did not specifically apply the Medicare HAC initiative to Medicaid.

The bill would require the Secretary to identify current state practices that prohibit payment for health care-acquired conditions and to incorporate into regulations these practices or elements of the practices that are applicable to Medicaid. The Secretary would be required to issue regulations to prohibit federal Medicaid matching payments for health care-acquired conditions by July 1, 2011. The new regulations would be required to ensure that the prohibition on payments for health care-acquired conditions would not result in Medicaid beneficiaries losing access to services. The Secretary would define health care-acquired conditions consistent with Medicare's HAC definition, but they would not be limited solely to conditions acquired in hospitals. In implementing regulations governing Medicaid payment for health care acquired conditions, the Secretary would be required to apply Medicare's regulations prohibiting hospital payments for HACs to the Medicaid program. In addition, the Secretary would be required to the extent practicable to publicly report on measures for hospital-acquired conditions utilized by CMS for adjustment of hospital payment amounts based on hospital-acquired infections.

[12] In creating the HAC program, the Secretary was to select conditions that: (1) were high cost, high volume, or both; (2) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; and (3) were reasonably preventable through the application of evidence-based guidelines.

[13] 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.

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

Prescription Drugs

Outpatient prescription drugs are an optional Medicaid benefit, but all states cover prescription drugs for most beneficiary groups. Medicaid law requires prescription drug manufacturers who wish to sell their products to Medicaid agencies to enter into rebate agreements with the Secretary on behalf of states. Under these agreements, drug manufacturers pay a rebate to state Medicaid agencies for drugs purchased for Medicaid beneficiaries, although purchases by Medicaid managed care organizations (MMCO) are exempted from the rebates.[15] 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 pharmaceutical manufacturers participated in Medicaid's drug rebate program.[16]

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 drug makers 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 each drug. Those prices, which serve as reference points for determining manufacturers' rebate obligations, must be reported for each formulation, dosage, and strength of prescription drugs purchased on behalf of Medicaid beneficiaries.

Prescription Drug Rebates (§2501)

For the purpose of determining rebates, Medicaid distinguishes between two types of drugs: (1) single source drugs (generally, those still under patent) and innovator multiple source drugs (drugs originally marketed under a patent or original new drug application but for which there now are generic equivalents); and (2) all other, non-innovator, multiple source drugs.

Rebates for the first category of drugs—drugs still under patent or those once covered by patents—have two components: a basic rebate and an additional rebate. Medicaid's basic rebate is determined by the larger of either a comparison of a drug's quarterly AMP to the best price for the same period, or a flat percentage (15.1%) of the drug's quarterly AMP. Drug manufacturers owe an additional rebate when their unit prices for individual products increased faster than inflation.

Currently, modifications to existing drugs—new dosages or formulations—generally are considered new products for purposes of reporting AMPs to CMS. As a result, drug makers sometimes can avoid incurring additional rebate obligations by making slight alterations to existing products, sometimes called line-extensions, and releasing these as new products. For example, manufacturers have developed new extended-release formulations of existing products which, because they are considered new products under existing Medicaid drug rebate rules, are given new base period AMPs. The new base period AMPs for line-extension products will be

[15] Selected drug purchases are exempted from the calculation of state Medicaid rebates, 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 (for Medicaid beneficiaries). 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 fee-for-service delivery system, and states can claim manufacturer rebates for these purchases.

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

higher than the original product's AMP. For the line-extension product, the manufacturer is unlikely to owe an additional rebate since the product's AMP will not have risen faster than the rate of inflation.

Public Health Service Act (PHSA) Sec. 340B requires pharmaceutical drug manufacturers that enter into Medicaid drug rebate agreements to discount outpatient drugs purchased by certain public health facilities (covered entities). In addition to other requirements, 340B hospitals and other covered entities are prohibited from obtaining multiple discounts for individual drugs and from diverting 340B drug purchases to other buyers.

Beginning January 1, 2010, the bill would, with certain exceptions, increase the flat rebate percentage used to calculate Medicaid's basic rebate for single source and innovator multiple source outpatient prescription drugs from 15.1% to 23.1% of AMP. The basic rebate percentage for multi-source, non-innovator and all other drugs would increase from 11% to 13% of AMP.[17]

Under the bill, the Secretary would be required to recover the additional funds states received from drug manufacturers that were attributable to increases in the minimum Medicaid rebate percentage. The Secretary would be authorized to reduce Medicaid payments to states by the state share (100% - the federal FMAP rate) of the additional prescription drug rebates that resulted from increases in the minimum rebate percentages.

The Secretary would estimate the additional rebate amounts to recover from states based on utilization and other data. In addition, when it was determined that the recovered amount from a state for a previous quarter under-estimated the actual rebate amount (state share) the Secretary would make further adjustments in the rebate recoveries. These state payment reductions would be considered overpayments to the state and disallowed against states' regular Medicaid quarterly draw similar to other overpayments, and these disallowances would not be subject to reconsideration.

The bill also would require drug manufacturers to pay rebates to states on drugs dispensed to Medicaid beneficiaries who receive care through Medicaid MCOs similar to the way rebates are required under current law for FFS beneficiaries. Medicaid capitation rates paid by states would be adjusted to include these rebates, and Medicaid MCOs would be subject to additional reporting requirements such as submitting data to states on the total number of units of each dose, strength, and package size by National Drug Code for each covered outpatient drug. Medicaid MCOs could utilize formularies as long as there was an exception process so that excluded drugs would be available through prior authorization. Drugs discounted under 340B would be excluded from this provision.

With certain exceptions, the bill would require that additional rebates for new formulations of single source or innovator multiple source drugs be the greater of the basic rebate for new product or the AMP of the new drug multiplied by highest additional rebate for any strength of the original product (calculated for each dose and strength of the product).[18] However, total rebate liability for each dosage form and strength of an individual single source or innovator multiple

[17] Certain outpatient single source and innovator multiple source drugs would receive a rebate of 17.1%. These drugs include clotting factor drugs and outpatient drugs approved by the Food and Drug Administration exclusively for pediatric indications.

[18] New orphan drug formulations would be exempted from the additional rebate requirements, regardless of whether the market exclusivity period had expired.

source drug would be limited to no more than 100% of that drug's AMP. Other features of the drug rebate program, such Medicaid's best price provision, would remain unchanged. All changes for this provision would begin January 1, 2010.

Elimination of Exclusion of Coverage of Certain Drugs (§2502)

Medicaid law excludes coverage of 11 drug classes, including barbiturates, benzodiazepines, and smoking cessation products. States have the option to cover excluded drugs, and most states cover barbiturates, and benzodiazepines, and smoking cessation drugs. States receive FFP when they cover these drugs. Coverage of prescription drugs for full benefit dual eligibles (individuals who are eligible for both Medicare and Medicaid) was transferred from state Medicaid programs to Medicare when Part D was implemented in January 2006. Barbiturates and benzodiazepines, two important drug classes for Medicaid beneficiaries, were excluded from Part D formularies (coverage). However, under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-271), Medicare prescription drug plans and Medicare Advantage plans will be required to include benzodiazepines and barbiturates in their formularies for prescriptions dispensed beginning on January 1, 2013. Barbiturates also will be required to be included in Medicare formularies for the indications of epilepsy, cancer, or chronic mental health disorder.

Beginning January 1, 2014, this provision would remove smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid's excluded drug list. States that covered prescription drugs would be required to cover these drugs for most Medicaid beneficiaries.

Providing Adequate Pharmacy Reimbursement (§2503)

Medicaid law requires the Secretary to establish upper limits on federal share of payments for prescription drugs. These limits are intended to encourage substitution of lower-cost generic equivalents for more costly brand-name drugs. When applied to multiple source drugs, those limits are referred to as federal upper payment limits (FUL). CMS calculates FULs and periodically publishes these prices. The DRA required the Secretary to use a new formula for FULs beginning January 1, 2007. The new FUL formula was to equal 250% of the average manufacturer price (AMP) of the least costly therapeutic equivalent. AMP was defined under DRA to be the average price paid to the manufacturer by wholesalers for drugs distributed to the retail pharmacy class of trade. DRA also reduced the number of multiple source products rated by the FDA as therapeutic and pharmaceutically equivalent from three to two. Manufacturers are required to report AMP to CMS. Current law allows the Secretary to contract for a survey of retail prices that represent a nationwide average consumer drug price, net of all discounts and rebates.

National pharmacy associations challenged the legality of the DRA's FUL methodology, published in a proposed rule CMS issued in 2007, because they claimed that for smaller community pharmacies, the new FULs would be below drug acquisition costs. 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 HHS or to the Department of Justice. The court's 2007 injunction was for an indefinite period and remains in place. In addition to the court injunction against using AMP to calculate Medicaid FULs, Section 203 of MIPPA imposed a moratorium on the use of AMP to set FULs and prohibited CMS from making AMP data available until October 1, 2009. Under MIPPA Section 203, until September 30, 2009, FULs could be set based on the pre-DRA methodology—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 published prices are significantly higher than AMPs.

