Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA

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Summary

The President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148) on March 23, 2010. Seven days later, a second bill, H.R. 4872, was signed into law by the President to modify P.L. 111-148. This second law, the Health Care and Education Reconciliation Act of 2010 (hereinafter referred to as the Reconciliation Act or HCERA; P.L. 111-152), was signed on March 30, 2010. Together these laws constitute what we now refer to as health reform law. Health reform law makes many significant changes to the private and public markets for health insurance, as well as modifies aspects of the publicly financed health care delivery system. It represents the most significant reform in health care financing since the establishment of Medicaid and Medicare in 1965. This report provides a summary of the Medicaid and CHIP provisions in health reform laws P.L. 111-148 and P.L. 111-152.

Regarding Medicaid eligibility, beginning in 2014, or sooner at state option, nonelderly, non-pregnant individuals with income below 133% of the federal poverty level (FPL) who were previously ineligible for Medicaid will be newly eligible for Medicaid. This change represents a significant expansion of eligibility under Medicaid. From 2014 to 2016, the federal government will cover 100% of the Medicaid costs of newly eligible individuals. In 2017, the federal share will be 95%, in 2018 it will be 94%, in 2019 it will be 93%, and in 2020 and beyond, the federal share for this population will be 90%.

The health reform law also adds new mandatory benefits to Medicaid, including, for example, coverage of services in free-standing birthing centers. Further, it expands state options for providing home and community-based services as an alternative to institutional care, and provides financial incentives to states to do so. Among the financing changes, the law reduces Medicaid disproportionate share hospital (DSH) payments. It also increases prescription drug rebates, certain pharmacy reimbursements, primary care physician payment rates for selected preventive care services, and federal spending for the territories, among other payment system reforms.

This report provides a summary of the Medicaid and CHIP provisions in P.L. 111-148 and P.L. 111-152. To help highlight the most important Medicaid and CHIP changes, applicable provisions are grouped into the following seven major issue areas: eligibility, benefits, financing, program integrity, demonstrations and grant funding, CHIP, and miscellaneous. The **Appendix** provides a cross walk between the provision titles and the amending sections of P.L. 111-148 and P.L. 111-152.

Another appendix will be added to the report, in an update, to include the effective dates of each provision. A forthcoming CRS report will include a more detailed timeline based on effective dates for all of the Medicaid and CHIP provisions.

Contents

Tables

Appendixes

Contacts

Introduction

The President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148) on March 23, 2010.[1] Seven days later, a second bill, H.R. 4872, was signed into law by the President to modify P.L. 111-148. This second law, entitled the Health Care and Education Reconciliation Act of 2010 (hereinafter referred to as the Reconciliation Act or HCERA; P.L. 111-152),[2] was signed on March 30, 2010.[3] Together these laws constitute what we now refer to as health reform law. Health reform law makes many significant changes to the private and public markets for health insurance, as well as modifies aspects of the publicly financed health care delivery system. It represents the most significant reform in health care financing since the establishment of Medicaid and Medicare in 1965.

In general, PPACA and HCERA expand health insurance coverage to many Americans who currently are uninsured, while attempting to reduce expenditures. They also offer mechanisms to increase care coordination, encourage more use of health prevention, and improve quality of care. More specifically, PPACA and HCERA (1) reform the private health insurance market, (2) impose a mandate for most legal U.S. residents to obtain health insurance,[4] (3) establish the American Health Benefits Exchanges (hereinafter referred to as exchanges) for individuals to shop for insurance coverage; (4) expand Medicaid eligibility; (5) create programs to improve quality of care and encourage more use of preventive services; (6) address healthcare workforce issues;[5] and (6) make a number of other Medicaid and Medicare program and federal tax code changes.

This report provides a summary of the Medicaid and CHIP provisions in P.L. 111-148 and P.L. 111-152. To help highlight the most important Medicaid and CHIP changes, applicable provisions are grouped into the following seven major issue areas: eligibility, benefits, financing, program integrity, demonstrations and grant funding, CHIP, and miscellaneous. The **Appendix** provides a cross walk between the provision titles and the amending sections of P.L. 111-148 and P.L. 111-152.

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[1] Passed by the Senate on December 24, 2009, and the House on March 21, 2010.

[2] The Reconciliation Act includes two titles: (1) Coverage, Medicare, Medicaid, and Revenues, and (2) Education and Health. Title I contains provisions related to health care and revenues including modifications made by the Reconciliation Act to P.L. 111-148. Title II includes amendments to the Higher Education Act of 1965, which authorizes most of the federal programs involving postsecondary education, and other health amendments.

[3] Passed by the House as an amendment in the nature of a substitute to H.R. 4872 on March, 21, 2010, and passed with amendments by the Senate on March 25, 2010. The House subsequently agreed to the Senate amendments and cleared the bill for the White House later that same day.

[4] For more information about the treatment of noncitizens and the verification of individual's eligibility for premium credits under the various health reform bills see CRS Report R40889, *Noncitizen Eligibility and Verification Issues in the Health Care Reform Legislation*, by Ruth Ellen Wasem.

[5] CRS Report R40943, *Public Health, Workforce, Quality, and Related Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)*, coordinated by C. Stephen Redhead and Erin D. Williams.

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

Congressional Budget Office and Joint Committee on Taxation Analysis

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) issued a revised cost estimate on March 20, 2010, for PPACA and HCERA. CBO estimated that PPACA and the HCERA will reduce federal budget deficits by $143 billion over the FY2010-FY2019 period as a result of changes in direct spending and revenue. CBO's $143 billion estimate is composed of $124 billion in reductions and revenue from health care provisions and $19 billion in spending reductions from education.[6] CBO's preliminary estimate of PPACA and the HCERA showed reductions in federal deficits of $138 billion (for health care and education) over the 2010-2019 period.[7] CBO and JCT previously estimated that PPACA by itself would reduce federal deficits by $118 billion over the 2010-2019 period.[8]

Overview of the Medicaid and CHIP Provisions in Health Reform Law

Key Medicaid and CHIP provisions included in health reform law are summarized below.

- *Eligibility-related reforms.* Beginning in 2014, or sooner at state option, the law requires states to expand Medicaid to certain individuals who are under age 65 with income up to 133% of the federal poverty level (FPL). This reform not only expands eligibility to a group that is not currently eligible for Medicaid (low income childless adults), but also raises Medicaid's mandatory income eligibility level for certain existing groups to 133% of the FPL and represents the most significant expansion of Medicaid eligibility in many years. The law also modifies income counting rules when determining Medicaid eligibility for certain populations.[9] From 2014 to 2016, the federal government will cover 100% of the Medicaid costs of these newly eligible individuals, with the percentage dropping to 90% (with states covering the difference) by 2020.
- *Maintenance of effort provisions.* The law requires states to maintain current Medicaid and CHIP eligibility levels—through 2013 for adults and 2019 for children.

[6] Congressional Budget Office, letter to Honorable Nancy Pelosi, March 20, 2010, available at http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager'sAmendmenttoReconciliationProposal.pdf.

[7] Congressional Budget Office, letter to the Honorable Nancy Pelosi, March 18, 2010, available at http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf.

[8] Congressional Budget Office, letter to the Honorable Harry Reid, March 11, 2010, available at http://www.cbo.gov/ftpdocs/113xx/doc11307/Reid_Letter_HR3590.pdf.

[9] For individuals whose income will be determined using the new income counting rules, the law also specifies that an income disregard in the amount of 5% FPL be deducted from an individual's income when determining Medicaid eligibility. This income counting rule effectively raises the upper income eligibility threshold for the new Medicaid eligibility group to 138% FPL.

- *Outreach and enrollment provisions.* The law includes provisions to encourage states to improve outreach, streamline enrollment, and coordinate with the proposed American Health Benefit Exchanges (exchanges).[10]
- *Benefit reforms.* The law adds new mandatory and optional benefits to Medicaid. Such mandatory benefits include coverage of free-standing birth clinics, and tobacco cessation services for pregnant woman. The law also authorizes states to offer new optional benefits such as preventive services for adults, health homes for persons with chronic conditions, and additional options for states to expand home and community-based services as an alternative to institutional care.
- *Payment and financing reforms.* Some of the law's reforms affecting payments and financing include (1) increases in federal matching payments for the eligibility expansions, (2) reductions in Medicaid disproportionate share hospital (DSH) allotments, (3) expenditure reductions for prescription drugs including revising the definition of the average manufacture's price (AMP) to help make AMP more closely reflect prices retail community pharmacies pay for prescription drugs, (4) reductions in inappropriate hospital expenditures for health care-acquired conditions, and (5) increases in primary care physician payment rates for selected services.
- *Increased funding for the Territories.* The law provides an increase on the territories' Medicaid spending caps beginning with the second quarter of FY2011.
- *Program integrity reforms.* The law creates enforcement and monitoring tools and imposes new data reporting and oversight requirements on states and providers. States will also be required to implement initiatives used by the Medicare program, such as a national correct coding initiative and a recovery audit contract program for their Medicaid programs. The law provides additional program integrity funding through indexing of the Medicaid Integrity Program for fiscal years beginning with FY2010.
- *Nursing home accountability.* The law adds a number of requirements to improve the transparency of information within facilities and chains, and provides long-term care (LTC) consumers with information on the quality and performance of nursing homes.
- *Demonstrations, pilot programs, and grants.* The law provides 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 of services.
- *CHIP-related provisions.* The law requires states to maintain the current CHIP structure through FY2019, but does not provide federal CHIP appropriations beyond FY2015, at which point, if future appropriations are insufficient, CHIP children will obtain comparable coverage through the exchanges or Medicaid, as applicable. If new funding is made available, states will receive higher federal matching rates for CHIP services beginning in FY2016. Upon enactment, states

[10] For a description of the exchanges, see CRS Report R40942, *Private Health Insurance Provisions in PPACA (P.L. 111-148)* , by Hinda Chaikind et al.

are required to maintain CHIP eligibility levels through FY2019 as a condition of receiving federal matching funds for Medicaid expenditures (notwithstanding the lack of corresponding federal CHIP appropriations for FY2016 through FY2019).

- *Miscellaneous Medicaid and CHIP reforms*. The law adds several offices within the Centers for Medicare and Medicaid Services (CMS) to better coordinate care across the Medicare and Medicaid/CHIP programs. One of these offices will be dedicated to improving coordination for beneficiaries eligible for both Medicare and Medicaid (dual eligibles). Another will add a Medicare and Medicaid Innovation Center to develop and test new payment and service delivery models to reduce Medicare, Medicaid, and CHIP expenditures, while preserving and enhancing quality of care for beneficiaries.

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.

Of the approximately 50 different eligibility "pathways" into Medicaid, including those that existed even before health reform law was enacted, some are mandatory while others may be offered at state option. Examples of groups that states must provide Medicaid to include pregnant women, and poor individuals with disabilities or poor individuals over age 64 who qualify for cash assistance under the Supplemental Security Income (SSI) program. 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.[11] Under prior law, "childless adults" (nonelderly adults who are not disabled, not pregnant and not parents of dependent children), for example, were generally *not* eligible for Medicaid, regardless of their income.

The health reform law makes several changes to Medicaid eligibility. PPACA adds two new mandatory eligibility groups, and several new optional eligibility groups. In addition, it makes several modifications to existing eligibility groups, changes the way income is counted for certain groups to determine if an individual meets Medicaid's income eligibility requirements, and adds provisions to facilitate outreach and enrollment in Medicaid, CHIP, and the Health Insurance exchanges.[12]

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

[12] Similar to existing state health reform models, such as the Massachusetts Connector, the Exchange will facilitate the purchase of qualified health benefit plans by individuals and businesses. The Exchange will not be a health insurer; but will provide eligible individuals and small businesses a vehicle to shop and compare insurers' health plans.

Medicaid and Health Insurance Reform

Medicaid Coverage for the Lowest-Income Populations

(P.L. 111-148: §2001 as modified by §10201; P.L. 111-152: §1004 and §1201)

Health reform law creates a new mandatory Medicaid eligibility category for all non-elderly, non-pregnant individuals (e.g., childless adults, certain parents, certain people with disabilities) 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 (hereinafter referred to as "newly eligible" individuals), the provision establishes 133% of FPL based on modified adjusted gross income (or MAGI as described below) as the new mandatory minimum Medicaid income eligibility level. For "newly eligible" individuals, Section 1004(e) of the HCERA requires states to apply an income disregard equal to the dollar amount equivalent (expressed as a percentage of the federal poverty line) of the difference between 133% FPL and an increase in such threshold by 5 percentage points. This provision makes the effective upper income eligibility threshold for "newly eligible" populations equal to 138% FPL.

Some individuals with disabilities who are not currently eligible for a state's Medicaid program—either because they do not meet the Supplemental Security Income program's (SSI's) definition of disability (used to determine disability for a number of Medicaid's eligibility groups) or they have income or asset levels that exceed their state's threshold—may now qualify for Medicaid under health reform law. Eligibility for Medicaid under this pathway will entitle them to Medicaid's comprehensive benefit package. Some individuals with disabilities who are currently enrolled in Medicaid may transfer to this eligibility pathway if it is determined to be more desirable, especially since no asset test applies (see the discussion following on MAGI).

As a conforming measure, the provision also changes the mandatory Medicaid income eligibility level for poverty-related children ages 6 to 19 from 100% FPL to 133% FPL (as applied under prior law to children under age 6). As in the case of the "newly eligible" populations, MAGI income counting rules and the 5% income disregard will apply. Thus, in 2014, most non-elderly citizens up to 138% FPL (i.e., 133% FPL with the 5% FPL income disregard) will be eligible for Medicaid.