CMS currently lacks authority to use either the pre-DRA formula (expired September 30, 2009) for setting FULs or the DRA authority (prohibited by MIPPA and the court's injunction). In the interim, until the court injunction is resolved or new legislation is offered to address the use of AMP or anther FUL formula, CMS issued a list of multiple source drug FULs on September 25, 2009 to establish the federal maximum that states may pay under Medicaid. However, most states also use Medicaid Acquisition Costs (MACs) to set their own ceiling prices, and these prices often are less than FULs.

Under the bill, the Secretary would be required to set FULs at 175% or more of the weighted average (determined on the basis of utilization) of the most recently reported monthly AMPs.[19] The bill also would restore the pre-DRA definition of multiple source drugs as three therapeutic and pharmaceutically equivalent products. The FUL formula would include certain technical specifications such as the use of a smoothing process for average prices and would clarify that the definition of AMP to include sales by (1) wholesalers for drugs distributed to retail community pharmacies, and (2) retail community pharmacies that purchase drugs directly from manufacturers. In addition, under the bill, AMP would exclude customary prompt pay discounts and other service and related fees, such as restocking charges and reimbursement for returned merchandise. Further, this provision would revise the definition of a multiple source drug from one marketed in a state during the rebate period to a product marketed during the period in the United States. Moreover, the bill would expand drug pricing disclosure requirements to include monthly weighted average AMPs and retail survey prices. Manufacturers would be required to report within 30 days of the end of each month of a rebate period the total number of units sold and used by the manufacturer to calculate the AMP for each covered outpatient drug. This provision would be effective as of the first quarter beginning at least six months after enactment, regardless of whether final regulations were issued.

340B Prescription Drug Discount Program Expansion[20] (§7101-7103)

Under Sec. 340B of the PHSA, pharmaceutical drug manufacturers that participate in the Medicaid drug rebate program are required to enter into pharmaceutical pricing agreements where they agree to discount covered outpatient drugs purchased by public health and related entities (covered entities). Covered entities include hospitals owned or operated by state or local government that serve a higher percentage of Medicaid beneficiaries, as well as federal grantees such as Federally Qualified Health Centers (FQHCs), FQHC look-alikes, family planning clinics, state-operated AIDS drug assistance programs, Ryan White CARE Act grantees, family planning and sexually transmitted disease clinics, and others, as identified in the PHSA. Covered entities do not receive discounts on inpatient drugs under the 340B program.

Under the bill, the list of covered entities eligible to receive 340B discounts would be expanded to include (1) certain children's and free-standing cancer hospitals excluded from the Medicare prospective payment system, (2) critical access and sole community hospitals, and (3) rural

[19] FULs would be set for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies.

[20] For more information on the Senate 340B provision, see CRS Report R40943, *Public Health, Workforce, Quality, and Related Provisions in H.R. 3590, as Passed by the Senate*.

referral centers. In addition, the bill would expand 340B discounts to inpatient drugs for participating hospital entities. Further, the bill would require the Secretary to develop systems to improve compliance and program integrity activities for manufacturers and covered entities, as well as administrative procedures to resolve disputes. Finally, within 18 months of enactment, the Government Accountability Office (GAO) would be required to submit to Congress a report that examines, among other issues, whether individuals receiving services through 340B covered entities are receiving optimal health care services. These provisions, except the GAO report requirement, would be effective and would apply to drug purchases beginning January 1, 2010.

Program Integrity

Program integrity (PI) initiatives are designed to combat fraud, waste, and abuse. 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, PI ensures that correct payments are made to legitimate providers for appropriate and reasonable services for eligible beneficiaries.

The federal government provides the majority of Medicaid spending to combat fraud and abuse, as part of an enhanced FMAP contribution. The federal match for administrative expenditures does not vary by state and is generally 50%; however 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) activities are matched at 75%, although the federal match is 90% for certain startup expenses.

In DRA, Congress provided new dedicated PI funding when it established a Medicaid Integrity Program (MIP) with an appropriation reaching $75 million annually to cover the cost of audits, overpayments identification, payment integrity and quality of care education, and other purposes. Congress provided an additional $25 million annually for five years beginning in FY2006 for Medicaid activities of the Health and Human Services 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.

Medicare and Medicaid PI activities traditionally have been mostly independent of each other with separate, though often similar, requirements for each program. In addition, there have been limited requirements for coordination of Medicare and Medicaid PI activities. As PI monitoring and prevention have advanced, there has been increased recognition of the need for closer coordination among entities involved in PI, as well as the need for more comparable rules and requirements applicable to Medicare, Medicaid, and CHIP.

The bill creates additional individual requirements to increase uniformity, and bolster Medicare, Medicaid and CHIP PI activities. For instance, the bill has a new provision that would introduce additional provider screening requirements and screening fees that, with certain exceptions, are comparable for Medicare and Medicaid. The bill also would create an integrated Medicare and Medicaid data repository to enhance program integrity data sharing that would be available to federal and state program integrity agencies. Moreover, a recovery audit contractor (RAC) requirement, similar to Medicare's RAC program, would be established for Medicaid (described below).

Expansion of the Recovery Audit Contractor (RAC) Program (§6411)

RACs are private organizations that contract with CMS to identify and collect improper payments made in Medicare's FFS program. In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), Congress required the Secretary to conduct a three-year demonstration of RACs. However, in December 2006, Congress passed the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432) which made the RAC program permanent and mandated its expansion nationwide by January 1, 2010. The TRHCA RAC expansion still applied only to Medicare Parts A and B, excluding managed care under Medicare Part C and prescription drug coverage under Part D. CMS began the national rollout of the permanent RAC program in 19 states in March 2009.

By December 31, 2010, states would be required to have established contracts, consistent with state law, and similar to the contracts the Secretary has established for the Medicare RAC program, with one or more RACs. These state RACs would identify underpayments, overpayments, and recoup overpayments made for services provided under state Medicaid plans as well as waivers. The state Medicaid RAC program would be subject to exceptions and requirements the Secretary may establish for the state RAC program. In addition, states would be required to make certain assurances for their RAC programs, including operation on a contingency basis, there would be an adverse determination appeal process, recoveries would be subject to quarterly expenditure estimates, and states would coordinate with other program integrity activities such as federal and state law enforcement.

Termination of Provider Participation Under Medicaid if Terminated Under Medicare or Other State Plan (§6501)

Subject to certain exceptions, the Secretary is required to exclude providers or individuals from Medicare or Medicaid 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 providers or individuals from Medicare or Medicaid participation who are involved in prohibited activities, 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 if it receives Medicare or Medicaid program participation applications that identify providers that have engaged in prohibited activities.

This provision would require states to terminate individuals or entities (or individuals or entities who owned, controlled, or managed entities) from their Medicaid programs if the entities had unpaid Medicaid overpayments (as defined by the Secretary), were suspended, excluded or terminated from Medicaid or Medicare participation, or were affiliated with individuals or entities who had been terminated from Medicaid. This provision would be effective January 1, 2011.

Medicaid Exclusion from Participation Relating to Certain Ownership, Control, and Management Affiliations (§6502)

Medicaid law requires states to exclude individuals or entities from Medicaid participation when a state is directed to do so by the Secretary, and to deny payment for any item or service furnished by the individual or entity. States are required to exclude these individuals and deny payment for a period specified by the Secretary.

The measure would require Medicaid agencies to exclude individuals or entities from Medicaid participation if the entity or individual owns, controls, or manages an entity that: (A) has unpaid or unreturned overpayments during the period as determined by the Secretary or the state; (B) is suspended, excluded, or terminated from participation in any Medicaid program; or (C) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation during the period. This provision would be effective January 1, 2011.

Billing Agents, Clearinghouses, or Other Alternate Payees Required to Register Under Medicaid (§6503)

As a condition of participation, certification, or recertification in Medicaid, the Secretary requires disclosing entities to supply upon request, either 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 5% or more of such entity. Disclosing entities include providers of service, independent clinical laboratories, renal disease facilities, managed care organizations or 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. Federal rules applicable to Medicaid state plans also require states to exclude individuals or entities from Medicaid participation when a state is directed to do so by the Secretary and to deny payment for any item or service furnished by the individual or entity.

The provision would require any agents, clearinghouses, or other alternate payees that submit claims on behalf of Medicaid health care providers to register with the state and the Secretary in a form and manner specified by the Secretary. This provision also would be effective January 1, 2011.

Requirement to Report Expanded Set of Data Elements Under MMIS to Detect Fraud and Abuse (§6504)

To administer their state Medicaid plans, states are required to operate an automated claims processing system and data base known as a Medicaid Management Information System (MMIS). The Secretary must approve states' MMISs and determine that they have met requirements including compatibility with Medicare claims processing and information systems, and consistency with uniform coding systems for claims processing and data interchange. MMISs also must be capable of providing timely and accurate data, meet other specifications as required by the Secretary, and provide for electronic transmission of claims data as well as be consistent with Medicaid Statistical Information Systems (MSIS) data formats. MSIS is an analytical database derived from MMIS claims level data. MMIS data primarily captures claims data when Medicaid beneficiaries receive their care on a FFS basis. For most states, managed care encounter

data or managed care claims level data generally are not reported or otherwise captured by state MMIS systems. Under managed care, MCOs are paid a capitated (fixed fee) regardless of the amount of care required by beneficiaries. Encounter data reporting requirements under state contracts with MMCOs vary. Medicaid agencies also do not report claims level managed care data to CMS through their MMISs.

This provision would require states, beginning in January 1, 2011, to collect and submit through their MMISs managed care data as identified by the Secretary for program integrity, program oversight, and administration. The Secretary would determine the data needed and how frequently these data would need to be submitted. In addition, beginning with contract years beginning after January 1, 2010, MMCO entities would be required to submit data elements as determined necessary by the Secretary for program integrity, program oversight, and administration.

Prohibition on Payments to Institutions or Entities Located Outside of the United States (§6505)

Under current Medicaid law, there are no specific prohibitions or limitations which would prevent Medicaid payments to institutions or entities located outside the United States. The measure would prohibit states from making any payments for items or services supplied to beneficiaries under a Medicaid state plan or waiver to any financial institution or entity located outside of the United States. This provision would be effective January 1, 2011.

Overpayments (§6506)

Medicaid law requires states to repay promptly the federal share of Medicaid overpayments when the state discovers overpayments occurred. States have 60 days after discovery of an overpayment 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. Once the 60 day recovery deadline has lapsed, payments would be readjusted.

Beginning with enactment, the bill would extend the time period for states to repay overpayments due to fraud to one year when the uncollectible debt (or any part) was an overpayment within one year of discovery because a determination of the amount of the overpayment was not made due to an ongoing judicial or administrative process, including the appeal of a judgment. When these overpayments due to fraud are pending, state repayments of the federal portion would not be due until 30 days after the date of the final judgment (including a final appeal determination). The Secretary would be required to issue regulations for states to use in adapting MMIS edits, conducting audits, or other appropriate actions to identify and correct recurring or ongoing overpayments. This provision would be effective upon enactment.

Mandatory State Use of National Correct Coding Initiative (§6507)

Working through health insurance contractors, CMS processes Part B Medicare claims which include payments for physician, laboratory, and radiology services. In 1996, to help ensure correct payment for these claims, CMS initiated a national correct coding initiative (NCCI). Under NCCI, CMS' contractors screen Medicare Part B claims with automated pre-payment edits. The software edits used by Medicare contractors are designed to detect anomalies that

indicate a claim has incorrect information. For example, NCCI edits can detect claims with duplicate services delivered to the same beneficiary on the same date of service. Medicaid law does not require the use of NCCI prepayment edits, but individual states conduct medical review and other pre- and post-payment reviews designed to detect fraud, waste, and abuse.

Under the bill, for Medicaid claims submitted beginning October 1, 2010, states would be required to add to their Medicaid Management Information Systems (MMISs) pre-payment edits to correct and control improper coding similar to the edits used by Medicare contractors under the NCCI. By September 1, 2010, the Secretary would be required to (1) identify NCCI methodologies that are compatible to Medicaid payment claims, and (2) identify methodologies that would be applicable to Medicaid, but for which no Medicare NCCI methodologies have been established. Further, the Secretary would be required to notify states of the NCCI methodologies (or successor initiatives) that were identified and how states should incorporate those methodologies into their Medicaid claims processing systems. Moreover, the Secretary would be required to submit a report to Congress by March 1, 2011 that includes the notice to states about the NCCI methodologies, and an analysis that supports the identification of NCCI methodologies to be applied to Medicaid claims.

General Effective Date for Medicaid and CHIP Program Integrity Activities (§6508)

States would be required to have implemented waste, fraud, and abuse programs specified under the bill before January 1, 2011, regardless of whether the Secretary had issued final regulations to implement these provisions. In situations where the Secretary determined that state legislation would be required (other than appropriation legislation) to amend the state plan or child health plan, then states would have additional time to comply with these requirements.

Other Program Integrity and Related Provisions Applicable to Medicaid

Provider Screening and Other Enrollment Requirements under Medicare, Medicaid, and CHIP (§6401, §10603)

The enrollment process for participation in Medicare, Medicaid, and CHIP differs for providers although Medicaid and CHIP have very similar requirements. This bill would require the Secretary, in consultation with the Office of the Inspector General (OIG), to establish similar procedures for screening providers and suppliers enrolling in the Medicare, Medicaid, and CHIP programs.

Procedures would be required to include a process for screening, enhanced oversight measures, disclosure requirements, moratoriums on enrollment, and requirements for developing compliance programs. The Secretary would have six months from enactment to develop the procedures, which would apply to both new and current providers. The Secretary would be required to implement these requirements within three years. The Secretary would determine the level of screening for providers depending on the provider's fraud risk category. At a minimum, all providers and suppliers would be subject to licensure checks, including checks across states.

The Secretary would have the authority to impose additional screening measures such as criminal background checks, fingerprinting, unannounced site visits, database checks, and periods of

enhanced oversight if necessary. To cover the costs of the screening, institutional providers and suppliers would be subject to fees, with some hardship exceptions and waivers for certain Medicaid providers when states can demonstrate that imposition of the fees might jeopardize beneficiaries' access to services. Fees would start at $500 for institutional providers and would be adjusted for inflation thereafter. The Secretary also would have authority to impose a temporary moratorium on enrolling new providers if necessary. The bill also would require Medicare, Medicaid, and CHIP providers and suppliers, within a particular industry or category, to establish a compliance program, adhering to standards established by the Secretary and the OIG.

Enhanced Medicare and Medicaid Program Integrity Provisions (§6402)

The Secretary would be required under the bill to enhance existing Medicare, Medicaid, and CHIP program integrity initiatives. As part of these enhancements, the Secretary would be required to use the same requirements for Medicare, Medicaid, and CHIP.

- ***Data Matching.*** Currently, claims and payment data for Medicare and Medicaid are housed in multiple databases. CMS is in the process of consolidating information stored in these databases into an Integrated Data Repository (IDR). This provision would require CMS to include in the IDR claims and payment data from the following programs: Medicare (Parts A, B, C, and D), Medicaid, CHIP, health-related programs administered by the Departments of Veterans Affairs (VA) and Defense (DOD), Social Security Administration, and the IHS. The priority would be the integration of Medicare claims and payment data. Data for the remaining programs would be integrated as time and funds permit.
- ***Access to Data.*** Inspectors General have substantial independence and power to carry out their mandate to combat waste, fraud, and abuse, including relatively unlimited authority to access all records and information of an agency. This provision would grant the OIG and the DOJ explicit access to Medicare, Medicaid, and CHIP payment and claims data (including Medicare Part D data) for the purposes of conducting law enforcement and oversight activities. The provision also would grant the OIG the authority to obtain information (i.e. supporting documentation, medical records, etc.) from any individual that directly or indirectly provides medical services payable by a federal health care program.
- ***Beneficiary Participation in Health Care Fraud Scheme.*** The provision would require the Secretary to impose penalties against beneficiaries entitled to or enrolled in Medicare, Medicaid, or CHIP that knowingly participate in a health care fraud offense.
- ***National Provider Identifier (NPI).*** Health care providers often have many different provider numbers, one for billing each private insurance plan or public health care program. The administrative simplification provisions of HIPAA required the adoption and use of a standard unique identifier for health care providers or NPI. All health care providers who are considered covered entities under HIPAA were required to obtain and submit claims using an NPI as of May 2007. This provision would require the Secretary to issue regulations before January 1, 2011 mandating that all Medicare and Medicaid providers include their NPI on all claims and enrollment applications.