During the transitional period between April 1, 2010 and January 1, 2014, states will 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 children 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 will be available for covering such individuals. (Beginning in 2014, states are *required* to extend Medicaid to the "newly eligible" group, and additional federal financial assistance will 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.)

PPACA also allows states to make a "presumptive eligibility" determination (subject to guidance that will be established by the Secretary) for "newly eligible" individuals or for individuals eligible for family coverage under Section 1931 of the Social Security Act (SSA),[13] if the state

[13] Section 1931 of the Social Security Act, added in 1996, allows states to cover low income parents with incomes (continued...)

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 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 prior law, such presumptive eligibility determinations could only be made for children, pregnant women, and certain women with breast or cervical cancer.

Financial Eligibility Requirements for "Newly Eligible" and Other Non-elderly Populations Determined Using Modified Adjusted Gross Income (MAGI)

(P.L. 111-148: §2001 as modified by §10201; P.L. 111-152: §1004)

Generally, Medicaid's financial eligibility requirements place limits on the maximum amount of income, and also sometimes, assets that individuals may possess to participate. Additional guidelines specify how states should calculate these amounts. The specific income and asset 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.

Under PPACA, asset tests and certain income disregards (e.g., type of expenses such as child care costs or block of income disregards where a specified portion of family income is not counted) will no longer be used to asses the financial eligibility of (1) "newly eligible" individuals, (2) other non-elderly populations eligible under prior law (subject to certain exceptions as specified below in the subsection titled "Financial Eligibility Requirements for Certain Populations Eligible Under Prior Law"), and (3) certain CHIP-eligible individuals. The new income test for these individuals will be based on MAGI, or in the case of an individual in a family greater than one, the household income of such family.[14]

MAGI is defined as the Internal Revenue Code's (IRC's) *Adjusted Gross Income (AGI),* which reflects a number of deductions, including trade and business deductions, losses from sale of property, and alimony payments, increased by tax-exempt interest and income earned by U.S. citizens or residents living abroad. Although PPACA prohibits any continued use of income disregards under Medicaid once the new income definitions are in place, the Reconciliation Act (Section 1004(e)) requires states determining individuals' Medicaid eligibility under MAGI to reduce their countable income by a certain amount. That amount will be 5% of the upper income limit for that Medicaid eligibility pathway. MAGI and household income will also be used to determine applicable premium and cost sharing amounts under the state plan or waiver.

(...continued)

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.

[14] MAGI and household income will 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 PPACA. For more information on MAGI and household income see CRS Report R40942, *Private Health Insurance Provisions in PPACA (P.L. 111-148)* , by Hinda Chaikind et al.

Financial Eligibility Requirements for Certain Populations Eligible Under Prior Law

(P.L. 111-148: §2001 and §2002 as modified by §10201)

Under health reform law, certain groups are exempted from income eligibility determinations based on MAGI. Prior law's income counting rules under Medicaid will continue to be used for determining eligibility for certain groups, including (1) individuals who 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 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, and/or coinsurance and deductibles). In addition, MAGI does 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.[15]

Any individual enrolled in Medicaid (under the state plan or a waiver) on January 1, 2014, who is determined ineligible for medical assistance solely because of the application of the new MAGI or household income counting rule will 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. At that point such persons could purchase insurance, with the help of subsidies, through state exchanges.

Finally, state use of MAGI and household income to determine income eligibility for Medicaid (and for any other purposes applicable under the state plan) will 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.

In general, these provisions take effect on January 1, 2014. For a state that chooses to transition to MAGI earlier, these provisions take effect upon the enactment of an individual state's law.

Medicaid Benefit Coverage for The New Mandatory Eligibility Group

(P.L. 111-148: §2001 as modified by §10201)

Medicaid's standard benefits are identified in federal statute and regulations and include a wide range of medical 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

[15] Long term care services include institutional services, such as nursing facility care and home or community-based services, such as home care, personal care, transportation, and care management, furnished under the state plan or a waiver.

enroll certain state-specified groups in benchmark and benchmark-equivalent benefit plans, as permitted under Section 1937 of the SSA.[16]

Under the new law, "newly eligible" individuals will receive either benchmark or benchmark-equivalent coverage, including Secretary-approved benchmark coverage, consistent with the requirements of Section 1937 of the SSA. Section 1937 excludes from benchmark or benchmark-equivalent coverage certain groups, including blind or disabled persons, hospice patients, etc. (Any newly eligible who fall into one of these groups would also be excluded from benchmark or benchmark-equivalent coverage.) Finally (as per the requirements of Section 1937), children covered under the "newly eligible" group must receive all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Maintenance of Medicaid Income Eligibility (MOE)

(P.L. 111-148: §2001 as modified by §10201)

Health reform law includes a Medicaid eligibility maintenance of effort (MOE) requirement in which states lose access to federal financial participation under Medicaid if their eligibility standards, methodologies, or procedures under the state's Medicaid plan (including any waivers) are more restrictive than the eligibility standards, methodologies, or procedures, under a plan (or waiver) in effect as of the date of enactment (i.e., March 23, 2010). For adult populations, the MOE requirements remain in effect from the date of enactment through the date the exchanges (established by the state under Section 1311 of PPACA) are fully operational, as determined by the Secretary. For any Medicaid eligible child who is under age 19 (or such higher age as the state may have elected), the MOE will continue through September 30, 2019.[17,18]

The requirement to use MAGI when determining Medicaid income eligibility (as described above) will not affect compliance with the MOE requirement. States will 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 will 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 will apply from the date the state submits the certification to the Secretary through December 31, 2013.

[16] For more information on benchmark and benchmark-equivalent coverage, including the recently enacted changes to this coverage, see the Benefits section of this report.

[17] Section 2101 P.L. 111-148 contains a CHIP MOE provision. 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*. Specifically, with the exception of waiting lists for enrolling children in CHIP or enrolling CHIP-eligible children in certified exchange plans, 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.

[18] For more information on the State Children's Health Insurance Program, see CRS Report R40444, *State Children's Health Insurance Program (CHIP): A Brief Overview*, by Elicia J. Herz, Chris L. Peterson, and Evelyne P. Baumrucker.

States are required to establish Medicaid income eligibility thresholds for state plan services (or waiver services) using MAGI levels that are not less than the effective income eligibility levels applicable as of the date of enactment. To meet the MOE requirements during the transition to MAGI and household income (described above), among other requirements, states are 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 will not lose coverage. The Secretary is permitted to waive provisions of Medicaid or CHIP to ensure that states establish income and eligibility determination systems that protect beneficiaries.

Health Care Power of Attorney

(P.L. 111-148: §2955)

Under the federal foster care program (SSA Title IV-E) a state is required to have in place a case review system for each child in foster care to, among other things, periodically review the child's status in foster care and to develop and carry out a permanency plan for the child. The case review system must ensure that a transition plan is developed for youth aging out of a state's foster care system. This usually occurs at age 18, but states can elect to cover foster care up to age 21. The plan must include specific options on housing, health insurance, education, local opportunities for mentors and continuing support services, and workforce supports and employment services. Under the Chafee Foster Care Independence Program (CFCIP; SSA §477), states receive funds to provide independent living services for youth who are expected to age out of foster care and for those who have already aged out of care. As part of their application for these funds, states must provide certain certifications regarding how the programs will be carried out. Finally, under the Stephanie Tubbs Jones Child Welfare Services Program (SSA Title IV-B, Subpart 1), states are required to develop a plan for the ongoing oversight and coordination of health care services for children in foster care. The state child welfare agency and the state agency that administers Medicaid must coordinate and collaborate in the development of this plan, and the plan must outline specific steps to ensure that children in foster care have their health care needs identified and appropriately met and that medical information for children in foster care is updated and appropriately shared.

Health reform law requires that the mandatory transition plan for a youth who is about to age out of foster care include information about the importance of designating another individual to make health care treatment decisions on behalf of the youth if he or she becomes unable to participate in these decisions and either does not have a relative who would be authorized to make these decisions under state law or does not want that relative to make those decisions. In addition, the transition plan must provide the youth with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under state law.

States are required, as part of their application for CFCIP funds, to certify that foster care (or former foster care) adolescents receiving independent living services also receive education about (1) the importance of designating an individual to make health care treatment decisions for them if appropriate, (2) whether a health care power of attorney, health care proxy, or other similar document is recognized under state law and (3) how to execute such a document if desired.

Finally, health reform law requires that the health care oversight plan developed collaboratively between the state child welfare agency and the state Medicaid agency outline steps to ensure that the health-care related components of the transition plan for youth aging out of foster care are met. These include options for health insurance, information about a health care power of

attorney, health care proxy, or other similar document recognized by state law, and the option to execute such a document. This provision is effective on October 1, 2010.

Medicaid Coverage for Former Foster Care Children

(P.L. 111-148: §2004 as modified by §10201)

Youth ages 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).

Health reform law adds 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. Health reform law also allows states to make "presumptive eligibility" determinations for these individuals. The provision also adds 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). Benchmark and benchmark equivalent plans[19] 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 is effective as of January 1, 2014.

Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment

(P.L. 111-148: §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. Under prior law, they were 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 previously

[19] For more information on benchmark and benchmark-equivalent coverage, including the recently enacted changes to this coverage, see the Benefits section of this report.

prohibited 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 medically needy. The medically needy group allows for the enrollment in Medicaid of certain persons with exceptionally high medical expenses.

The law makes three major changes to current Medicaid law. First, states are now 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 are now required to apply spousal impoverishment protections when determining eligibility for medically needy individuals applying for certain home and community-based services. These two changes will sunset after a five-year period beginning on January 1, 2014. Third, another provision in the law states to use the HCBS state plan benefit option (Section 1915 (i)) as an eligibility pathway for Medicaid for certain people with long-term care needs. Spousal impoverishment rules will now apply to this new eligibility pathway. See the description of these provisions entitled "Removal of Barriers to Providing Home and Community-Based Services".

Optional Eligibility Expansions

Non-elderly, Non-pregnant Individuals with Family Income Above 133% of the FPL

(P.L. 111-148: §2001 as modified by §10201)

Beginning on January 1, 2014 the law creates 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. States have the option of covering these individuals up to a maximum level specified in the Medicaid state plan (or waiver), and income eligibility for this new group will be determined based on MAGI.[20] States will be permitted to phase in Medicaid coverage to these new individuals based on their 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. States may rely on this state plan option to meet the MOE requirements, as described in the Maintenance of Medicaid Income Eligibility (MOE) provision above. The increased FMAP determined under the American Recovery and Reinvestment Act of 2009 is not available for this new optional eligibility group.

State Eligibility Option for Family Planning Services

(P.L. 111-148: §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

[20] For individuals whose income will be determined using MAGI, the law also specifies that an income disregard in the amount of 5% FPL be deducted from an individual's income when determining Medicaid eligibility.

Medicaid for populations who are not otherwise eligible for traditional Medicaid (e.g., non-pregnant, non-disabled childless adults) through special waivers.

Health reform law adds a new optional categorically needy eligibility group to Medicaid. This new group will 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 will be limited to family planning services and supplies and will also include related medical diagnosis and treatment services.

The new law also allows states to make a "presumptive eligibility" determination for individuals eligible for such services through the new optional eligibility group. In addition, states will not be allowed to provide Medicaid coverage through benchmark or benchmark-equivalent plans,[21] which are permissible alternatives to traditional Medicaid benefits, unless such coverage includes family planning services and supplies. This provision is effective upon enactment.

Removal of Barriers to Providing Home and Community-Based Services

(P.L. 111-148: §2402)

Under the Deficit Reduction Act of 2005 (P.L. 109-171, 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

Federal law imposes certain limitations on the characteristics of beneficiaries who may obtain these section 1915(i) services in a state. Some of these restrictions change under health reform law. Specifically, according to prior law, this state plan option could only be extended to those Medicaid beneficiaries whose income did not exceed 150% of poverty and who met a state's needs-based criteria. The needs-based criteria, defined by states, could be no 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 new law allows states to extend access to this benefit to persons with income up to 300% of the SSI benefit rate who are receiving HCBS services under a home and community-based waiver authorized under sections 1915 (c), (d) or (e) of the SSA, or under Section 1115 off SSA (Research and Demonstration waivers). Furthermore, the law established section 1915(i) as a new optional eligibility pathway into the program. Under the new law, states may also extend full Medicaid benefits, as well as this HCBS state plan benefit, to this new eligibility group.

Targeting

Under prior law, states could target the section 1915(i) benefit to a selected population by defining a single benefit package, either broadly or narrowly, specifying that needs-based criteria

[21] For more information on benchmark and benchmark-equivalent coverage, including the recently enacted changes to this coverage, see the Benefits section of this report.

for access to the benefit as expansive or narrow, and extending coverage to geographic areas that are either statewide or less than statewide. Prior law also allowed states to cap enrollment numbers and create waiting lists for those above the cap.

The new law changes the way states can target specific populations in their states under section 1915(i). First, prior law allowed states the ability to use this benefit option to offer only a single benefit package to a single target population. The new law allows states to offer different packages of services to different target groups of beneficiaries. States can now 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 will be for five-year periods (including an initial five-year period and five-year renewal periods). Enrollment and/or the provision of services can be phased-in, (as long as the phase-in is accomplished prior to the end of the initial five-year period).