- ***Withholding of Federal Matching Payments for States that Fail to Report Enrollee Encounter Data in MSIS***. The Secretary would be permitted to withhold federal matching payments for services provided to Medicaid beneficiaries when states did not submit encounter data (as determined by the Secretary) for those beneficiaries in timely manner.
- ***Permissive Exclusions.*** HHS OIG has the authority to exclude health care providers from participation in federal health care programs. Exclusions are mandatory under certain circumstances, and permissive in others (i.e., HHS OIG has discretion in whether to exclude an entity or individual). This provision would subject any individual or entity that makes a false statement or misrepresentation on an application to enroll or participate in a federal health care program to the OIG's permissive exclusion authority. The provision would explicitly apply to Medicare Advantage plans, Prescription Drug Plans, and Medicaid managed care plans as well as their participating providers and suppliers.
- ***Civil Monetary Penalties (CMPs).*** Section 1128A of the SSA authorizes the imposition of CMPs on a person, organization, agency, or other entity that engages in various types of improper conduct with respect to federal health care programs. The bill generally provides for CMPs of up to $10,000 for each false claim submitted, $15,000 or $50,000 under other circumstances, and an assessment of up to three times the amount claimed. The bill would add additional actions that would be subject to CMPs. Among other changes, the following individuals would be subject to CMPs: individuals who have been excluded from a federal health care program, but who order or prescribe an item or service; individuals who make false statements on enrollment applications, bids, or contracts; or individuals who know of an overpayment and do not return the overpayment.
- ***Testimonial Subpoena Authority.*** The testimonial subpoena authority grants the authority to issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence that relates to matters under investigation or in question. Under this provision, the Secretary would be able to issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence that relates to matters under investigation or in question by the Secretary. The Secretary also would have the ability to delegate this authority to the OIG and the CMS administrator for the purposes of a program exclusion investigation.
- ***Medicare and Medicaid Integrity Programs.*** Under the Medicare Integrity Program (MIP), CMS contracts with private entities to conduct a variety of activities designed to protect Medicare from fraud, waste, and abuse. Activities include auditing providers, identifying and recovering improper payments, educating providers about fraudulent providers, and instituting a Medicare-Medicaid data matching program. Established by DRA, the Medicaid Integrity Program (MIP) is modeled after Medicare's MIP program. Medicaid MIP provides HHS with dedicated resources to contract with entities to reduce fraud, waste, and abuse, and to add 100 full-time equivalent MIP staff. This provision would require both Medicare and Medicaid Integrity Program contractors to provide the Secretary and the OIG with performance statistics, including the number and amount of overpayments recovered, the number of fraud referrals,

and the return on investment for such activities. The Secretary also would be required to conduct evaluations of eligible entities at least every three years. Within six months of the fiscal year end, the Secretary would be required to submit a report to Congress describing the use and effectiveness of MIP funds.

Improving Nursing Home Transparency, Enforcement, and Staff Training (§6101-§6107, §6111-§6114, and §6121)

Medicare and Medicaid laws require skilled nursing facilities (SNF) and nursing facilities (NF) to be administered in a manner that will ensure residents' well-being. The Secretary establishes requirements for SNF and nursing homes that will protect the safety, health, welfare, and rights of residents. Facilities undergo regular survey and certification inspections to ensure their compliance with these standards. SNF and nursing home inspections identify deficiencies where facilities fail to meet federal standards. Deficiencies can range from minor problems to major safety and life-threatening conditions. State and federal officials may impose civil monetary penalties on facilities that fail to meet standards or fail to correct deficiencies. In extreme cases, federal and state officials can install new facility management, assume control of facilities, or even close SNF or nursing homes that jeopardize residents' well-being.

The measure would enhance certain accountability requirements for Medicare certified SNF and Medicaid certified NF. The changes in these sections would require SNFs and NFs to maintain and make available additional information on facility ownership and organizational structure, as well as to establish new staff compliance and ethics training programs. The changes in these sections also would require the Secretary to establish additional requirements for SNFs and NFs to develop and implement compliance and ethics programs.

The Secretary would further be required to enhance the SNF and NF information available on the Medicare Nursing Home Compare website, and to ensure that information is prominent, easily accessible, searchable, and readily understandable to long-term care consumers. SNFs would be required to report wage and benefit expenditures for direct care staff. In addition, the Secretary, in consultation with private sector experts, would be required to redesign Medicare and Medicaid cost reports to capture wage and benefit reporting by SNFs and NFs. The Secretary would be required to develop a new standardized complaint form that facilities and states would be required to make available to all stakeholders and consumers. The changes in these sections would require SNFs and NFs to electronically report direct staffing information to the Secretary following specifications the Secretary would establish in consultation with stakeholders. GAO would be required to conduct a study of the Centers for Medicare & Medicaid Services Five-Star rating system. Additional civil money penalties would be established that both the Secretary and states could impose on SNFs or NFs found to have quality of care issues and other deficiencies that jeopardized residents' safety. The Secretary would be required to develop, test, and implement a national independent monitoring demonstration for large interstate and intrastate SNF and NF chains.

Further, the bill would establish new requirements for SNF and NF administrators to inform residents and their representatives, as well as the Secretary, states, and other stakeholders of planned facility closures. SNF and NF administrators who failed to comply with the closure notice requirements could be subject to penalties up to $100,000 and exclusion from federal health program participation. The Secretary also would be required to conduct demonstration projects on best practices for culture change and use of information technology in SNFs and NFs. The Secretary would also be required to revise initial nurse aide training, competency, and

evaluation requirements to include dementia and abuse prevention. Finally, the Secretary also would be authorized to revise dementia management training and patient abuse prevention in ongoing nurse training, competency, and evaluation requirements. Effective dates for the nursing home transparency provisions vary, but mostly are within two years of enactment.

Demonstrations and Grant Funding

Money Follows the Person (§2403)

Under the Money Follows the Person (MFP) Rebalancing Demonstration, the Secretary awarded competitive grants to states to meet the following objectives: (1) increase the use of home and community-based, rather than institutional, long-term care (LTC) services; (2) eliminate barriers that prevent or restrict the flexible use of Medicaid funds to support services for individuals in settings of their choice; (3) increase Medicaid's ability to assure home and community-based LTC services to individuals transitioning from institutions to a community settings; and (4) ensure that procedures are in place to provide quality assurance home and community-based LTC services. To participate, individuals must be (1) residing in, and have been residing in for not less than six months and not more than two years, an inpatient facility; (2) receiving Medicaid benefits for inpatient services furnished by such inpatient facility; and (3) continuing to require the level of care provided in an inpatient facility, among other requirements.

The bill would extend the MFP Rebalancing Demonstration through September 30, 2016 and would extend the deadline for the submission of the final evaluation report to September 30, 2016. The provision would also change the demonstration eligibility rules by requiring that individuals reside in an inpatient facility for not less than 90 consecutive days, and by removing the maximum length of stay for eligibility purposes. The provision would also exclude Medicare-covered short-term rehabilitative services from counting toward the 90-day period. This provision would be effective 30 days after enactment.

Demonstration Project to Evaluate Integrated Care Around Hospitalization (§2704)

There is no related provision in current law. The bill would establish a Medicaid demonstration that would evaluate whether quality could be improved and Medicare payments reduced by making bundled payments to hospitals and physicians for the delivery of integrated care. Such payments would be made for episodes of care that include beneficiaries' hospital stays and concurrent physician services. Under the demonstration, bundled payments would be based on the beneficiary's severity of illness, among others requirements. States could target selected categories of beneficiaries, such as those with particular diagnoses, or those in particular geographic regions. Finally, participating hospitals would be required to have, or to establish, robust discharge planning programs that would appropriately place beneficiaries in, or ensure that they have access to, post-acute care settings. This demonstration project would be limited to eight states, and required to begin on January 1, 2012 and end on December 31, 2016.

Medicaid Global Payment System Demonstration Project (§2705)

Under Medicaid FFS, the state directly (or through a fiscal intermediary) pays for each covered service received by a Medicaid beneficiary. All states pay Medicaid-certified hospitals using a prospectively determined payment system for each case or day of hospitalization. Aggregate Medicaid payments vary based on the number of cases.

Under the bill, the Secretary, in coordination with the proposed Center for Medicare and Medicaid Innovation would be required to establish the Medicaid Global Payment System Demonstration Project in no more than five states. The demonstration would be required to be operational from FY2010 through FY2012. Under the project, payments to an eligible safety net[21] hospital system or network would be adjusted from a FFS payment structure to a global, capitated payment model (a fixed-dollar payment for patient care, which does not vary by the amount of services delivered). The Secretary would have the authority to modify or terminate the project during an initial testing period, and would be required to submit an evaluation by the Innovation Center, as well as recommendations for legislative and administrative action, no later than 12 months after the demonstration's completion. The bill would authorize to be appropriated such sums as necessary to finance this demonstration project.

Pediatric Accountable Care Organization Demonstration Project (§2706)

Accountable care organizations (ACOs) are defined by experts as groups of providers (e.g. combinations of one or more hospitals, physician groups, and/or other health care providers) that are jointly responsible, through shared bonuses or penalties, for the quality and cost of health care services for a given population of beneficiaries. Under the proposed Medicare Shared Savings Program in the bill, groups of providers who voluntarily meet certain statutory criteria, including quality measurements, could be recognized as ACOs and be eligible to share in the cost-savings they achieve for the Medicare program. An eligible ACO would be defined as a group of providers and suppliers who have an established mechanism for joint decision making, and would be required to participate in the shared savings program for a minimum of three years, among other requirements. An ACO would include practitioners (physicians, regardless of specialty; nurse practitioners; physician assistants; and clinical nurse specialists) in group practice arrangements; networks of practices; and partnerships or joint-venture arrangements between hospitals and practitioners; among others.

The bill would establish the Pediatric Care Organization demonstration project, where participating states would be authorized to allow pediatric medical providers, who voluntarily meet certain statutory criteria, including quality measurement criteria, to be recognized as ACOs and be eligible to share in the cost-savings they achieve for the Medicaid program, in the same manner as an ACO is recognized and provided with incentive payments under the proposed Medicare Shared Savings Program. ACOs could include pediatric physicians in group practice arrangements, or in networks of practices, and those in joint-venture arrangements with hospitals, among others. To receive an incentive payment, qualified ACOs would be required to meet both quality performance guidelines created by the Secretary, in consultation with states and pediatric

[21] Safety net hospitals are defined as hospitals that accept patients regardless of their ability to pay, and a substantial share of their patient mix consists of the uninsured and Medicaid patients.

providers, and a minimum annual savings level, as established by a participating state, for expenditures on items and services covered under Medicaid and CHIP. The Secretary would be responsible for determining the amount of the annual incentive payment, which would be a portion of savings and could establish an annual cap on total incentive payments. The bill would authorize an appropriation of such sums as may be necessary to finance this demonstration project.

Medicaid Emergency Psychiatric Demonstration Project (§2707)

Medicaid does not reimburse for services provided to residents of institutions for mental disease (IMD), except to those individuals who are under age 21 receiving inpatient psychiatric care and to individuals age 65 and over. IMDs are defined under Medicaid statute as hospitals, nursing facilities, or other institutions with more than 16 beds that are primarily engaged in providing diagnosis and treatment of persons with mental diseases.

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.

The bill would establish a three-year Medicaid demonstration project in which eligible states would be required to reimburse certain IMDs that are not publicly owned or operated for services provided to Medicaid eligibles aged 21 through 64 who require medical assistance to stabilize a psychiatric emergency medical condition, as defined by the bill. The state would be required to establish a mechanism for in-stay review (to be applied before the third day of the inpatient stay) to determine whether the patient has been stabilized, as defined by the bill. Eligible states would be selected by the Secretary based on geographic diversity. Out of funds not otherwise appropriated, the provision would provide budget authority in advance of appropriations in an amount equal to $75 million for FY2011. Such funds would remain available for obligation for five years through December 31, 2015. An evaluation would be conducted on whether access to inpatient mental health services under Medicaid increased, among other things. A final report would be submitted to Congress by the Secretary.

Grants for School-Based Health Centers (§4101(a))

The bill would establish a grant program to support the establishment of school-based health centers. The proposal would appropriate $50 million for each fiscal year from FY2010 through FY2013, for a total of $200 million, to remain available until expended. The use of such funds for any service that is not authorized or allowed by federal, state, or local law would be prohibited. The Secretary would be required to establish criteria and application procedures for awarding grants under this program. The Secretary would also be directed to give preference in awarding grants to school-based health centers serving a large population of children eligible for Medicaid or CHIP. Eligible entities must use these grant funds only for expenditures for facilities, equipment or similar costs. No grant funds could be used for personnel or health care

expenditures. (Another provision, described in a separate CRS report,[22] would provide grants under the PHSA for the *operation* of school-based health centers.)

Grants for Prevention of Chronic Disease in Medicaid (§4108)

There is no related provision in current law. The Secretary would be authorized to award grants to states to provide incentives for Medicaid beneficiaries to participate in programs to promote healthy lifestyles. These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries, and have demonstrated success in helping individuals lower cholesterol and/or blood pressure, lose or control weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions. The purpose of this initiative is to test approaches that may encourage behavior modification and determine scalable solutions.

The provision would authorize the appropriation of $100 million in funding for these grants during a five-year period. Under this bill, the Secretary would be required to award grants beginning on January 1, 2011, or the date on which the Secretary develops program criteria, whichever is earlier. These criteria will be developed using relevant evidence based research including the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry of Evidence-Based Programs and Practices. The state initiatives would be required to last at least three years of the five-year program spanning January 1, 2011, through January 1, 2016.

After the Secretary develops and institutes an outreach and education campaign to make states aware of the grants, states may submit a proposal and apply for funds to provide incentives to Medicaid enrollees who successfully complete healthy lifestyle programs. States are permitted to collaborate with community-based programs, non-profit organizations, providers, and faith-based groups, among others. States awarded such grants would be required to conduct an outreach and education campaign aimed at Medicaid beneficiaries and providers. States receiving grants would be required to establish a system to track beneficiary participation and validate changes in health risk and outcomes; establish standards and health status targets for participating Medicaid beneficiaries; evaluate the effectiveness of the program and provide the Secretary these evaluations; report to the Secretary on processes that have been developed and lessons learned; and report on preventive services as part of reporting on quality measures of Medicaid managed care programs. A state awarded a grant would be required to submit semi-annual reports including information on the specific use of the funds, an assessment of program implementation, and assessment of quality improvements and clinical outcomes, and an estimate of cost savings resulting from such program. This provision would exempt states from requirement 1902(a)(1) of the SSA, which relates to the statewide accessibility for medical assistance programs.

The Secretary would be required to enter into a contract with an independent entity or organization to conduct an evaluation of the initiatives. This report should address the effect of the state initiative of the utilization of health care services, the extent to which special populations, such as adults with disabilities, are able to participate in the program, the level of satisfaction experienced by the Medicaid beneficiaries, and the additional administrative costs incurred as a result of providing the incentives.

[22] For information about this related provision, see CRS Report R40943, *Public Health, Workforce, Quality, and Related Provisions in H.R. 3590, as Passed by the Senate*, coordinated by (name redacted) and (name redacted).

The Secretary would be required to submit an initial report to Congress before January 1, 2014. This initial report would include an interim evaluation based on information provided by states and recommendations on whether funding for expanding or extending the initiatives should continue beyond January 1, 2016. The Secretary would be required to submit a final report before July 1, 2016 that would include the independent contractor assessment together with recommendations for appropriate legislative and administrative actions.

Any incentives received by a beneficiary would not be considered for the purpose of determining eligibility for, or benefits under any program funded whole or in part with federal funds, such as Medicaid.

Funding of Childhood Obesity Demonstration Project (§4306)

CHIPRA included several provisions designed to improve the quality of care under Medicaid and CHIP. Among other quality initiatives, this law directed the Secretary of HHS to initiate a demonstration to develop a comprehensive and systematic model for reducing child obesity. A total of $25 million was authorized to be appropriated over FY2009 through FY2013. The bill would replace the authorization in current law with an appropriation of $25 million for fiscal years 2010 through 2014 to carry out the comprehensive demonstration project for reducing childhood obesity.

Miscellaneous

Medicaid Improvement Fund Rescission (§2007)

In the Supplemental Appropriations Act, 2008 (P.L. 110-252), Congress directed the Secretary to establish a Medicaid Improvement Fund (MIF) to be used by CMS to improve the management of the Medicaid program, including improved oversight of contracts and contractors and evaluation of demonstration projects. MIF funding was to be available in addition to existing CMS budget authority and was to total $100 million in FY2014, and $150 million in FYs 2015-2018. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) had revised funding for Physician Assistance and Quality Initiative and these funds were to be used for MIF activities. The bill would rescind any unobligated MIF funds (as of the date of enactment) for FYs 2014 through 2018 (which were to total $700 million).

Removal of Barriers to Providing Home and Community-Based Services (§2402)

Secretary would be required to promulgate regulations to ensure that all states develop service systems that are designed to: (1) allocate resources for services in a manner that is responsive to the changing needs of beneficiaries receiving non-institutionally-based Long-Term Care services and supports and that maximizes their independence; (2) provide the support for such beneficiaries to design an individualized self-directed, community-supported life; (3) improve coordination among providers to achieve more consistent administration of policies and procedures across federally and state-funded programs. among others.

Funding to Expand State Aging and Disability Resource Centers (§2405)

Established under the Older Americans Act (OAA), Aging and Disability Resource Centers (ADRCs) provide information and assistance to elderly persons and individuals with physical disabilities, serious mental illness, and/or developmental/intellectual disabilities. ADRCs also serve as a single point of entry for enrollment in publicly-administered LTC services, including those funded by Medicaid and OAA. Out of any funds in the Treasury not otherwise appropriated, the bill would appropriate to the Secretary, acting through the Assistant Secretary of Aging, $10 million for each of FY2010 through FY2014 to carry out ADRC initiatives.

Sense of the Senate Regarding Long-Term Care (§2406)

The bill would express the sense of the Senate that the 111th Congress should comprehensively address long-term services and supports in a way that guarantees elderly and disabled individuals the care they need, and that would make long term services and supports available in the community as well as in institutions.

Five-Year Period for Dual Eligible Demonstration Projects (§2601)

Some elderly and disabled individuals, referred to as dual eligibles, qualify for health insurance under both Medicare and Medicaid. These dual eligible individuals qualify for Medicare Part A and/or Parts B and D and, because they meet Medicare eligibility requirements, and are eligible for Medicaid because they have limited income and assets.