Second, under the new law, states are no longer allowed to cap the number of persons eligible for this benefit.

Third, to help states contain enrollment, Medicaid law allows states to modify their needs-based criteria without having to obtain prior approval from the Secretary, if actual enrollment in 1915(i) exceeds states' projected enrollment, and certain other requirements are met. Under prior law, states that made their needs-based criteria more stringent were required to continue enrollment of those individuals who would become ineligible based on the new criteria for at least 12 months. Under the health reform law, such individuals will continue to be eligible until such time as the individuals no longer meets the state's former needs-based criteria.

Benefits

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

Outreach and Enrollment Facilitation

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

(P.L. 111-148: §1413)

Under health reform law, the Secretary is required to establish a system to ensure that individuals who apply for health insurance coverage through an exchange and are found to be eligible for Medicaid or CHIP are enrolled in Medicaid or CHIP. To do this, the Secretary is required to develop and distribute a standard application form for all state health subsidy programs.

States will 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 will be permitted to submit their forms online, by telephone, in person, or by mail to a state exchange, Medicaid, or CHIP program. However, states will be required to develop a secure,

electronic interface for eligibility for premium assistance for the purchase of health insurance through an exchange based on the standard application form. States will 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 will 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 is effective January 1, 2014.

Enrollment Simplification and Coordination with State Health Insurance Exchanges

(P.L. 111-148: §2201)

As a condition of the Medicaid state plan and receipt of any federal financial assistance after January 1, 2014, health reform law requires states to meet the following requirements:

(1) States will 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 exchanges, 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 exchanges 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 exchanges 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 exchanges 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 an 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 will be required to comply with the requirements for the system established under §1413 (relating to streamlined procedures for enrollment through exchanges, Medicaid and CHIP); and

(4) States are required to establish a website (not later than January 1, 2014) that links Medicaid to the state exchanges. 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 exchanges to compare benefits, premiums, and cost-sharing. In the case of a child, the website must allow individuals to compare benefits they will receive under Medicaid to the coverage available through exchange plans (including any supplemental Medicaid benefits that are required so the exchange coverage meets basic minimum standards established by the law). The law does 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

(P.L. 111-148: §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.

Health reform law allows 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 are subject to guidance established by the Secretary and will 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 are 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 will 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 is effective on January 1, 2014.

Standards and Best Practices to Improve Enrollment of Vulnerable and Underserved Populations

(P.L. 111-148: §2201)

The Children's Health Insurance Program Reauthorization Act (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 are directed to a national enrollment campaign, and 10% will be targeted to outreach for American Indian and Alaska Native children. The remaining 80% are 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 are also 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.

Health reform law requires 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 must be published no later than April 1, 2011. Not later than two years after enactment and annually thereafter, the Secretary is 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

(P.L. 111-148: §2001 as modified by §10201)

Health reform law requires 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 are also 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 is 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

(P.L. 111-148: §2001(c))

As an alternative to traditional benefits, the Deficit Reduction Act (DRA; P.L. 109-171) gave states the option to provide Medicaid to state-specified groups through enrollment in benchmark and benchmark-equivalent coverage similar to coverage available under the State Children's Health Insurance Program (CHIP). Benchmark coverage includes (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 coverage must include 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 option 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.

Health reform law modifies benchmark and benchmark-equivalent benefit packages available under Medicaid. Such packages will be required to provide at least essential benefits as of January 1, 2014. Essential health benefits will 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 will be added to the list of basic services that must be covered under the plan. Also, for benchmark-equivalent coverage, states will 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 will 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 these requirements apply to a group health plan. Coverage that provides EPSDT services will be deemed to meet the mental health services parity requirement.

Premium Assistance

(P.L. 111-148: §2003 as modified by §10203(b))

Health reform law also permits states to offer premium assistance with wrap-around benefits (i.e., Medicaid covered services not included in employer plans) to Medicaid child populations when it is cost-effective to do so. Premium assistance plans are determined cost effective if (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, or (2) the aggregate 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).[22] However, beneficiaries will not be required to apply for enrollment in employer plans, and individuals will be permitted to disenroll from such plans at any time. In addition, states will 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 are effective as if included in P.L. 111-3 (CHIPRA).

Birthing Centers

(P.L. 111-148: §2301)

Health reform law also requires Medicaid coverage of care provided in free-standing birthing centers. In addition, states will 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 is effective on the date of enactment (except if state legislation is required, in which case additional time for compliance is permitted).

Adult Preventive Care

(P.L. 111-148: §4106)

Currently, 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. Also under prior law, some preventive services may be available to Medicaid adults (persons age 21 and over) through an optional benefit covering "other diagnostic, screening, preventive and rehabilitative services." Under P.L. 111-148, the previously existing Medicaid option to provide "other diagnostic, screening, preventive, and rehabilitation services" will be explicitly 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. The effective date of this provision will be January 1, 2013.

For the purposes of this provision, non-pregnant adults under age 65 who qualify for Medicaid are classified as either (1) newly eligible individuals (i.e., those *ineligible* for Medicaid based on state eligibility criteria in place on December 1, 2009) or (2) formerly eligible individuals (i.e., those *eligible* for Medicaid based on state eligibility criteria in place on December 1, 2009).

Beginning January 1, 2013, the regular FMAP (which generally ranges between 50 to 76% in any given fiscal year, depending on the state) will be explicitly available for adult preventive services and immunizations. In addition, states will receive an increased FMAP for these services when certain conditions are met. For the "newly eligible individuals" that receive adult preventive services (including immunizations) for which cost-sharing is prohibited, states will receive a one percentage point increase in their FMAP, in addition to the increased FMAP applicable to services

[22] The cost effectiveness test for Medicaid state plan option for premium assistance for children was modified under P.L. 111-148: §10203(b).

provided to newly eligible mandatory individuals. Those increased FMAPs for adult preventive services for newly eligible individuals will be 101% for each of 2014 through 2016, 96% in 2017, 95% in 2018, 94% in 2019, and 91% in 2010 and beyond.

For most formerly eligible individuals that receive adult preventive services (including immunizations) for which cost-sharing is prohibited, states will receive the regular FMAP plus an additional one percentage point.

Smoking Cessation Services for Pregnant Women

(P.L. 111-148: §4107)

Pregnancy-related services are a mandatory benefit for the majority of Medicaid beneficiaries. Those services include prenatal, delivery, postpartum care, family planning services, as well as services to ameliorate conditions that complicate pregnancy (e.g., those that threaten the carrying the fetus to full-term or the safe delivery of the fetus). P.L. 111-148 adds counseling and pharmacotherapy to promote cessation of tobacco use by pregnant women as a mandatory benefit under Medicaid beginning on October 1, 2010. Such coverage includes prescription and non-prescription tobacco cessation agents approved by the Food and Drug Administration (FDA). Services will 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.[23] Cost-sharing for such counseling and pharmacotherapy for pregnant women will be prohibited, as is true for other pregnancy-related services under Medicaid. Beginning January 1, 2013, states will receive a one percentage point increase in their regular FMAP for these smoking cessation services for pregnant women if they elect to cover the new optional adult preventive care benefit (described above).

Scope of Coverage for Children Receiving Hospice Care

(P.L. 111-148: §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. PPACA allows payment for services, as defined by the state, provided to Medicaid children, also 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 also applies to CHIP, and is effective upon enactment.

Community First Choice Option

(P.L. 111-148: §2401 and P.L. 111-152: §1205)

[23] States will be allowed to continue to exclude coverage of agents to promote smoking cessation for other Medicaid beneficiaries, as permitted in prior law.

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)); and (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.

Health reform law allows states to offer consumer-directed personal care attendant services under a new statuary authority, and provides an increased match rate for doing so of 6 percentage points. Beginning October 1, 2011, states can offer home and community-based attendant services as an optional benefit to Medicaid beneficiaries whose income does not exceed 150% of the federal 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.

Services offered under this benefit option will include, among others, home and community-based attendant services and supports to assist eligible individuals in accomplishing ADLs, IADLs, and health-related tasks. Such services must be delivered under a person-centered plan of care in which attendants are selected, managed, and dismissed by the individual (or his or her representative). Services and supports may also include expenditures for transition costs, such as from a nursing home to the community. Such costs might include first month's rent and utilities, bedding, and basic kitchen supplies, among others. Further, attendants must be qualified to deliver such services and may include family members (as defined by the Secretary).

To obtain approval from the Secretary to offer this benefit, states must (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) in the first full fiscal year of operation, 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.

No later than December 31, 2013, the Secretary must submit to Congress an interim report on the findings of the evaluation. A final report on the community-based attendant services and supports option is due to Congress by December 31, 2015.

State Option to Provide Health Homes for Enrollees with Chronic Conditions

(P.L. 111-148: §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.

PPACA establishes 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.

In states that choose to offer this benefit option, individuals with chronic conditions will be eligible. For the purpose of this benefit, chronic conditions 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, can be established by the Secretary.

To assemble their health home, patients can designate providers, teams of health care professionals operating with providers, or health teams. A designated provider can 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 will establish the standards for qualification.

The health home state option will be funded though a federal/state matching program. States will be reimbursed for payments by the federal government at a 90% FMAP for the first eight fiscal quarters. States that choose to implement it will receive assistance according to the Federal Medical Assistance Percentage (FMAP) after the first eight fiscal year quarters. States can 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 will not exceed $25 million.

The Secretary is required to use an independent entity to evaluate this program. The evaluation will focus on whether the program reduces hospital admissions, emergency room visits, and admissions to skilled nursing facilities. The evaluation will 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

(P.L. 111-148: §2402)

See "Eligibility" section for provision description.

Clarification of The Definition of Medical Assistance

(P.L. 111-148: §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. PPACA clarifies that "medical assistance" encompasses both payment for services provided and the services themselves. This provision is effective upon enactment.

Financing

Financing for Medicaid 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 federal 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. FY2010 FMAPs ranged from a high of 75.67% in Mississippi to a low of 50.00% in 10 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 Health Reform

(P.L. 111-148: §2001 as modified by §10201, and P.L. 111-152: §1201 and §1202)

Federal Funding for Existing Eligibility Groups

Beginning in 2014, expansion states, (those that, as of March 23, 2010, offered full Medicaid state plan benefits for parents and childless adults up to at least 100% FPL—see provision definitions below) will get an increased FMAP for childless adults who were *not* newly eligible,[24] rather than receiving the regular FMAP (or no federal funds, in the case of states that used state-only funding for this population). The increase will be a certain percentage (i.e., "transition percentage")[25] of the difference between the state's regular FMAP and the FMAP it receives for "newly eligibles" as illustrated in the last row of **Table 1**.

Between January 1, 2014 and December 31, 2015, specified expansion states will 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 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 will 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. The only state that appears to qualify for the 2.2 percentage point increase is Vermont.

Federal Funding for "Newly Eligible" Populations

Under health reform law, states will receive 100% FMAP for the cost of providing benchmark or benchmark-equivalent coverage to the "newly eligible" individuals (defined for the purposes of this subsection below), from 2014 through 2016.[26] For "newly eligible" individuals, the FMAP rate will be 95% in 2017, 94% in 2018, 93% in 2019, and 90% afterward (see the first row of **Table 1** for a summary of the additional federal financial assistance that would be available under PPACA). Finally, 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.

For the purposes of this financing provision:

[24] Specifically, childless adults who would have been previously eligible for coverage in the state through a Section 1115 waiver.

[25] 50% in 2014, 60% in 2015, 70% in 2016, 80% in 2018, and 100% thereafter.

[26] Federal financial participation for some of the Medicaid benefit-related provisions under PPACA (e.g., adult preventive care, tobacco cessation services for pregnant women) are tied to the FMAP rates states will receive for "newly eligible" populations. Federal financial participation for these provisions will also be impacted by the proposed changes to the FMAP rates for "Newly Eligible" populations under the reconciliation bill.

- "Newly eligible" individuals are 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 are defined as medical assistance that includes all services of the same amount, duration, and scope, or that is determined by the Secretary to be substantially equivalent to the Medicaid state plan services available to categorically eligible mandatory coverage groups.
- "Expansion states" are defined as states (as of March 23, 2010) that had health benefits coverage (that includes inpatient hospital services) for parents and non-pregnant childless adults with income of 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 law requires 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" are defined as states that, as of March 23, 2010, 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 Medicaid Medical Assistance Payment (FMAP) Rates for Required Medicaid Expansions, Beginning 2014

	2014	2015	2016	2017	2018	2019	2020+
"Newly eligible" adults in all states	100%	100%	100%	95%	94%	93%	90%
Previously eligible childless adults in expansion states	75%-90%	80%-92%	85%-94%	86%-92%	90%-92.6%	93%	90%

Source: Table prepared by CRS Specialist in Health Care Financing, Chris L. Peterson, based on provisions in P.L. 111-148, as amended by P.L. 111-152.

Notes: "Expansion states" are those that, as of the date of PPACA's enactment (March 23, 2010), had covered parents and childless adults up to 100% FPL. Although the Department of Health and Human Services will make the official determination of which states will be considered "expansion states" under PPACA and the HCERA, existing Medicaid eligibility information suggests that 11 states and the District of Columbia meet this definition including Arizona, Delaware, Hawaii, Maine, Massachusetts, Minnesota, New York, Pennsylvania, Vermont, Washington, and Wisconsin. The FMAP ranges for previously eligible childless adults (i.e., individuals who would have been previously eligible for full benefit coverage in the state) under PPACA and HCERA represent the potential FMAP rate based on regular FMAPs ranging from the statutory minimum (50%) to 80%. (The highest regular FMAP since 2000 was 77.08%, although FMAPs are permitted statutorily to go to 83%.)