Current federal law gives the Secretary authority to waive selected Medicaid and Medicare requirements, as well as approve waivers to reach previously ineligible populations. Some projects have been approved that waive both Medicare and Medicaid rules to implement statewide initiatives to coordinate service delivery, benefit packages, and reimbursement for dual eligibles. Initially, waivers can be approved for periods ranging from two- to five-year periods and renewed for additional periods of up to five years.

The bill would authorize the Secretary to initially approve Medicaid waivers for up to five years. This authority would apply to demonstrations as well as home- and community-based waivers for coordinating care of dual eligibles (and for non dual eligible beneficiaries if they were included under the waiver). In addition, the provision would give the Secretary authority to approve Medicaid waiver extensions for additional five-year periods when requested by states, unless the waivers did not met the conditions for the previous period, or it was no longer cost effective, efficient, or consistent with Medicaid policy.

Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries (§2602)

There are no specific requirements under Medicare and Medicaid rules for the programs to coordinate care for dual eligible individuals. Under the bill, the Secretary would be required to establish a federal coordinated health care office (CHCO) within CMS by March 1, 2010. The CHCO director would be appointed by, and in the direct line of management to, the CMS Administrator. The purpose of the CHCO would be to bring together officers and employees of the Medicare and Medicaid programs at CMS to (1) integrate benefits and (2) improve care coordination. The CHCO would have the following goals:

1. to provide dual eligible individuals full access to the benefits to which they are entitled under the Medicare and Medicaid programs;
2. to simplify the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs;
3. to improve the quality of health care and long-term services for dual eligible individuals;
4. to increase beneficiaries' understanding of, and satisfaction with, coverage under the Medicare and Medicaid programs;
5. to eliminate regulatory conflicts between rules under the Medicare, and Medicaid programs;
6. to improve care continuity and ensure safe and effective care transitions;
7. to eliminate cost-shifting between the Medicare and Medicaid programs and among related health care providers; and
8. to improve the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

Under the bill, the CHCO would have the following specific responsibilities: (1) to provide states, specialized Medicare Advantage plans for special needs individuals—special needs plans, and other entities or individuals qualified to develop programs that align Medicare and Medicaid benefits for dual eligible individuals; (2) to support state efforts with education and tools to coordinate and align acute care and LTC services for dual eligible individuals with other items and services furnished under the Medicare program; (3) to support state and CMS efforts to coordinate contracting and oversight for integrating Medicare and Medicaid programs; (4) to consult with the MedPAC and MACPAC on enrollment and benefit policies for dual eligible individuals; and (5) to study the provision of drug coverage for new full-benefit dual eligibles and to monitor and report on total annual expenditures, health outcomes, and access to benefits for all dual eligibles.

The bill's CHCO provision would require the Secretary to submit a report to Congress under the annual budget transmittal. The report would be required to contain recommendations for legislation that could improve care coordination and benefits for dual eligible individuals.

Adult Health Quality Measures (§2701)

The bill would add a federal initiative to collect and report quality of care data for adults enrolled in Medicaid. Among several activities, the Secretary would publish a recommended core set of adult health quality measures, including such measures in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time. The Secretary would be required to publish an initial core set of measures by January 1, 2012. Also, no later than January 1, 2013, the Secretary, in consultation with the states, would be required to develop a standardized format for reporting information based on this initial core measurement set. States would be encouraged to use these measures to voluntarily report such data.

As with existing law regarding quality of care reporting for Medicaid children, before January 1, 2014, and every three years thereafter, the Secretary would be required to submit a report to Congress that describes the Secretary's efforts to improve, for example, the duration and stability

of coverage for adults under Medicaid, the quality of care of different services for such individuals, the status of voluntary state reporting of such data, and any recommendations for legislative changes needed to improve quality of care provided to Medicaid adults.

Within one year after the release of the recommended core set of adult health quality measures, the Secretary would also be required to establish a Medicaid Quality Measurement Program (MQMP). To this end, the Secretary would be required to award grants and contracts for developing, testing, and validating emerging and innovative evidence-based measures applicable to Medicaid adults. Not later than two years after the establishment of the MQMP, the Secretary would be required to publish recommended changes to the initial core set of adult health quality measures based on the results of testing, validation, and the consensus process for development of these measures.

This bill would not restrict coverage under Medicaid or CHIP to only those services that are evidence-based.

The bill also includes annual state reporting requirements to include, for example, state-specific adult health quality measures, including information collected as part of external quality reviews of managed care organizations and through benchmark plans (if applicable). The Secretary would be required to collect, analyze and make publicly available the information reported by states, before September 30, 2014, and annually thereafter.

Finally, to carry out these activities, the bill would appropriate $60 million for each of fiscal years 2010 through 2014. These funds would remain available until expended.

MACPAC Assessment of Policies Affecting All Medicaid Beneficiaries (§2801, §399V-4)

CHIPRA 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. MACPAC is similar to MedPAC which reviews Medicare program policies.

Beginning in 2010, the commission will submit an annual report to Congress containing the results of these reviews and MACPAC's recommendations regarding these policies. The commission will also 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.

The bill would make a number of changes to the federal statute that established MACPAC. For example, MACPAC's review and assessment of payment policies under Medicaid and CHIP

would be expanded to include how factors affecting expenditures and payment methodologies enable beneficiaries to obtain services, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations. Additional topics that MACPAC would be required to review and assess would include policies related to eligibility, enrollment and retention, benefits and coverage, quality of care, and interactions between Medicaid and Medicare and how those interactions affect access to services, payments and dual eligibles. MACPAC would also be required to report to Congress on any Medicaid and CHIP regulations that affect access, quality and efficiency of health care.

In carrying out its duties, MACPAC would be authorized to obtain necessary data from any state agency responsible for administering Medicaid or CHIP, as a condition for receiving federal matching funds under either program. The bill would require MACPAC to seek state input and review state data, and to consider state information in its recommendations and reports. Both MACPAC and MedPAC would be required to coordinate and consult with the Federal Coordinated Health Care Office (established under Section 2081 of this bill[23]) before making recommendations regarding Medicare beneficiaries who are dually eligible. Changes to Medicaid policy affecting dual eligibles are the responsibility of the MACPAC.

For FY2010, the bill would appropriate $11 million for MACPAC. Of this total, $9 million would come from the Treasury out of any funds not otherwise appropriated, and $2 million would come from FY2010 CHIP funds, and would remain available until expended. Funding in subsequent years is not addressed in this provision. This provision would be effective upon enactment.

Protections for American Indians and Alaska Natives (§2901)

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. These programs, which may be operated by Indian Tribes (ITs) or Tribal Organization (TOs), are eligible to receive reimbursements from Medicare, Medicaid, CHIP, state programs and third parties such as private insurance. American Indians and Alaska Natives receiving services through IHS programs or at IHS facilities may not be charged premiums, cost-sharing or similar charges in Medicaid. By regulation IHS is the payer of last resort for contract health services (i.e., services that IHS, ITs, or TOs may purchase, through contract, with providers in instances where the facility or program cannot provide the needed care). Under a newly permitted option enacted under the Children's Health Insurance Reauthorization Act (CHIPRA, P.L. 111-3), states may facilitate Medicaid enrollment—including under certain conditions, automatically enrolling those eligible—by relying on a finding of eligibility from specified "Express Lane" agencies (e.g., those that administer programs such as Temporary Assistance for Needy Families, Medicaid, CHIP, and food stamps). IHS, ITs, TOs, and urban Indian Organizations (UIOs) are not among the specified "Express Lane" agencies.

The bill would make a number of modifications related to IHS-eligible American Indians and Alaska Natives eligible for, or enrolled in, Medicaid and CHIP. It would designate programs operated by IHS, an IT, TO or a UIO as the payer of last resort for services provided to eligible American Indians and Alaska Natives, including services covered by Medicaid and CHIP. It would add IHS, ITs, TOs and UIOs to the list of agencies that could serve as "Express Lane"

[23] For a comparison of Private Health Insurance Provisions, see CRS Report R40981, *A Comparative Analysis of Private Health Insurance Provisions of H.R. 3962 and Senate-Passed H.R. 3590*, coordinated by (name redacted).

agencies. In addition, the bill would prohibit cost-sharing for American Indians and Alaska Natives enrolled in a qualified health plan offered through the exchange.[24]

Establishment of Center for Medicare and Medicaid Innovation within CMS (§3021, §10306)

There is no requirement under current law for a Medicare and Medicaid Innovation Center within CMS. The SSA gives the Secretary broad authority to develop research and demonstration projects to test new approaches to paying providers, delivering health care services, or providing benefits to Medicare and Medicaid beneficiaries. This provision of the bill would require the Secretary to establish by January 1, 2011, a Medicare and Medicaid Innovation Center within CMS. The Innovation Center would test innovative payment and service delivery models to reduce Medicare, Medicaid, and CHIP program expenditures, while preserving or enhancing the quality of care furnished to beneficiaries.