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

(P.L. 111-148: §10202)

Under Medicaid, states make available a broad range of institutional and home and community-based long-term care services to certain Medicaid enrollees. States are required to offer only some of these services. For those services that are offered, states define them differently, using criteria that place limits on the amount, duration, and scope of the benefits. States also restrict benefits to just those 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 institutions for mental diseases (IMDs). Home and community-based services are generally defined as long-term care services offered under Medicaid's mandatory home health state plan benefit, and a variety of optional state plan benefits, including personal care, case management or targeted case management, respiratory care for persons who are ventilator-dependent, Program of All-inclusive Care for the Elderly (PACE), transportation, home and community-based services (under section 1915(i) of the Social Security Act), and Medicaid home and community-based 1915(c) and (d) waivers.

Health reform law allows qualifying states to receive bonus payments for increasing their share of Medicaid long-term care spending on HCBS and reducing their share of Medicaid LTC spending on institutional care. To receive payments, states will 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%, the state must achieve a 25% target on HCBS by October 1, 2015, to receive bonus payments. Such states will receive an FMAP increase of 5 percentage points on eligible medical assistance payments. Other states will be required to reach a target of 50% by October 1, 2015, to qualify for payments. These states will receive an FMAP increase of 2 percentage points for eligible payments. In no case may the aggregate amount of payments made by the Secretary to states exceed $3 billion. The balancing incentive period begins October 1, 2011, and ends on September 30, 2015.

To receive incentive payments, a state is 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 care services and supports during the balancing incentive period and to achieve the target spending percentage applicable to the state. For states proposing to expand the Section 1915(i) benefit, the application must include a description of the state's election to increase the eligibility level above 150% of the FPL to a percentage not exceeding 300% of the SSI benefit rate. Regarding a state's structural changes, the application must include a description of the new or expanded offerings of those services that the state will provide and the projected costs of such services.

To qualify for payments, states may not apply more restrictive eligibility standards, methodologies, or procedures then were in effect on December 31, 2010. In addition, states must agree to use additional incentive payments for new or expanded offerings of HCBS services under Medicaid. Further, states must agree to implement the following:

- **no wrong door-single entry point system**—a statewide system enabling consumers to access all long-term care services through an agency, organization, coordinated network, or portal;

- **conflict-free case management services**—to develop a service plan, arrange for services, support the beneficiary (and, if appropriate, the caregiver) in directing his or her services, and conduct ongoing monitoring; and
- **core standardized assessment**—instruments for determining eligibility for non-institutionally based long-term care services, uniformly used across the state, to determine the beneficiary's needs for training, support services, medical care, transportation, and other services, and develop an individual service plan.

States must also collect data from providers and others on services, quality, and outcomes measures.

Disproportionate Share Hospital Payments

(P.L. 111-148: §2551 as modified by §10201(e); P.L. 111-152: §1203)

Under Medicaid, states are required to make disproportionate share hospital (DSH) adjustments to the payment rates of hospitals treating large numbers of low-income and Medicaid patients. The DSH provision is intended to recognize the disadvantaged situation of those hospitals. States must define, in their state Medicaid plans, hospitals that qualify as DSH hospitals and their DSH payment formulas. DSH hospitals must include at least all hospitals meeting minimum criteria and may not include hospitals that have a Medicaid utilization rate below 1%. The DSH payment formula also must meet minimum criteria, and DSH payments for any specific hospital cannot exceed a hospital-specific cap based on the unreimbursed costs of providing hospital services to Medicaid and uninsured patients.

In claiming federal DSH matching dollars, states cannot exceed their state-specific allotment amounts, calculated for each state based on a statutory formula. In determining these allotments for states, special rules apply to "low DSH states" (those in which total DSH payments for FY2000 were less than 3% of the state's total Medicaid spending on benefits). For low DSH states for FY2004 through FY2008, the allotment for each of these years was equal to 16% more than the prior year's amount. For years beginning in FY2009, DSH allotments for all states are equal to the prior year amount increased by the change in the consumer price index for all urban consumers (CPI-U). For FY2009, federal DSH allotments across states and the District of Columbia totaled to nearly $10.6 billion. Provisions under ARRA provided additional temporary DSH funding for states that increases total federal DSH allotments to nearly $10.9 billion.

Under prior 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.

P.L. 111-152 requires the Secretary to make aggregate reductions in Medicaid DSH allotments equal to $500 million in FY2014, $600 million in FY2015, $600 million in FY2016, $1.8 billion in FY2017, $5.0 billion in FY2018, $5.6 billion in FY2019, and $4.0 billion in FY2020.

To achieve these aggregate reductions, the Secretary will be required to:

(1) impose the largest percentage reduction on states that

- have the lowest percentage of uninsured individuals (determined on the basis of data from the Bureau of the Census, audited hospital cost reports, and other information likely to yield accurate data) during the most recent fiscal year with available data, or
- do not target their DSH payments to hospitals with high volumes of Medicaid patients, and hospitals that have high levels of uncompensated care (excluding bad debt);

(2) impose a smaller percentage reduction on low DSH states; and

(3) take into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation for a coverage expansion approved under a section 1115 waiver as of July 31, 2009.

For a state with a DSH allotment of $0 in the second, third and fourth quarters of FY2012, the provision will set that state's DSH allotments at $47.2 million, and for a state with a DSH allotment of $0 in FY2013, the provision will set that state's DSH allotment at $53.1 million. These provisions apply to Tennessee.

Under PPACA, for the last three quarters of FY2012, Hawaii's DSH allotment will be $7.5 million. For FY2013 forward, Hawaii's annual DSH allotment will be increased in the same manner applicable to low DSH states (i.e., adjusted by the percentage change in the Consumer Price Index for All Urban Consumers, 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

(P.L. 111-148: §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. States' FMAP rates returned to normal for the last quarter of FY2004 and continued until the ARRA enhanced rates in FY2009.

During the most recent recession, Congress provided states additional economic stimulus funding, including enhanced FMAP rates, when ARRA became law in February 2009.[27] States, the District of Columbia and the territories, received enhanced FMAP rates under ARRA for the

[27] FY2011 FMAP rates for all states are available at http://aspe.hhs.gov/health/fmap.htm.

recession period which began with the first quarter of FY2009 and continues 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 territories chose the 30% spending cap increase. 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.

PPACA Section 2006 provides for additional FMAP above the regular FMAP levels for qualifying "disaster-recovery FMAP adjustment" states once the ARRA adjustment is no longer in effect (January 1, 2011). To qualify for this adjustment, states must (1) have been declared by the President as a major disaster area during the preceding seven fiscal years under Sec. 401 of the Stafford Act for which every county or parish was determined to merit federal assistance, and (2) for FY2011, have its regular FMAP be at least three percentage points lower than the state's highest regular FMAP since FY2008 (excluding the ARRA 6.2-point and unemployment adjustments). Only three states will meet the second requirement—Louisiana (8.86 points), Hawaii (4.71 points), and North Dakota (3.40 points). Of those, only Louisiana meets the first requirement. For the portion of FY2011 not in the ARRA recession adjustment period (i.e., after December 31, 2010), PPACA will provide Louisiana with an FMAP of 68.04% (rather than the currently slated 63.61%). The FMAP of 68.04% will be 13.4-point drop from its latest ARRA FMAP, which is still the second-largest drop (behind Hawaii's 15.6-point drop) from the latest ARRA-adjusted FMAPs.[28] State eligibility for disaster relief would be re-determined annually. In the future, other states may qualify for the special disaster relief FMAP increase if they meet both requirements. This Section is effective January 1, 2011.

Payments to the Territories

(P.L. 111-148: §2005 as modified by §10201; P.L. 111-152: §1204)

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 (hereinafter 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

[28] For more information on the federal medical assistance percentage (FMAP), see CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by Chris L. Peterson.

services or cease payments to providers until the next fiscal year. Finally, the FMAP for all the territories is set at 50%.

Health reform law permits the territories to establish exchanges (in accordance with the exchange-related provisions in PPACA), not later than October 13, 2013. Out of funds not otherwise appropriated, $1.0 billion is appropriated for the period between 2014 and 2019 for the purpose of providing premium and cost-sharing assistance to residents of the territories to obtain health insurance coverage through the exchanges. Of this amount, the Secretary is to allocate $925 million for Puerto Rico, and a portion (as specified by the Secretary) of the remaining $75 million for any other territory that chooses establish exchanges. Under this provision, territories are to be treated as states and required to structure their exchanges in a manner so there is no gap in assistance between individuals eligible for Medicaid and those eligible for premium and cost sharing assistance.

Territories that do not elect to establish a exchanges as of the specified date are entitled to an increase in their existing Medicaid funding caps. For the period between July 1, 2011, and September 30, 2019, $6.3 billion in total additional payments are available for distribution among each territory in an amount that is proportional to the capped amounts available to the territories under current law. Current law rules regarding funds spent on specified administrative activities will apply, and the provision is effective July 1, 2011.

Payments for Primary Care Providers

(P.L. 111-152: §1202)

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

P.L. 111-148 did not have a provision addressing payments to primary care providers. However, there was a provision in the Affordable Health Care for America Act (H.R. 3962), the health reform bill passed by the House. Under the Reconciliation Act (P.L. 111-152), states will be required to set Medicaid payments for primary care services [i.e., evaluation and management (E&M) services defined by Medicare as of December 31, 2009, and as subsequently modified by the Secretary, and services related to immunization administration for vaccines and toxoids] relative to Medicare payment rates. Primary care services furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine will be paid at the Medicare rate for these services or higher (or if greater, the Medicare 2009 payment rate will be applicable).

With respect to Medicaid managed care, P.L. 111-152 also requires that, in the case of E&M services, these new payment rates will apply, regardless of the manner in which such payments are made, including in the form of capitation or partial capitation (e.g., payments made on a “per member per month” basis, rather than for each specific unit of service delivered).

For services furnished in 2013 and 2014, the federal government will fully finance the portion of primary care service payments by which the new minimum payment rates exceed the state's existing payment rates as of July 1, 2009. That is, the federal FMAP percentage for the additional costs born by a state will equal 100% in those two years.

Payments to Providers for Health-Care Acquired Conditions

(P.L. 111-148: §2702)

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.

The DRA required the Secretary to initiate a hospital-acquired condition (HAC) program.[29] 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.[30] Medicaid was not covered by DRA's HAC policy or CMS's national coverage decisions.

Although Medicaid was not specifically covered by the DRA requirements for Medicare, CMS issued guidance in July 2008 to help states appropriately align Medicaid inpatient hospital payment policies with Medicare's HAC payment policies.[31] 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.

PPACA requires 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 is required to issue regulations to prohibit federal Medicaid matching payments for health care-acquired conditions by July 1, 2011. These new regulations are to ensure that the prohibition on payments for health care-acquired conditions does not result in Medicaid beneficiaries losing access to services. PPACA requires the Secretary to define health care-acquired conditions consistent with Medicare's HAC definition, but may exclude certain conditions when they are inapplicable to Medicaid beneficiaries.

[29] In creating the HAC program, the Secretary was to select conditions that (1) were high cost, high volume, or both; (2) resulted 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.

[30] 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.

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

In implementing regulations governing Medicaid payment for health care acquired conditions, the Secretary is required to apply Medicare's regulations prohibiting hospital payments for HACs to the Medicaid program. In addition, the Secretary is required, to the extent practicable, to publicly report on measures for HACs utilized by CMS for adjustment of hospital payment amounts based on hospital-acquired infections.

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.[32] 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.[33]

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

(P.L. 111-148: §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

[32] 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.

[33] 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.

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.

Under previous law, 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 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 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, with certain exceptions, PPACA increases 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 increases from 11% to 13% of AMP.[34]

PPACA also requires the Secretary to recover the additional funds states received from drug manufacturers from increases in the basic Medicaid rebates. The Secretary is authorized to reduce Medicaid payments to states for the additional prescription drug rebates that resulted from increases in the minimum rebate percentages—the difference between 15.1% of AMP and 23.1% of AMP for single source products and the difference between 11% and 13% for generic products. PPACA requires the Secretary to estimate the additional rebate amounts to recover from states based on utilization and other data. In addition, when it is determined that the recovered amount from a state for a previous quarter under-estimated the actual rebate amount (state share) the Secretary is required to make further adjustments to recover the additional rebates from states. These state payment reductions are considered overpayments to the state and disallowed against states' regular Medicaid quarterly draw, similar to other overpayments. These disallowances are not subject to reconsideration.

PPACA also requires 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 previous law for FFS beneficiaries. Medicaid capitation rates paid by states are to be adjusted to include these rebates, and Medicaid MCOs are 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 can utilize formularies as long as there is an exception process so that excluded drugs are available

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

through a prior authorization process. Drugs discounted under 340B are excluded from the requirements in this section (§2501 of P.L. 111-148).

With certain exceptions, PPACA requires that additional rebates for new formulations of single source or innovator multiple source drugs be calculated as 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).[35] However, total rebate liability for each dosage form and strength of an individual single source or innovator multiple source drug is capped at 100% of that drug's AMP. Other features of the drug rebate program, such Medicaid's best price requirement, are unchanged by PPACA. HCERA amended PPACA to clarify that the calculation of the additional rebate for new formulations of existing drugs (line extensions) applied to single source or innovator multiple source drugs only in oral solid dosage forms. Changes in this provision begin January 1, 2010, except for the MMCO rebates which begin March 23, 2010.

Elimination of Exclusion of Coverage of Certain Drugs

(P.L. 111-148: §2502)

Previous Medicaid law excludes coverage of 11 drug classes, including barbiturates, benzodiazepines, and smoking cessation products. States had the option to cover excluded drugs, and most states cover barbiturates, and benzodiazepines, and smoking cessation drugs. States received 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 (were not covered by Medicare Part D). However, under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275), Medicare prescription drug plans and Medicare Advantage plans will be required to include benzodiazepines and barbiturates in their formularies for prescriptions dispensed beginning January 1, 2013. Barbiturates also will be required to be included in Medicare formularies for epilepsy, cancer, or chronic mental health disorders.

PPACA requires that smoking cessation drugs, barbiturates, and benzodiazepines be removed from Medicaid's excluded drug list. When this provision takes effect beginning January 1, 2014, states that cover prescription drugs will be required to cover barbiturates, benzodiazepines, and smoking cessation products for most Medicaid beneficiaries.

Providing Adequate Pharmacy Reimbursement

(P.L. 111-148: §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

[35] New orphan drug formulations are exempted from the additional rebate requirements, regardless of whether the market exclusivity period has expired. Orphan drugs, as designated by Sec. 526 of the Federal Food, Drug, and Cosmetic Act, are used to treat individuals suffering from rare diseases.

limits are referred to as federal upper payment limits (FUL). CMS calculates FULs and periodically publishes these prices. 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. Previous 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 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. MIPPA Section 203 authorized CMS to set FULs 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—until September 30, 2009. In general, these published prices are significantly higher than AMPs.

Under previous law, CMS lacked authority to use the pre-DRA formula (expired September 30, 2009) for setting FULs or the DRA authority (prohibited by MIPPA). In addition, CMS is bound by the court's injunction preventing the use of the DRA formula. On September 25, 2009, prior to the expiration of authority to use the pre-DRA formula, CMS issued a list of multiple source drug FULs 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.

PPACA requires the Secretary to set FULs at 175% or more of the weighted average (determined on the basis of utilization) of the most recently reported monthly AMPs.[36] PPACA restores the pre-DRA definition of multiple source drugs as three therapeutic and pharmaceutically equivalent products. PPACA also includes technical changes to the FUL formula such as a smoothing process for average manufacturer prices to reduce short-term volatility and clarification that AMP excludes the following:

1. customary prompt pay discounts to wholesalers;
2. *bona fide* service fees paid by manufacturers to wholesalers and RCPs, such as distribution service fees, inventory management fees, product stocking allowances, and administrative services agreements and patient care programs (medication compliance and patient education programs);

[36] FULs are set for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies.

3. reimbursement by manufacturers for recalled, damaged, expired, or unsaleable returned goods;
4. payments received from, and rebates or discounts to, large purchasers such as pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, hospitals, clinics, mail order pharmacies, long-term care providers, manufacturers, or any other entity that does not conduct business as a wholesaler or a retail community pharmacy.

Further, PPACA revises 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, PPACA expands drug pricing disclosure requirements to include monthly weighted average AMPs and retail survey prices. Manufacturers are 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. Assuming the court injunction is lifted, Section 2503 takes effect the first day of the first calendar quarter that begins at least six months after PPACA's enactment, regardless of whether final regulations were issued (January 1, 2011).

340B Prescription Drug Discount Program Expansion[37]

(P.L. 111-148: §7101-7103 as modified by P.L. 111-152: §2302)

Under Section 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.

PPACA and HCERA expand the list of covered entities eligible to receive 340B discounts 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 referral centers. PPACA requires 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. Further, within 18 months of enactment (September 23, 2011), the Government Accountability Office (GAO) is required to submit to Congress a report that examines, among other issues, whether individuals receiving services through 340B covered entities receive optimal health care services. With the exception of the GAO report, the 340B changes are effective and apply to drug purchases that began January 1, 2010.[38]

[37] For more information on the PHSA Sec. 340B provisions, see CRS Report R40943, *Public Health, Workforce, Quality, and Related Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)*, coordinated by C. Stephen Redhead and Erin D. Williams.

[38] PPACA expanded 340B discounts to inpatient drugs for hospital entities, but this provision was repealed in HCERA. Similarly, PPACA required hospital entities to issue credits to Medicaid programs for inpatient drugs purchased for Medicaid beneficiaries. This provision was also repealed in HCERA.

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 and states contribute equally to fund most Medicaid and CHIP activities to combat waste, fraud, and abuse, although for some activities, the federal government provides additional funds through enhanced matching rates. All states (and the District of Columbia) receive the same federal match rate for administrative expenditures, including most PI activities, which is generally 50%. States receive higher federal matching rates for selected administrative activities such as 90% for the design, development, and installation of required claims processing and information retrieval systems—Medicaid Management Information Systems (MMIS); 75% for the operation of MMIS; 90% for the start up of Medicaid Fraud Control Units (MFCUs); and 75% for ongoing MFCU operation.

Congress provided additional dedicated funding for Medicaid program integrity activities in the Deficit Reduction Act of 2005, (DRA, P.L. 109-171). Under DRA, among many other changes, Congress established a Medicaid Integrity Program (MIP) that included annual appropriations reaching $75 million. This MIP funding was to support and enhance state PI efforts by expanding and sustaining national PI activities in the areas of provider audits, overpayment identification, and payment integrity and quality of care education.

PPACA created additional requirements to increase uniformity, and bolster Medicare, Medicaid and CHIP PI activities. For instance, PPACA introduced additional provider screening requirements that are applicable to Medicare, Medicaid, and CHIP. PPACA creates an integrated Medicare and Medicaid data repository to enhance PI data sharing to be available to federal and state agencies and law enforcement officials. Moreover, PPACA established a recovery audit contractor (RAC) requirement for Medicaid (described below), similar to Medicare's RAC program.

Expansion of the Recovery Audit Contractor (RAC) Program

(P.L. 111-148: §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. 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.

PPACA requires states to establish by December 31, 2010 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 are to identify underpayments, overpayments, and recoup overpayments made for services provided under state Medicaid plans as well as waivers. The state Medicaid RAC program is subject to exceptions and requirements the Secretary may establish for the state RAC program. In addition, states are required to make certain assurances for their RAC programs, including that the RAC (1) operates on a contingency basis; (2) has an appeal process for adverse determinations in place; (3) recoveries are subject to quarterly expenditure estimates; and (4) states coordinate with other PI organizations such as federal and state law enforcement agencies.

Termination of Provider Participation Under Medicaid if Terminated Under Medicare or Other State Health Care Program

(P.L. 111-148: §6501)

Under previous Medicaid law, 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 is required to promptly notify the Department of Health and Human Services Office of the Inspector General (HHS/OIG) if it receives Medicare or Medicaid program participation applications that identify providers who have engaged in prohibited activities.

In this Section, PPACA requires 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. The changes in this provision are effective January 1, 2011.

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

(P.L. 111-148: §6502)

Previous Medicaid law requires states to exclude individuals or entities from Medicaid participation when states are 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.

PPACA requires Medicaid agencies to exclude individuals or entities from Medicaid participation if the entity or individual owns, controls, or manages an entity that (1) has unpaid or unreturned overpayments during the period as determined by the Secretary or the state; (2) is suspended, excluded, or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation during the period. This provision is effective January 1, 2011 (see §6508, General Effective Date below).

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

(P.L. 111-148: §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.

This provision in PPACA requires 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 the Secretary is required to specify. This provision is effective January 1, 2011 (see §6508, General Effective Date below).

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

(P.L. 111-148: §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 approves states' MMISs and determines if 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 are required to 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. Medicaid managed care organizations (MMCO) 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.

Beginning in January 1, 2011, PPACA requires states to collect and submit through their MMISs managed care data as identified by the Secretary for program integrity, program oversight, and administration. The Secretary is to determine the data needed and how frequently these data are required to be submitted. In addition, for contract years beginning after January 1, 2010, MMCOs are 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

(P.L. 111-148: §6505)

Under previous Medicaid law, there were no specific prohibitions or limitations which prevent Medicaid payments to institutions or entities located outside the United States. This provision in PPACA prohibits 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 Section is effective January 1, 2011 (see §6508, General Effective Date below).

Overpayments

(P.L. 111-148: §6506)

Previous Medicaid law requires states to repay promptly the federal share of Medicaid overpayments when the state discovers overpayments occurred. States had 60 days after discovery of an overpayment to recover, or attempt to recover, the overpayment before an adjustment was made to their federal matching payment. Adjustments in federal payments were made at the end of the 60 days, whether or not states had recovered the funds. When states were unable to recover overpayments because the debts were discharged in bankruptcy or were otherwise uncollectable, federal matching payments were not adjusted.

Beginning with enactment, PPACA extends 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 are not due until 30 days after the date of the final judgment (including a final appeal determination). PPACA requires the Secretary 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 went into effect March 23, 2010.

Mandatory State Use of National Correct Coding Initiative

(P.L. 111-148: §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.

Beginning with claims submitted on October 1, 2010, PPACA requires states to add to their MMISs pre-payment edits to correct and control improper coding, similar to the NCCI edits used by Medicare contractors. By September 1, 2010, the Secretary is required to (1) identify NCCI methodologies compatible with Medicaid claims, and (2) identify methodologies applicable to Medicaid, but for which no Medicare NCCI methodologies had been established. Further, the Secretary is required to notify states of NCCI methodologies (or successor initiatives) applicable to Medicaid that were identified and how states are to incorporate those methodologies into their Medicaid claims processing systems. Moreover, the Secretary is 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

(P.L. 111-148: §6508)

States are be required to implement PPACA's Medicaid program integrity Sections by January 1, 2011, regardless of whether final regulations were issued. 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 will 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

(P.L. 111-148: §6401 as amended by §10603)

The process for enrolling providers and suppliers in Medicare, Medicaid, and CHIP is different depending on the program and the type of provider, although Medicaid and CHIP requirements are similar. PPACA requires the Secretary, in consultation with the HHS/OIG, to establish similar procedures for screening providers and suppliers enrolling in the Medicare, Medicaid, and CHIP programs. These procedures are required to include processes for screening providers, enhanced oversight measures, disclosure requirements, moratoriums on enrollment, and requirements for developing compliance programs.

By January 1, 2011, the Secretary is required to develop procedures, which apply to both new and current providers. The Secretary is required to implement these requirements within three years. Further, the Secretary is required to determine the level of screening for providers depending on the provider's fraud risk category (as determined by the Secretary). At a minimum, all providers and suppliers are subject to licensure checks, including checks across states.

The Secretary has authority to impose additional screening requirements 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, new institutional providers and suppliers are subject to application 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 start at $500 for institutional providers and are adjusted for inflation thereafter; individual providers are exempt from application fees. The Secretary also has authority to impose a temporary moratorium on enrolling new providers if necessary. Further, PPACA requires Medicare, Medicaid, and CHIP providers and suppliers, within a particular industry or category, to establish compliance programs that adhere to standards established by the Secretary and the HHS/OIG.

Enhanced Medicare and Medicaid Program Integrity Provisions

(P.L. 111-148: §6402, as modified by P.L. 111-152: §1304)

PPACA requires the Secretary to enhance existing Medicare, Medicaid, and CHIP program integrity initiatives. As part of these enhancements, the Secretary is required to apply some of the same requirements to Medicare, Medicaid, and CHIP.

- ***Data Matching.*** Under previous law, 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 in PPACA requires 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 Indian Health Service (IHS). The priority is to be given to integration of Medicare and Medicaid claims and payment data. Other program data, including CHIP, will be integrated as appropriate.
- ***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 in PPACA grants the HHS/OIG and the DOJ explicit access to Medicare, Medicaid, and CHIP payment and claims data (including Medicare Part D data) to conduct law enforcement and oversight activities. This provision further grants the HHS/OIG the authority to obtain information from providers, suppliers, beneficiaries (as long as privacy protections are observed) including supporting documentation necessary to valid payment claims, such as medical records, but also any records necessary for evaluation of the economy, efficiency, and effectiveness of Medicare and Medicaid programs.
- ***Beneficiary Participation in Health Care Fraud Scheme.*** This provision in PPACA requires the Secretary to impose administrative penalties on beneficiaries entitled to or enrolled in Medicare, Medicaid, or CHIP if they knowingly participate in health

care fraud offenses. In addition, beneficiaries are required to return overpayments within 60 days of receipt of those payments or be subject to enforcement action.