The Secretary would be required to identify and select payment and service delivery models that also improve the coordination, quality, and efficiency of health care services. In addition, the Secretary would be required to select models that address a defined population for which there are deficits in care leading to poor clinical outcomes, and may include models which allow states to test and evaluate fully integrating care for beneficiaries eligible for both Medicare and Medicaid (dual eligibles), including the management and oversight of all funds, as well as to test and evaluate all-payer payment systems that would include dual eligibles. The Secretary would have authority to limit testing of models to certain geographic areas.

Further, the Secretary would be required to conduct an evaluation of each model tested, and make the results of these evaluations publicly available. The bill would authorize an appropriation of $5 million for the design, implementation, and evaluation of models for FY2010; $10 billion for FY2011 through FY2019; and $10 billion for each subsequent 10 fiscal year period beginning with 2020. Beginning in 2012, and at least every other year thereafter, the Secretary would be required to submit to Congress a report on the Medicare and Medicaid Innovation Center.

GAO Study and Report on Causes of Action (§3512)

There are no requirements in current law for the Comptroller General and the Government Accountability Office (GAO) to conduct a study and issue a report on causes of action. Under this provision, GAO would be required to conduct a study to determine if the development, recognition, or implementation of guidelines or other standards under selected provisions in the bill would result in new causes of action or claims. The GAO study would include three Medicaid-related and 11 other non-Medicaid related provisions in the bill as shown in **Table 2**.

[24] For a comparison of Indian Health Care Improvement Provisions, see CRS memorandum for general distribution, Side-by-Side Comparisons of H.R. 3962, Division D, as passed by the House with Similar Provisions in S. 1679, as Passed by the Senate, available from (name redacted).

Table 2. Bill Sections to be Included in GAO Study on Causes of Action.

Section Number	Section Title
Medicaid Related Provisions	
Sec. 2701	Adult Health Quality Measures
Sec. 2702	Payment Adjustments for Health Care Acquired Conditions
Sec. 3021	Establishment of Center for Medicare and Medicaid Innovation
Non-Medicaid Provisions	
Sec. 3001	Hospital Value-Based Purchase Program
Sec. 3002	Improvements to the Physician Quality Reporting Initiative (PQRI)
Sec. 3003	Improvements to the Physician Feedback Program
Sec. 3007	Value-based Payment Modifier Under Physician Fee Schedule
Sec. 3008	Payment Adjustment for Conditions Acquired In Hospitals
Sec. 3013	Quality Measure Development
Sec. 3014	Quality Measurement
Sec. 3025	Hospital Readmission Reduction Program
Sec. 3501	Health Care Delivery System Research, Quality Improvement
Sec. 4003	Task Force on Clinical and Preventive Services
Sec. 4301	Research to Optimize Delivery of Public Health Services

Source: Title X of Senate bill in the Nature of a Substitute to H.R. 3590.

GAO would be required to submit the study on causes of action to appropriate congressional committees within two years after enactment of the bill.

Public Awareness of Preventive and Obesity-Related Services (§4004(i))

There is no related provision in current law. The bill would require the Secretary to provide guidance and relevant information to states and health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children and adults. Each state would be required to design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services. The Secretary would be required to report to Congress on these efforts, beginning no later than January 1, 2011, and every three years thereafter, through January 1, 2017. The provision would authorize to be appropriated such sums as necessary to carry out these activities.

Section 1115 Waiver Transparency (§10201)

Section 1115 of the Social Security Act authorizes the Secretary to waive certain statutory requirements for conducting research and demonstration projects that further the goals of Titles XIX (Medicaid) and XXI (CHIP). States submit proposals outlining the terms and conditions of

the demonstration program to the Centers for Medicare & Medicaid Services (CMS) for approval prior to implementation. In 1994, CMS issued program guidance that impacts the waiver approval process and includes the procedures states are expected to follow for public involvement in the development of a demonstration project. States were required to provide CMS a written description of their process for public involvement at the time their proposal was submitted.

Public involvement requirements for the waiver approval process continued through the early 2000s. In a letter to state Medicaid directors issued May 3, 2002, CMS listed examples of ways a state may meet requirements for public involvement (e.g., public forums, legislative hearings, a website with information and a link for public comment).

The bill would impose statutory requirements regarding transparency in the application and renewal of Medicaid and CHIP Section 1115 demonstration programs that impact eligibility, enrollment, benefits, cost-sharing, or financing. Not later than 180 days after the date of enactment of this subsection, the Secretary would be required to promulgate regulations that provide for (1) a process for public notice and comment at the state level, including public hearings, sufficient to ensure a meaningful level of public input; (2) requirements relating to (a) the goals of the program to be implemented or renewed under the demonstration project; (b) the expected state and federal costs and coverage projections of the demonstration project; and (c) the specific plans of the state to ensure that the demonstration project will be in compliance with title XIX or XXI; (3) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input; (4) a process for the submission to the Secretary of periodic reports by the state concerning the implementation of the demonstration project; and (5) a process for the periodic evaluation by the Secretary of the demonstration project. The Secretary would be required to generate annual report to Congress concerning actions taken by the Secretary with respect to applications for demonstration projects under this section.

Appendix A. Effective Dates for Referenced Medicaid and CHIP Provisions in the bill

Section	Amended or Added by Title X	Provision Title	Effective Date
Eligibility Provisions			
Sec. 1413.		Streamlining of procedures for enrollment through an exchange and State Medicaid, CHIP, and health subsidy programs.	January 1, 2014
Sec. 2001.	Sec. 10201.	Medicaid coverage for the lowest income populations.	January 1, 2014, or earlier at state option
Sec. 2001.	Sec. 10201.	New reporting requirements.	January 1, 2015
Sec. 2002.	Sec. 10201.	Income eligibility for nonelderly determined using modified gross income.	January 1, 2014, or earlier at state option
Sec. 2003.	Sec. 10203(b).	Requirement to offer premium assistance for employer-sponsored insurance.	Effective as if included in P.L. 111-3 (CHIPRA)
Sec. 2004.	Sec. 10201.	Medicaid coverage for former foster care children.	January 1, 2014
Sec. 2201.		Enrollment simplification and coordination with State Health Insurance Exchanges.	January 1, 2014
Sec. 2202.		Permitting hospitals to make presumptive eligibility determinations for all Medicaid eligible populations.	January 1, 2014
Sec. 2303.		State eligibility option for family planning services.	Upon enactment
Sec. 2404.		Protection for recipients of home and community-based services against spousal impoverishment.	January 1, 2014
Sec. 2901.		Special rules relating to Indians.	Upon enactment
Sec. 9021.		Exclusion of health benefits provided by Indian tribal governments.	Upon enactment
Benefit Provisions			
Sec. 2001(c).		Modifications to DRA benchmark and benchmark-equivalent coverage	January 1, 2014
Sec. 2301.		Coverage for freestanding birth center services.	Upon enactment
Sec. 2302.		Concurrent care for children.	Upon enactment
Sec. 2304.		Clarification of definition of medical assistance.	Upon enactment
Sec. 2401.		Community First Choice Option.	October 1, 2010
Sec. 2402.		Removal of barriers to providing home and community-based services.	The first day of the first fiscal year quarter that begins after enactment
Sec. 2703.		State option to provide health homes for enrollees with chronic conditions.	January 1, 2011
Sec. 4106.		Improving access to preventive services for eligible adults in Medicaid.	January 1, 2013

Section	Amended or Added by Title X	Provision Title	Effective Date
Sec. 4107.		Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid.	October 1, 2010
Financing Provisions			
Sec. 2005.	Sec. 10201	Payments to territories.	January 1, 2011
Sec. 2006.		Special adjustment to FMAP determination for certain states recovering from a major disaster.	January 1, 2011
Sec. 2101.	Sec. 10203(c)	Additional federal financial participation for CHIP and distribution of CHIP allotments among states.	Fully financed by the federal government from January 1, 2014-December 31, 2016. Newly eligibles fully financed from January 1, 2017-December 31, 2018
Sec. 2102.		Technical corrections to CHIP statute.	Effective as if included in P.L. 111-3 (CHIPRA) and P.L. 111-5 (ARRA)
Sec. 2501.		Prescription drug rebates.	January 1, 2010
Sec. 2502.		Elimination of exclusion of coverage of certain drugs.	January 1, 2014
Sec. 2503.		Providing adequate pharmacy reimbursement.	The first day of the first calendar year quarter beginning at least six months after enactment, regardless of whether final regulations were issued
Sec. 2551.	Sec. 10201(e)	Disproportionate share hospital payments.	Starting after FY2012 or later (depending on state spending patterns)
Sec. 2702.	Sec. 10303.	Payment adjustment for health care-acquired conditions.	July 1, 2011
Sec. 7101.		Expanded participation in 340B program.	January 1, 2010
Sec. 7102.		Improvements to 340B program integrity.	January 1, 2010
Sec. 7103.		GAO study to make recommendations on improving the 340b program.	Within 18 months of the date of enactment
Sec. 10202.		Incentives for states to offer home and community-based services as a long term care alternative to nursing homes.	October 1, 2011
Sec. 10203.		Extension of CHIP funding through FY2015 and other related provisions.	Selected provisions would be effective as if included in P.L. 111-3; others would be effective upon enactment
Sec. 10203 (a), (b), (d).		CHIP annual allotments.	Effective as if included in P.L. 111-3 (CHIPRA)