- ***National Provider Identifier (NPI).*** Health care providers often have multiple provider numbers, one number for billing each private insurance plan or public health care program. The administrative simplification provisions of Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) 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 requires the Secretary to issue regulations before January 1, 2011 mandating that all Medicare and Medicaid providers include NPIs on all payment claims and enrollment applications.
- ***Withholding of Federal Matching Payments for States that Fail to Report Enrollee Encounter Data in the Medicaid Statistical Information System (MSIS)***. The Secretary is permitted to withhold federal matching payments for services provided to Medicaid beneficiaries if states do not report encounter data to MSIS (as determined by the Secretary) for those beneficiaries in timely manner (as determined by the Secretary).
- ***Permissive Exclusions.*** HHS/OIG has the authority to exclude health care providers from federal health care program participation. Exclusions are mandatory in some circumstances, and permissive in others (i.e., HHS/OIG has discretion in whether to exclude an entity or individual). This provision subjects individuals or entities that make false statements or misrepresentations on applications to enroll or participate in federal health care programs to the OIG's permissive exclusion authority. PPACA explicitly applies to Medicare Advantage plans, Prescription Drug Plans, and MMCOs as well as these entities' participating providers and suppliers.
- ***Civil Monetary Penalties (CMPs).*** Previous law authorized the imposition of CMPs on individuals, organizations, agencies, or other entities that engage in improper conduct under federal health care programs. PPACA 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. PPACA also adds additional actions that are subject to CMPs. Among other changes, the following individuals are subject to CMPs: those who have been excluded from a federal health care program, but who order or prescribe an item or service; those who make false statements on enrollment applications, bids, or contracts; and those who know of an overpayment and do not return the overpayment.
- ***Testimonial Subpoena Authority.*** Under PPACA, the Secretary has 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 by the Secretary. The Secretary also can delegate this authority to the HHS/OIG and the CMS administrator for program exclusion investigations.
- ***Increased Medicare and Medicaid Integrity Program Funding.*** Under the Medicare Integrity Program, 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.

DRA established the a comparable program for Medicaid, the Medicaid Integrity Program (MIP). The Medicaid MIP provides dedicated resources to contract with entities to reduce fraud, waste, and abuse. PPACA requires both Medicare and Medicaid Integrity Program contractors to supply the Secretary and the HHS/OIG with performance statistics, including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment for these activities. The Secretary also is required to conduct evaluations of eligible entities at least every three years. Within six months of each fiscal year end, the Secretary is required to submit a report to Congress that describes the use and effectiveness of MIP funds.

Section 6402 of PPACA increased Health Care Fraud and Abuse Control (HCFAC) account funding. HCFAC funds are used for a number of health care fraud and abuse activities, but the majority of the funds are used for Medicare activities. HCERA (Sec. 1304) further increases those HCFAC funds, bringing them up to the levels proposed in the House health care reform bill, the Affordable Health Care for American Act (H.R. 3962). In addition, HCERA amended PPACA and increased MIP funding by indexing MIP funds to annual changes in the consumer price index, beginning with FY2010.

Improving Nursing Home Transparency, Enforcement, and Staff Training

(P.L. 111-148: §6101-§6107, §6111-§6114, and §6121)

Previous Medicare and Medicaid law requires skilled nursing facilities (SNF) and nursing facilities (NF) to be administered in a manner that will ensure residents' well-being. The Secretary was required to establish SNF and NF requirements to 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 NF 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 NFs that jeopardize residents' well-being.

PPACA enhances certain accountability requirements for Medicare certified SNFs and Medicaid certified NFs. The changes in these sections 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. Further, these sections require the Secretary to establish additional requirements for SNFs and NFs to develop and implement compliance and ethics programs.

The Secretary is 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 (LTC) consumers. SNFs are required to report wage and benefit expenditures for direct care staff. In addition, the Secretary, in consultation with private sector experts, is required to redesign Medicare and Medicaid cost reports to capture wage and benefit reporting by SNFs and NFs. The Secretary is required to develop a new standardized complaint form that facilities and states are required to make available to all stakeholders and consumers. The changes in these sections require SNFs and NFs to electronically report direct staffing information to the Secretary following specifications the Secretary establishes in consultation with stakeholders. GAO is required to conduct a study of CMS' nursing home Five-Star rating system. PPACA establishes additional civil money penalties

that both the Secretary and states have authority to impose on SNFs or NFs found to have quality of care issues and other deficiencies that jeopardized residents' safety. The Secretary is required to develop, test, and implement a national independent monitoring demonstration for large interstate and intrastate SNF and NF chains.

Further, PPACA establishes 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 fail to comply with the closure notice requirements are subject to penalties up to $100,000 and exclusion from federal health program participation. The Secretary also is required to conduct demonstration projects on best practices for culture change and use of information technology in SNFs and NFs. Moreover, PPACA requires the Secretary to revise initial nurse aide training, competency, and evaluation requirements to include dementia and abuse prevention. Finally, PPACA authorizes the Secretary to revise dementia management training and patient abuse prevention in ongoing nurse training, competency, and evaluation requirements.

Demonstrations and Grant Funding

Money Follows the Person

(P.L. 111-148: §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.

P.L. 111-148 extends the MFP Rebalancing Demonstration through September 30, 2016 and extends the deadline for the submission of the final evaluation report to September 30, 2016. The provision also changes the demonstration's 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 excludes Medicare-covered short-term rehabilitative services from counting toward the 90-day period. This provision become effective 30 days after enactment.

Demonstration Project to Evaluate Integrated Care Around Hospitalization

(P.L. 111-148: §2704)

There is no related provision in prior law. The law establishes a Medicaid demonstration that will evaluate whether quality can be improved and Medicare payments reduced by making bundled

payments to hospitals and physicians for the delivery of integrated care. Such payments will be made for episodes of care that include beneficiaries' hospital stays and concurrent physician services. Under the demonstration, bundled payments will be based on the beneficiary's severity of illness, among others requirements. States can target selected categories of beneficiaries, such as those with particular diagnoses, or those in particular geographic regions. Finally, participating hospitals will be required to have, or to establish, robust discharge planning programs that appropriately place beneficiaries in, or ensure that they have access to, post-acute care settings. This demonstration project is limited to eight states, and is required to begin on January 1, 2012 and end on December 31, 2016.

Medicaid Global Payment System Demonstration Project

(P.L. 111-148: §2705)

Under Medicaid fee-for-service, 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 P.L. 111-148, the Secretary, in coordination with the proposed Center for Medicare and Medicaid Innovation is required to establish the Medicaid Global Payment System Demonstration Project in no more than five states. The demonstration is required to be operational from FY2010 through FY2012. Under the project, payments to an eligible safety net[39] hospital system or network will 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 will have the authority to modify or terminate the project during an initial testing period, and will 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 law authorizes to be appropriated such sums as necessary to finance this demonstration project.

Pediatric Accountable Care Organization Demonstration Project

(P.L. 111-148: §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 Medicare Shared Savings Program established under P.L. 111-148, groups of providers who voluntarily meet certain statutory criteria, including quality measurements, will be recognized as ACOs and be eligible to share in the cost-savings they achieve for the Medicare program. Under the new program, an eligible ACO is defined as a group of providers and suppliers who have an established mechanism for joint decision-making, and participate in the shared savings program for a minimum of three years, among other requirements. An ACO will include practitioners (physicians - regardless of

[39] 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.

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.

Health reform law also establishes the Pediatric Care Organization demonstration project, where participating states are authorized to allow pediatric medical providers who voluntarily meet certain statutory criteria, including quality measurement criteria, to be recognized as ACOs. Such ACOs are also authorized 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 newly established Medicare Shared Savings Program. ACOs can 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 will be required to meet both quality performance guidelines created by the Secretary, in consultation with states and pediatric 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 is responsible for determining the amount of the annual incentive payment, which will be a portion of savings and can establish an annual cap on total incentive payments. The law authorizes an appropriation of such sums as may be necessary to finance this demonstration project.

Medicaid Emergency Psychiatric Demonstration Project

(P.L. 111-148: §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 new law establishes a three-year Medicaid demonstration project in which eligible states are 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 provision. A participating state is 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 provision. Eligible states will be selected by the Secretary based on geographic diversity. Out of funds not otherwise appropriated, the provision provides budget authority in advance of appropriations in an amount equal to $75 million for FY2011. Such funds will remain available for obligation for five years through December 31, 2015.

The Secretary is required to conduct an evaluation to determine the impact of this demonstration project. The evaluation will include an assessment of access to inpatient mental health services, average lengths of stays, emergency room utilization, discharge planning, impact on other mental health service costs, and a recommendation regarding whether the project should be continued beyond December 31, 2013 and expanded on a national basis. The Secretary is required to submit a final report to Congress no later than December 31, 2013.

Grants for School-Based Health Centers

(P.L. 111-148: §4101(a))

P.L. 111-148 creates a grant program to support the establishment of school-based health centers. This new law appropriates $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 is prohibited for any service that is not authorized or allowed by federal, state, or local law. The Secretary is required to establish criteria and application procedures for awarding grants under this program. The Secretary will 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 can be used for personnel or health care expenditures. (Another provision, described in a separate CRS report,[40] provides grants under the Public Health Service Act for the *operation* of school-based health centers.)

Incentives for Prevention of Chronic Diseases in Medicaid

(P.L. 111-148: §4108)

The Secretary is 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 authorizes the appropriation of $100 million in funding for these grants during a five-year period. Under the new law, the Secretary is required to award grants beginning on January 1, 2011, or the date on which the Secretary develops program criteria, whichever is earlier. These criteria are to 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 must 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

[40] For information about this related provision, see CRS Report R40943, *Public Health, Workforce, Quality, and Related Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)*, coordinated by C. Stephen Redhead and Erin D. Williams.

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 will be required to conduct an outreach and education campaign aimed at Medicaid beneficiaries and providers. They will also 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 that is awarded a grant will be required to submit semi-annual reports, including information on the specific use of the funds, an assessment of program implementation, quality improvements and clinical outcomes, and an estimate of cost savings resulting from the program. This provision exempts states from the requirement 1902(a)(1) of the SSA, which relates to the statewide accessibility for medical assistance programs.

The Secretary is 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.

The Secretary is required to submit an initial report to Congress before January 1, 2014. This initial report should 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 is then required to submit a final report before July 1, 2016 that will include the independent contractor assessment together with recommendations for appropriate legislative and administrative actions.

Any incentives received by a beneficiary will 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

(P.L. 111-148: §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. P.L. 111-148 replaces 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.

State 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 coverage 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. 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 the percentage *not* paid by the federal government through the 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 FY2010, the E-FMAP for CHIP ranges from 65% to 83%.

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.

P.L. 111-148 makes a number of changes to CHIP for future years. These changes are described below. (Other provisions affecting both Medicaid and CHIP are described in other sections of this report.)

Additional Federal Financing Participation for CHIP

(P.L. 111-148: §2101 as modified by §10203(c); P.L. 111-152: §1004(b)(2))

P.L. 111-148 maintains the current CHIP structure, and provides CHIP appropriations through FY2015. In the event that future federal CHIP allotments are insufficient to provide coverage to all eligible CHIP children, states will be required to establish procedures to ensure that such children not eligible for Medicaid receive coverage through certified plans in state-established exchanges.

Under P.L. 111-148, states will receive a 23 percentage point increase in the CHIP match rate (E-FMAP), subject to a cap of 100%, for FY2016 through FY2019 (although no CHIP appropriations are provided for those years). The 23 percentage point increase will not apply to certain expenditures.[41]

Upon enactment, states will 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 when federal CHIP funding is no longer available, states can *not* implement eligibility standards, methodologies, or procedures that are *more* restrictive than those

[41] Certain expenditures include 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.

in place on the date of enactment. However, states can expand their current income eligibility levels—that is, states can enact *less* restrictive standards, methodologies or procedures.

In the event that federal CHIP allotments are not available after September 30, 2015, the only exchange plans available to children who would have been eligible for CHIP will be those that have been certified by the Secretary. With respect to such certification, not later than April 1, 2015, for each state, the Secretary will be required to review the benefits offered for children and the associated cost-sharing for exchange plans, and must certify that such plans have been determined to be at least comparable to the benefits and cost-sharing protections provided under each state's CHIP plan. States will 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 will be required to establish procedures to ensure that those children are enrolled in a certified exchange plan.

Prior to PPACA, for FY2009 through FY2013, states can receive bonus payments when their Medicaid enrollment among children exceeds a defined baseline, and they also implement certain outreach and enrollment activities. Under P.L. 111-148, the Medicaid enrollment bonuses included in CHIPRA (P.L. 111-3) will not apply beyond the current authorization period; bonus payments will not be available after FY2013.

Beginning January 1, 2014, states will be required to use modified adjusted gross income (MAGI) to determine Medicaid and CHIP eligibility (excluding Express Lane determinations), premiums and cost-sharing. States will be required to treat as CHIP children those who are 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 will continue as under current law.

Finally, a new Medicaid section added by P.L. 111-148 regarding Medicaid programs' coordination with state health insurance exchanges will also apply to CHIP programs.

Distribution of CHIP Allotments Among States

(P.L. 111-148: §2101 as modified by §10203(d))

Prior to PPACA, federal CHIP allotments were appropriated through FY2013, with an allotment formula that was similar for all recent odd-numbered years and for all recent even-numbered years. PPACA extends federal CHIP allotments by two years and makes the allotments for FY2014 and FY2015 similar to how they were to occur in FY2012 and FY2013 under prior law.

In particular, based on prior law, for FY2012, the allotment for a state (or territory) will be calculated as the prior-year allotment and any prior-year Contingency Fund spending (for states that experience shortfalls of federal CHIP funds; described in further detail below), multiplied by the state's growth factor for the year.[42] Under PPACA, this will also be the basis for states' FY2014 allotments.

[42] For the FY2009 allotment formula, the state's 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 (continued...)

Based on prior law for 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. Under PPACA, this will also be the basis for states' FY2015 allotments.

As per prior 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 was 20% of the CHIP available national allotment. For FY2010 through FY2013, the appropriation will be such sums as are necessary for making payments to eligible states for the fiscal year, as long as the annual payments do 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.

P.L. 111-148 extends the authority for the Child Enrollment Contingency Fund through FY2015. For FY2013 through FY2015, the appropriation for the Fund will be such sums as are necessary for making payments to eligible states for the fiscal year, as long as the annual payments do 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 FY2013 through FY2015 for the federal share of expenditures for CHIP children above a target enrollment level.

Finally, prior CHIP statute permitted 11 early expansion "qualifying states" to draw some CHIP funds for Medicaid children above 133% of poverty level. P.L. 111-148 extends this authority through FY2015.

Extension of Funding for CHIP Through FY2015 and Other Related Provisions

(P.L. 111-148: §10203(a), §10203(b), and §10203(d))

Revisions to the Child Health Quality Measurement Initiative

Under prior law, a child health quality measurement initiative was established 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.

(...continued)

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.

Under P.L. 111-148, the Secretary is required to establish by regulation the criteria for certifying health plans as qualified health plans generally available through the exchange. 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 exchanges, and utilize a standard format for presenting health plan benefit options. PPACA also requires exchange plans seeking certification to report to the Secretary at least annually (and in a manner specified by the Secretary) these pediatric quality reporting measures.

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

Under current law states are permitted to purchase family coverage under a group health plan or health insurance that includes CHIP children (through what is called a family coverage variance program), 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 aggregate 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, and states must ensure that CHIP minimum benefits are provided, CHIP cost-sharing ceilings are met, and the children to be enrolled have not had group coverage for a specified period of time (typically four to six months)[43]

Under Medicaid law, including a Medicaid expansion CHIP program, states may implement a premium assistance program if the employer plan is comprehensive and cost-effective for the state. Under prior Medicaid law, an individual's enrollment in an employer plan was considered cost-effective if paying the premiums, deductible, coinsurance and other cost-sharing obligations of the employer plan was less expensive than the state's expected cost of directly providing Medicaid-covered services. To meet the comprehensiveness test under Medicaid, current law requires states to provide coverage for those Medicaid-covered services that are not included in the private plans. In other words, states must provide "wrap-around" benefit coverage.

CHIPRA created a new state plan option to offer premium assistance for Medicaid and CHIP-eligible children and/or parents of Medicaid and/or CHIP-eligible children where the family has access to employer-sponsored insurance (ESI) coverage, if the employer pays at least 40% of the total premium, the employer's group health plan qualifies as "creditable coverage"[44] (as defined by the Public Health Service Act), and the coverage is offered to all individuals in a nondiscriminatory way (as defined by the Internal Revenue Code of 1986). Under CHIPRA, a state offering premium assistance may not require CHIP eligible individuals to enroll in an employer's plan; individuals eligible for CHIP and for employment-based coverage may choose to enroll in regular CHIP rather than the premium assistance program. The premium assistance subsidy will generally be the difference between the worker's out-of-pocket premium that

[43] CHIP premium assistance programs approved under state plan authority are referred to as family coverage variance programs. As of June 7, 2007, there were two states—New Jersey and Massachusetts—with operational family coverage variance programs under CHIP.

[44] Benefits provided under a health flexible spending arrangement or a high deductible health plan are specifically excluded as credible health coverage under CHIPRA.

included the child(ren) versus only covering the employee. For employer plans that do not meet CHIP benefit requirements, a wrap-around is required. The law also stipulates that the premium assistance provisions under Medicaid, not CHIP, will apply to children enrolled in a Medicaid expansion CHIP program.

Under prior law (as enacted under CHIPRA), for the child's coverage using premium assistance, no cost-effectiveness test was required regarding the cost of the private coverage (plus any necessary wrap-around) relative to regular CHIP coverage. CHIPRA established a separate test for family coverage. If the CHIP cost of covering the entire family in the employer-sponsored plan was less than regular CHIP coverage for the eligible individual(s) alone, then the premium assistance subsidy could be used to pay the entire family's share of the premium.

P.L. 111-148 applies the cost-effectiveness definition used under the CHIP family coverage variance authority to (1) the coverage of Medicaid beneficiaries in employer-sponsored group health plans, (2) the premium assistance option for children under Medicaid, and to (3) the new CHIPRA state plan option to offer premium assistance for Medicaid and CHIP-eligible children and/or parents of Medicaid and/or CHIP-eligible children.

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.

P.L. 111-148 makes 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 annual agency expenditures made on behalf of an employee enrolled in a state health plan with dependent coverage (for the most recent state fiscal year) is at least the amount of such expenditures made for state FY1997, adjusted for medical inflation 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

Prior to PPACA, federal statute provided yearly total allotments for CHIP. Specific annual amounts were appropriated for fiscal years starting with FY1998 ($4.295 billion) through FY2012 ($14.982 billion). For FY2013 only, two semi-annual allotments were made available. For the first half of the fiscal year, $2.85 billion was to be available, and for the second half of the fiscal year, another $2.85 billion. 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.

P.L. 111-148 strikes the current law language that provides semi-annual allotments for FY2013, and replaces that language with an appropriation of $17.406 billion for FY2013. The new law also provides an appropriation of $19.147 billion for FY2014, and establishes two semi-annual allotments for FY2015. For the first half of FY2015, $2.85 billion will be made available, and for the second half of FY2015, another $2.85 billion. P.L. 111-148 also modifies 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.

Prior law appropriated $100 million in outreach and enrollment grants above and beyond the regular CHIP allotments for FY2009 through FY2013. Ten percent of the allocation is to be directed to a national enrollment campaign, and 10% will be targeted to outreach for Native American children. The remaining 80% is to 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 are also targeted at proposals that address cultural and linguistic barriers to enrollment.

P.L. 111-148 expands the time period for the outreach and enrollment grants through FY2015. This provision also changes the appropriation level to $140 million for FY2009 through FY2015.

Technical Corrections to the CHIP Statute

(P.L. 111-148: §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.

PPACA corrects selected provisions in CHIPRA and ARRA, including (1) making an adjustment to the FY2010 CHIP allotments for certain previously approved Medicaid expansion programs; (2) clarifying a reference to certain lawfully residing immigrants in CHIP statute; (3) deleting 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) for comparing the Current Population Survey (CPS) and the American Community Survey (ACS), using estimates of "high performing states" (i.e., those in the lowest one-third of states in terms of their percentage of uninsured, low-income children); and (5) stipulating that the alternative premiums and cost-sharing provision in Medicaid will 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 are effective as if they were included in the enactment of P.L. 111-3 and P.L. 111-5.

Miscellaneous

Medicaid Improvement Fund Rescission

(P.L. 111-148: §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 each FY2015-FY2018. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) revised funding for Physician Assistance and Quality Initiative and these funds were to be used for MIF activities. In December 2009, the Department of Defense Appropriations Act, 2010 (P.L. 111-118) was passed. P.L. 111-118 reduced the amount of funding available for MIF in 2014 from $22.3 billion to $20.7 billion. PPACA rescinds any unobligated MIF funds (as of the date of enactment) for FYs 2014 through 2018.

Removal of Barriers to Providing Home and Community-Based Services

(P.L. 111-148: §2402)

Secretary is required to promulgate regulations to ensure that all states develop service systems designed to: (1) allocate resources for services in a manner that is responsive to the changing needs of long-term care beneficiaries receiving home and community-based services and that maximizes their independence; (2) provide the support for such beneficiaries to design an individualized self-directed, community-supported life; and (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

(P.L. 111-148: §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 law appropriates 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

(P.L. 111-148: §2406)

The law expresses 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 makes long term services and supports available in the community as well as in institutions.

Five-Year Period for [Dual Eligible] Demonstration Projects

(P.L. 111-148: §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 are eligible for Medicaid because they have limited income and assets.

Previous federal law gives the Secretary authority to waive selected Medicaid and Medicare requirements, as well as approve waivers to reach individuals who otherwise would be ineligible for Medicaid. 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.

PPACA authorizes the Secretary to initially approve Medicaid waivers for up to five years. This authority applies 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 Secretary has authority to approve Medicaid waiver extensions for additional five-year periods when requested by states, unless the waivers did not meet the conditions for the previous period, or the waiver was no longer cost effective, efficient, or consistent with Medicaid policy.

Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries

(P.L. 111-148: §2602)

There are no specific requirements under previous Medicare and Medicaid law or regulations for the programs to coordinate care for dual eligible individuals. PPACA requires the Secretary to establish a federal coordinated health care office (CHCO) within CMS by March 1, 2010. CMS's Administrator will appoint the CHCO director, who also will report to the CMS Administrator. The CHCO's purpose is to "bring together" Medicare and Medicaid program staff at CMS for purpose of (1) integrating benefits and (2) improving care coordination for dual eligible beneficiaries. The CHCO established under PPACA has 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 care 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.

PPACA also assigns the CHCO the following specific responsibilities:

1. to provide states, specialized Medicare Advantage plans for special needs individuals—special needs plans, physicians, and other entities or individuals qualified to develop programs, with the education and tools necessary to develop programs that align benefits for duals under Medicare and Medicaid;
2. to support state efforts to coordinate contracting and oversight by states and CMS on the integration of Medicare and Medicaid programs consistent with CHCO goals;
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.

Under PPACA, the Secretary is required to submit a report to Congress under the annual budget transmittal. The report is required to contain recommendations for legislation that could improve care coordination and benefits for dual eligible individuals.

Adult Health Quality Measures

(P.L. 111-148: §2701)

P.L. 111-148 adds a federal initiative to collect and report quality of care data for adults enrolled in Medicaid. Among several activities, the Secretary will 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 is 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, is required to develop a standardized format for reporting information based on this initial core measurement set. States will 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 is 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 is required to establish a Medicaid Quality Measurement Program (MQMP). To this end, the Secretary is 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 is 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. P.L. 111-148 does not restrict coverage under Medicaid or CHIP to only those services that are evidence-based.

The new law 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 will 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, P.L. 111-148 appropriates $60 million for each of fiscal years 2010 through 2014. These funds will remain available until expended.

MACPAC Assessment of Policies Affecting All Medicaid Beneficiaries

(P.L. 111-148: §2801, and §10607)

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.

P.L. 111-148 makes 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 will 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 will be required to review and assess 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 is also required to report to Congress on any Medicaid and CHIP regulations that affect access, quality and efficiency of health care.

MACPAC must also conduct an independent review of the alternatives to current tort litigation under new state demonstration grants established for this purpose under this new law. This review will assess the impact of such alternatives on the Medicaid and CHIP programs and their

beneficiaries, including an analysis of the impact of these alternatives on the efficiency and effectiveness of these two programs. A report on these tort reform activities, including findings and recommendations, is due to Congress no later than December 31, 2016.

In carrying out its duties, MACPAC is authorized to obtain necessary data from any state agency responsible for administering Medicaid or CHIP. The provision of these state data is a condition for receiving federal matching funds under either program. P.L. 111-148 requires MACPAC to seek state input and review state data, and to consider state information in its recommendations and reports. Both MACPAC and MedPAC are required to coordinate and consult with the Federal Coordinated Health Care Office (established under §2081 of this new law) 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, P.L. 111-148 appropriates $11 million for MACPAC. Of this total, $9 million will come from the Treasury out of any funds not otherwise appropriated, and $2 million will come from FY2010 CHIP funds, and will remain available until expended. Funding in subsequent years is not addressed in this provision. This provision is effective upon enactment.

Protections for American Indians and Alaska Natives

(P.L. 111-148: §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. Facilities are permitted to retain these reimbursements and use them to increase available services.[45] Prior to PPACA, IHS, an IT, or a TO was only considered the payor of last resort for contract health services—services that these facilities purchase through contract, with providers in instances where the facility or program cannot provide the needed care. PPACA designates programs operated by IHS, an IT, TO, or an urban Indian organization (UIO) as the payer of last resort for services provided to eligible American Indians and Alaska Natives, including services covered by Medicaid and CHIP. IHS funds are limited and tribal members have raised concerns about which program is considered the payor of last resort.[46] This provision will clarify such issues, and, as a result, may provide additional funding to programs operated by the IHS, ITs, TOs, or UIOs.

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

[45] CRS Report R41152, *Indian Health Care Improvement Act Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Elayne J. Heisler and Roger Walke. PPACA makes a number of changes to health care provided by IHS, ITs, and TOs within the Indian Health Care Improvement provisions within the bill. Provisions described in this report may also relate to these facilities receiving reimbursements from Medicaid and CHIP.

[46] U.S. Congress, Senate Committee on Indian Affairs, OVERSIGHT HEARING on Promises Made, Promises Broken: The Impact of Chronic Underfunding of Contract Health Services, 111th Cong., 1st sess., December 3, 2009. See statement by Connie Whidden, Health Director, Seminole Tribe of Florida.

Assistance for Needy Families, Medicaid, CHIP, and food stamps); however, IHS, ITs, TOs, and UIOs were not among the specified "Express Lane" agencies in CHIPRA. American Indians and Alaska Natives face a number of barriers to enrolling in Medicaid and CHIP. GAO found that some tribes have the ability to determine Medicaid eligibility for some of their tribal members, which can facilitate Medicaid enrollment.[47] PPACA permits IHS, ITs, TOs, and UIOs to serve as "Express Lane" agencies; this may increase Medicaid and CHIP enrollment among American Indians and Alaska Natives.