Section	Amended or Added by Title X	Provision Title	Effective Date
Program Integrity Provisions			
Sec. 6101-6107, 6111-6114, and 6121.		Nursing home transparency.	Various effective dates
Sec. 6401.	Sec. 10603.	Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP.	Within 180 days of the date of enactment
Sec. 6402.		Enhanced Medicare and Medicaid program integrity provisions.	January 1, 2011
Sec. 6411.		Expansion of the Recovery Audit Contractor (RAC) program.	December 31, 2010
Sec. 6501.		Termination of provider participation under Medicaid if terminated under Medicare or other state plan.	January 1, 2011
Sec. 6502.		Medicaid exclusion from participation relating to certain ownership, control, and management affiliations.	January 1, 2011
Sec. 6503.		Billing agents, clearinghouses, or other alternate payees required to register under Medicaid.	January 1, 2011
Sec. 6504.		Requirement to report expanded set of data elements under MMIS to detect fraud and abuse.	MMCOs to submit Encounter data - January 1, 2010. State reporting requirements - January 1, 2011
Sec. 6505.		Prohibition on payments to institutions or entities located outside of the United States.	January 1, 2011
Sec. 6506.		Overpayments.	Upon enactment
Sec. 6507.		Mandatory state use of national correct coding initiative.	By September 1, 2010, identify portions of NCCI to use; Effective for claims filed on or after October 1, 2010; Report to Congress by March 1, 2011
Demonstration and Grant Funding Provisions			
Sec. 2403.		Money follows the person rebalancing demonstration.	30 days after enactment
Sec. 2704.		Demonstration project to evaluate integrated care around a hospitalization.	January 1, 2012
Sec. 2705.		Medicaid global payment system demonstration project.	FY2010
Sec. 2706.		Pediatric accountable care organization demonstration Project.	January 1, 2012
Sec. 2707.		Medicaid emergency psychiatric demonstration project.	FY2011
Sec. 4101.		School-based health centers.	Upon enactment

Section	Amended or Added by Title X	Provision Title	Effective Date
Sec. 4108.		Incentives for prevention of chronic diseases in Medicaid.	January 1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever is earlier
Sec. 4306.		Funding for childhood obesity demonstration project.	Upon enactment
Miscellaneous Provisions			
Sec. 2007.		Medicaid Improvement Fund rescission.	Upon enactment
Sec. 2405.		Funding to expand State Aging and Disability Resource Centers.	Upon enactment
Sec. 2406.		Sense of the Senate regarding long-term care.	Upon enactment
Sec. 2601.		Five-year period for demonstration projects.	Upon enactment
Sec. 2602.		Providing federal coverage and payment coordination for dual eligible beneficiaries.	March 1, 2010
Sec. 2701.		Adult health quality measures.	January 1, 2012
Sec. 2801.	Sec. 399V-4.	MACPAC assessment of policies affecting all Medicaid beneficiaries.	Upon enactment
Sec. 3021.	Sec. 10306.	Center for Medicare and Medicaid Innovation within CMS.	January 1, 2011
	Sec. 3512.	GAO study and report causes of action.	Within two years of date of enactment
Sec. 4004(i).		Public awareness of preventative and obesity related services.	Secretary shall provide guidance to states upon enactment; Secretary shall report to Congress no later than January 1, 2011
	Sec. 10201.	Section 1115 waiver transparency.	Not later than 180 days after the date of enactment

Appendix B. Glossary of Terms

ACIP—Advisory Committee on Immunization Practices

ACO—Accountable Care Organization

ADHC—Adult Day Health Care

ADL—Activity of Daily Living

ADRC—Aging and Disability Resource Center

AFDC—Aid to Families with Dependent Children

AMP—Average Manufacture Price

ARRA—American Recovery and Reinvestment Act of 2009

ASP—Average Sales Price

BBA—Balanced Budget Act of 1997

BIA—Bureau of Indian Affairs

BMI—Body Mass Index

CBO—Congressional Budget Office

CCI—Correct Coding Initiative

CDC—Centers for Disease Control and Prevention

CFR—Code of Federal Regulations

CG—Comptroller General of the United States

CHCO—Coordinated Health Care Office

CHIP—Children's Health Insurance Program

CHIRPA—Children's Health Insurance Program Reauthorization Act of 2009

CLASS—Community Living Assistance Services and Supports

CMI—Center for Medicare and Medicaid Innovation

CMP—Civil Monetary Penalties

CMS—Center for Medicare and Medicaid Services

CoPs—Conditions of Participation

CPI—Consumer Price Index

CPI-U—Consumer Price Index for Urban Consumers

CPS—Current Population Survey

CRIPA—Civil Rights of Institutionalized Persons Act

DME—Durable Medical Equipment

DOD—Department of Defense

DOJ—Department of Justice

DRA—Deficit Reduction Act of 2005

DSH—Disproportionate Share Hospitals

E & M—Evaluation and Management

E-FMAP—Enhanced FMAP

EPHI—Protected Health Information in Electronic Form

EPSDT—Early and Periodic Screening, Diagnostic and Treatment

ESI—Employer Sponsored Insurance

FCA—False Claims Act

FDA—Food and Drug Administration

FEHBP—Federal Employees Health Benefits Program

FERA—Fraud Enforcement and Recovery Act of 2009

FFP—Federal Financial Participation

FFS—Fee for Service

FMAP—Federal Medical Assistance Percentage

FPL—Federal Poverty Level

FQHC—Federally-Qualified Health Centers

FUL—Federal Upper Payment Limit

GAO—Government Accountability Office

GME—Graduate Medical Education

GSA—Government Services Administration

HAC—Hospital Acquired Condition

HCBS—Home- and Community-Based Services

HCFAC—Health Care Fraud and Abuse Control

HH—Home Health

HHS—Department of Health and Human Services

HIPDB—Healthcare Integrity and Protection Databank

HIPPA—Health Insurance Portability and Accountability Act of 1996

HMO—Health Maintenance Organization

HRSA—Health Resources and Services Administration

IADL—Instrumental Activity of Daily Living

ICF/MR—Intermediate Care Facility for the Mentally Retarded

IDR—Integrated Data Repository

IHS—Indian Health Services

IMD—Institutions for Mental Disease

IT—Indian Tribe

LEI—List of Excluded Individuals

LEIE—List of Excluded Individuals/Entities

LIS—Low-Income Subsidy

LTC—Long-Term Care

MA—Medicare Advantage

MACPAC—Medicaid and CHIP Payment and Access Commission

MedPAC—Medicare Payment Advisory Commission

MCO—Managed Care Organization

MFP—Money Follows the Person

MGI—Modified Gross Income

MIP—Medicaid Integrity Program

MIPPA—Medicare Improvements for Patients and Providers Act of 2008

MMA—Medicare Prescription Drug, Improvement, and Modernization Act of 2003

MMCO—Medicaid Managed Care Organization

MMIS—Medicaid Management Information System

MMSEA—Medicare, Medicaid, and SCHIP Extension Act of 2007

MOE—Medicaid Eligibility Maintenance of Effort

MOU—Memorandum of Understanding

MSIS—Medicaid Statistical Information System

MSP—Medicare Savings Program

NDC—National Drug Code

NPDB—National Practitioner Databank

NPI—National Provider Identifier

O/PDECP—Office or Program of Dual Eligible Coordination and Protection

OAA—Older Americans Act

OACT—Office of the Chief Actuary

OIG—Office of Inspector General

OMB—Office of Management and Budget

OTC—Over-the-Counter

PACE—Programs of All-inclusive Care for the Elderly

PAQI—Physician Assistance and Quality Initiative

PDP—Prescription Drug Plan

PECOS—Provider Enrollment, Chain and Ownership System

PHI—Protected Health Information

PRWORA—Personal Responsibility and Work Opportunity Reconciliation Act of 1996

QI—Qualifying Individual

QIO—Medicare Quality Improvement Organizations

QMBs—Qualified Medicare Beneficiaries

RAC—Recovery Audit Contractor

RHC—Rural Health Clinic

SBHC—School-Based Health Clinic

SLMB—Specified Low-Income Medicare Beneficiaries

SNF—Skilled Nursing Facilities

SPA—State Plan Amendment

SSA—Social Security Act

SSI—Supplemental Security Income

STC—Special Terms and Conditions

TANF—Temporary Assistance to Needy Families

TFC—Therapeutic Foster Care

TMA—Transitional Medical Assistance

TO—Tribal Organization

TRHCA—Tax Relief and Health Care Act

USC—United States Code

USPSTF—United States Preventive Services Task Force

VA—Department of Veterans Affairs

VFC—Vaccines for Children

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