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. PPACA also prohibits cost-sharing for American Indians and Alaska Natives enrolled in a qualified health plan offered through the newly established exchanges. American Indians and Alaska Natives are not charged for services provided by IHS, an IT, or a TO.[48] Given this, there may be few incentives to enroll in a private health insurance plan that charges premiums or copayments. This exclusion should facilitate American Indian and Alaska Native enrollment in private health insurance offered through the exchanges.[49]

Establishment of Center for Medicare and Medicaid Innovation within CMS

(P.L. 111-148: §3021 as modified by §10306)

Under Medicaid and Medicaid law, the Secretary has broad authority to develop research and demonstration projects that test new approaches to paying providers, deliver health care services, or provide benefits to Medicare and Medicaid beneficiaries. This section of PPACA requires the Secretary to establish a CMI within CMS by January 1, 2011. The CMI is to 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 is 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 is 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 include dual eligibles. Under PPACA, the Secretary has authority to limit the testing of models to selected geographic areas.

Further, the Secretary is required to conduct an evaluation of each model tested, and make the results of these evaluations available publicly. PPACA authorizes an appropriation of $5 million for the design, implementation, and evaluation of models for FY2010; $10 billion for FY2011

[47] U.S. Government Accountability Office, *Medicare and Medicaid: CMS and State Efforts to Interact with the Indian Health Service and Indian Tribes* , 08-724, July 11, 2008.

[48] Ibid. UIOs may charge copayments, and PPACA permits ITs and TOs to charge some copayments. See *Indian Health Care Improvement Act Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)*, by Elayne J. Heisler and Roger Walke.

[49] See CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind et al., for description of the exchanges.

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 is required to submit a report to Congress on the CMI.

GAO Study and Report on Causes of Action

(P.L. 111-148: §3512)

Under this provision, GAO is required to conduct a study to determine if the development, recognition, or implementation of guidelines or other standards under selected provisions in the law might result in new causes of action or claims. The GAO study will include three Medicaid-related and 11 other non-Medicaid related provisions in the law as shown in **Table 2**.

Table 2. Law 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: PPACA, Titles II, III, and IV, Strengthening Quality, Affordable Health Care for All Americans.

GAO is required to submit the study on causes of action to appropriate congressional committees within two years of enactment of PPACA (March 23, 2012).

Public Awareness of Preventive and Obesity-Related Services

(P.L. 111-148: §4004(i))

Health reform law requires 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 will be required to design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services. The Secretary is 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 authorizes to be appropriated such sums as necessary to carry out these activities.

Section 1115 Waiver Transparency

(P.L. 111-148: §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 Medicaid and 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).

Health reform law imposes 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 is 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 is in compliance with SSA Titles XIX and 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 is required to submit an annual report to Congress concerning actions taken by the Secretary with respect to applications for demonstration projects under this section.

Appendix. Statutory References for Medicaid and CHIP provisions

Tables A-1 through A-7 track statutory changes made to the Social Security Act by titles II, IV, VI, and X in P.L. 111-148 followed by changes made in P.L. 111-152. The provision descriptions in the tables are grouped by subject matter into the following categories: eligibility, benefits, financing, program integrity, demonstrations and grant funding, CHIP and miscellaneous.

Table A-1. Health Reform Law: Statutory References for Medicaid Changes to Eligibility

Provision	P.L. 111-148		P.L. 111-152
	Title II, Amendments to SSA	Title X, Amendments to Title II	Amendments to P.L. 111-148
Medicaid Coverage for the Lowest-Income Populations	Sec. 2001	Sec. 10201	Sec. 1004 and Sec. 1201
Financial Eligibility Requirements for 'Newly Eligible' and Other Non-Elderly Populations Determined Using Modified Adjusted Gross Income (MAGI)	Sec. 2001	Sec. 10201	Sec. 1004
Financial Eligibility Requirements for Certain Populations Eligible Under Prior Law	Sec. 2001 and Sec. 2002	Sec. 10201	n/a
Medicaid Benefit Coverage for The New Mandatory Eligibility Group	Sec. 2001	Sec. 10201	n/a
Maintenance of Medicaid Income Eligibility (MOE)	Sec. 2001	Sec. 10201	n/a
Medicaid Coverage for Former Foster Care Children	Sec. 2004	Sec. 10201	n/a
Health Care Power of Attorney	Sec. 2955	n/a	n/a
Protection for Recipients of Home- and Community-Based Services Against Spousal Impoverishment	Sec. 2404	n/a	n/a

Provision	P.L. 111-148		P.L. 111-152
	Title II, Amendments to SSA	Title X, Amendments to Title II	Amendments to P.L. 111-148
Optional Expansion: Non-Elderly, Non-Pregnant Individuals with Family Income Above 133% of the FPL	Sec. 2001	Sec. 10201	n/a
Optional Expansion: State Eligibility Option for Family Planning Services	Sec. 2303	n/a	n/a
Optional Expansion: Removal of Barriers to Providing Home- and Community- Based Services	Sec. 2402	n/a	n/a
Outreach and Enrollment Facilitation: Streamlining Procedures for Enrollment Through a Health Insurance Exchange and Medicaid, CHIP, and Other Health Subsidy Programs	Sec. 1413	n/a	n/a
Outreach and Enrollment Facilitation: Enrollment Simplification and Coordination with State Health Insurance Exchanges	Sec. 2202	n/a	n/a
Outreach and Enrollment Facilitation: Permitting Hospitals to Make Presumptive Eligibility Determinations for All Medicaid Eligible Populations	Sec. 2202	n/a	n/a
Outreach and Enrollment Facilitation: Standard and Best Practices to Improve Enrollment of Vulnerable and Undeserved Populations	Sec. 2201	n/a	n/a
Outreach and Enrollment Facilitation: New Reporting Requirements	Sec. 2001	Sec.10201	n/a

Source: Prepared by CRS based on provisions in P.L. 111-148, as amended by P.L. 111-152.

Table A-2. Health Reform Law: Statutory References for Medicaid Changes to Benefits

Provision	P.L. 111-148		P.L. 111-152
	Title II, IV, Amendments to SSA	Title X, Amendments to Title II, IV	Amendments to P.L. 111-148
Modifications to DRA Benchmark and Benchmark-Equivalent Coverage	Sec. 2001(c)	n/a	n/a
Premium Assistance	Sec. 2003	Sec. 10203(b)	n/a
Birthing Centers	Sec. 2301	n/a	n/a
Smoking Cessation Services for Pregnant Women	Sec. 4107	n/a	n/a
Adult Preventive Care	Sec. 4106	n/a	n/.a
Scope of Coverage for Children Receiving Hospice Care	Sec. 2302	n/a	n/a
Community First Choice Option	Sec. 2401	n/a	n/a
State Option to Provide Health Homes for Enrollees with Chronic Conditions	Sec. 2703	n/a	n/a
Changes to Existing Medicaid Benefits: Removal of Barriers to providing Home- and Community- Based Services	Sec. 2402	n/a	n/a
Changes to Existing Medicaid Benefits: Clarification of the Definition of Medical Assistance	Sec. 2304	n/a	n/a

Source: Prepared by CRS based on provisions in P.L. 111-148, as amended by P.L. 111-152.

Table A-3. Health Reform Law: Statutory References for Medicaid Changes to Financing

Provision	P.L. 111-148		P.L. 111-152
	Title II, Amendments to SSA	Title X, Amendments to Title II	Amendments to P.L. 111-148
Payments to States: Additional Federal Financial Assistance Under Health Reform	Sec. 2001	Sec. 10201	Sec. 1201 and Sec. 1202
Payments to States: Incentives for States to Offer Home and Community-Based Services as Long-Term Care Alternative to Nursing Homes	n/a	Sec. 10202	n/a
Payments to States: Disproportionate Share Hospital Payments	Sec. 2551	Sec.10201(e)	Sec. 1203
Payments to States: Special FMAP Adjustment for States Recovering from a Major Disaster	Sec. 2006	n/a	n/a
Payments to The Territories	Sec. 2005	Sec. 10201	Sec. 1204
Payments for Primary Care Providers	n/a	n/a	Sec. 1202
Payments to Providers for Health Care- Acquired Conditions	Sec. 2702	n/a	n/a
Prescription Drugs: Prescription Drug Rebates	Sec. 2501	n/a	n/a
Prescription Drugs: Elimination of Exclusion of Coverage of Certain Drugs	Sec. 2502	n/a	n/a
Prescription Drugs: Providing Adequate Pharmacy Reimbursement	Sec. 2503	n/a	n/a
Prescription Drugs: 340B Prescription Drug Discount Program Expansion	Sec. 7101-7103	n/a	Sec. 2302

Source: Prepared by CRS based on provisions in P.L. 111-148, as amended by P.L. 111-152.

Table A-4. Health Reform Law: Statutory References for CHIP and Medicaid Changes to Program Integrity

Provision	P.L. 111-148		P.L. 111-152
	Title VI, Amendments to SSA	Title X, Amendments to Title VI	Amendments to P.L. 111-148
Expansion of the Recovery Audit Contractor (RAC) Program	Sec. 6411	n/a	n/a
Termination of Provider Participation Under Medicaid of Other State Health Care Program	Sec. 6501	n/a	n/a
Medicaid Exclusion from Participation Relating to Certain Ownership, Control, and Management Affiliations	Sec. 6502	n/a	n/a
Billing Agents, Clearinghouses, or Other Alternate Payees Required to Register Under Medicaid	Sec. 6503	n/a	n/a
Requirement to Report Expanded Set of Data Elements Under MMIS to Detect Fraud and Abuse	Sec. 6504	n/a	n/a
Prohibition on Payments to Institutions or Entities Located Outside of the United Sates	Sec. 6505	n/a	n/a
Overpayments	Sec. 6506	n/a	n/a
Mandatory State Use of National Correct Coding Initiatives	Sec. 6507	n/a	n/a
General Effective Date for Medicaid and CHIP Program Integrity Activities	Sec. 6508	n/a	n/a
Other Program Integrity and Related Provisions Applicable to Medicaid: Provider Screening and Other Enrollment Requirements under Medicare, Medicaid and CHIP	Sec. 6401	Sec. 10603	n/a
Other Program Integrity and Related Provisions Applicable to Medicaid: Enhanced Medicare and Medicaid Program Integrity Provisions	Sec. 6402	n/a	Sec. 1302
Other Program Integrity and Related Provisions Applicable to Medicaid: Improving Nursing Home Transparency, Enforcement and Staff Training	Sec. 6101-6107 Sec. 6111-6114 Sec. 6121	n/a	n/a

Source: Prepared by CRS based on provisions in P.L. 111-148, as amended by P.L. 111-152.

Table A-5. Health Reform Law: Statutory References for Medicaid Changes to Demonstrations and Grant Funding

Provision	P.L. 111-148		P.L. 111-152
	Title II, IV, Amendments to SSA	Title X, Amendments to Title II, IV	Amendments to P.L. 111-148
Money Follows the Person	Sec. 2403	n/a	n/a
Demonstration Project to Evaluate Integrated Care Around Hospitalization	Sec. 2704	n/a	n/a
Medicaid Global Payment System Demonstration Project	Sec. 2705	n/a	n/a
Pediatric Accountable Care Organization Demonstration Project	Sec. 2706	n/a	n/a
Medicaid Emergency Psychiatric Demonstration Project	Sec. 2707	n/a	n/a
Grants for School-Based Health Centers	Sec. 4104(a)	n/a	n/a
Grants for Prevention of Chronic Disease	Sec. 4108	n/a	n/a
Funding of Childhood Obesity Demonstration Project	Sec. 4306	n/a	n/a

Source: Prepared by CRS based on provisions in P.L. 111-148, as amended by P.L. 111-152.

Table A-6. Health Reform Law: Statutory References for Changes to CHIP

Provision	P.L. 111-148		P.L. 111-152
	Title II, Amendments to SSA	Title X, Amendments to Title II	Amendments to P.L. 111-148
Additional Federal Financing Participation for CHIP	Sec. 2101	Sec. 10203(c)	n/a
Distribution of CHIP allotments Among States	Sec. 2101	Sec. 10203(d)	n/a
Extension of Funding for CHIP Through FY2015 and Other Related Provisions	n/a	Sec. 10203(a) Sec. 10203(b) Sec. 10202(d)	n/a

Source: Prepared by CRS based on provisions in P.L. 111-148, as amended by P.L. 111-152.

Table A-7. Health Reform Law: Statutory References for Miscellaneous Changes to Medicaid

Provision	P.L. 111-148		P.L. 111-152
	Title II, Amendments to SSA	Title X, Amendments to Title II	Amendments to P.L. 111-148
Medicaid Improvement Fund Rescission	Sec. 2007	n/a	n/a
Removal of Barriers to Providing Home- and Community- Based Services	Sec. 2402	n/a	n/a
Funding to Expand State Aging and Disability Resource Centers	Sec. 2405	n/a	n/a
Sense of the Senate Regarding Long-Term Care	Sec. 2406	n/a	n/a
Five-Year Period for [Dual Eligible] Demonstration Projects	Sec. 2601	n/a	n/a
Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries	Sec. 2602	n/a	n/a
Adult Health Quality Measures	Sec. 2701	n/a	n/a
MACPAC Assessment of Policies Affecting All Medicaid Beneficiaries	Sec. 2801 Sec. 399V-4	n/a	n/a
Protections for American Indians and Alaska Natives	Sec. 2901	n/a	n/a
Establishment of Center for Medicare and Medicaid Innovation within CMS	Sec. 3021	Sec. 10306	n/a
GAO Study and Report on Causes of Action	Sec. 3512	Sec. 3512	n/a
Public Awareness of Preventive and Obesity-Related Services	Sec. 4004(i)	n/a	n/a
Section 1115 Waiver Transparency	n/a	Sec. 10201	n/a

Source: Prepared by CRS based on provisions in P.L. 111-148, as amended by P.L. 111-152.

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