



Medicaid and CHIP: Changes Made by the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152) to the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148)

Evelyne P. Baumrucker, Coordinator
Analyst in Health Care Financing

Cliff Binder, Coordinator
Analyst in Health Care Financing

Julie Stone
Specialist in Health Care Financing

Elicia J. Herz
Specialist in Health Care Financing

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Summary

On March 23, 2010, the President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148), as passed by the Senate on December 24, 2009, and the House on March 21, 2010. PPACA will, among other changes, modify Medicaid and the Children's Health Insurance Program (CHIP) statutes. In addition, on March 21, 2010, the House passed an amendment in the nature of a substitute to H.R. 4872, the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152). After being passed by the House, HCERA was subsequently amended and passed by the Senate before being approved again by the House on March 25, 2010. HCERA was signed by the President on March 30, 2010. HCERA, which amends PPACA, combined with PPACA form the health care reform law.

HCERA includes the following 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 HCERA to PPACA. 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, which include other changes to PPACA.

This report provides a brief summary of PPACA followed by a discussion of the modifications made to the Medicaid and CHIP provisions by HCERA. This report reflects legislative language in HCERA as passed by the House on March 25, 2010. Selected highlights of the Medicaid and CHIP amendments made by HCERA to PPACA include the following:

- primary care physician payment rates for selected patient treatments were increased;
- the definition of the average manufacturer price (AMP) was revised to help make AMP more closely reflect manufacturers' average prices;
- the effective date of the Community First Choice Option was delayed;
- state FMAP rates for newly eligible populations were changed, as were income counting rules for certain populations;
- the territories' spending rate caps were increased beginning with the second quarter of FY2011;
- additional program integrity funding was provided through indexing of the Medicaid Integrity Program for fiscal years beginning with FY2010; and
- Medicaid Disproportionate Share Hospital (DSH) payment reductions were modified.

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Background

On March 23, 2010, the President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as passed by the Senate on December 24, 2009, and the House on March 21, 2010. PPACA, among other changes, modified Medicaid and the Children's Health Insurance Program (CHIP) statutes. On March 21, 2010, the House passed an amendment in the nature of a substitute to H.R. 4872, the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152). After being passed by the House, HCERA was subsequently amended and passed by the Senate before being approved again by the House on March 25, 2010. HCERA was signed by the President on March 30, 2010. HCERA, which amends PPACA, combined with PPACA to form the health care reform law.

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The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JTC) issued a revised cost estimate on March 20, 2010, for enacting both H.R. 3590 (now PPACA) and HCERA with a manager's amendment. CBO estimated that PPACA and HCERA together will reduce federal budgets deficits by \$143 billion over the 2010-2019 period as a result of changes in direct spending and revenue. CBO's \$143 billion estimate is composed of \$124 billion in expenditure reductions and revenue from health care provisions and \$19 billion in spending reductions from education.¹ CBO previously had issued a preliminary cost estimate for PPACA and HCERA. In CBO's preliminary estimate, PPACA and HCERA would have reduced federal deficits by \$138 billion (for health care and education) over the 2010-2019 period.² CBO and JTC previously estimated that H.R. 3590 by itself would yield a net reduction in federal deficits of \$118 billion over the 2010-2019 period.³

This report provides a brief summary of PPACA followed by a discussion of the modifications made by HCERA to the Medicaid and CHIP provisions in PPACA.

Summary of PPACA

PPACA consists of 10 titles that cover a variety of topics. In general, this law extends health insurance coverage to many currently uninsured Americans. It also has provisions to reduce expenditures, increase care coordination, encourage more use of health prevention, and improve quality of care. PPACA will reform the private health insurance market, impose a mandate for most legal U.S. residents to obtain health insurance, establish health insurance "Exchanges" that

¹ Congressional Budget Office, letter to Honorable Nancy Pelosi, March 20, 2010, available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager'sAmendmenttoReconciliationProposal.pdf>.

² Congressional Budget Office, letter to the Honorable Nancy Pelosi, March 18, 2010, available at <http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf>.

³ 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.

will subsidize health insurance coverage for eligible individuals; expand Medicaid eligibility; address healthcare workforce issues; and implement a number of other Medicaid and Medicare program and federal tax code changes. Key Medicaid and CHIP provisions in PPACA are summarized below.

- *Eligibility-related reforms.* PPACA will require 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 who is not currently eligible for Medicaid (low income childless adults), but also raises Medicaid's mandatory income eligibility level for certain existing groups from 100% to 133% of the FPL.
- *Maintenance of effort provisions.* PPACA will require states to maintain current Medicaid and CHIP coverage levels—through 2013 for adults and 2019 for children.
- *Outreach and enrollment provisions.* PPACA includes provisions to encourage states to improve outreach, streamline enrollment, and coordinate with the proposed American Health Benefit Exchanges (Exchange).⁴
- *Benefit reforms.* PPACA will add new mandatory and optional benefits to Medicaid. Such mandatory benefits include premium assistance for employer-sponsored health insurance, 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.
- *Financing reforms.* PPACA introduces measures to reduce the growth of Medicaid expenditures and increases federal matching payments for the eligibility expansions.
- *Cost control reforms.* Some of the PPACA's cost control measures include (1) proposed reductions in Medicaid disproportionate share hospital (DSH) payments, (2) expenditure reductions for prescription drugs, and (3) payment reforms to reduce inappropriate hospital expenditures for health care-acquired conditions.
- *Program integrity reforms.* PPACA 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.
- *Nursing home accountability.* PPACA adds a number of requirements to improve the transparency of information within facilities and chains, as well as provides long-term care (LTC) consumers with information on the quality and performance of nursing homes.

⁴ For a description of the Exchange, see CRS Report R40942, *Private Health Insurance Provisions in Senate-Passed H.R. 3590, the Patient Protection and Affordable Care Act*, by Hinda Chaikind et al.

- *Demonstrations, pilot programs, and grants.* PPACA will provide the Secretary of the Department of Health and Human Services (the Secretary) and state Medicaid and CHIP programs with opportunities to test models for improving the delivery, quality, and payment of services.
- *CHIP-related provisions.* PPACA requires states to maintain the current CHIP structure through FY2019, but does not provide federal CHIP appropriations beyond FY2013.
- *Miscellaneous Medicaid and CHIP reforms.* PPACA 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.

Medicaid and CHIP Modifications to PPACA by HCERA

The health care-related provisions in Title I of the HCERA modifies selected provisions in PPACA. What follows is a brief discussion of these Medicaid and CHIP-related changes. Each section contains a brief description of existing Medicaid law and related background, an explanation of the provision in PPACA, and a discussion of the changes enacted under HCERA.

Federal Funding for the States

To qualify for Medicaid, 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. Generally, Medicaid's financial 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. Of the approximately 50 different eligibility "pathways" into Medicaid, some are mandatory while others may be covered at state option.

The federal government's share of Medicaid costs is determined by a formula in statute. This formula, referred to as the federal medical assistance percentage (FMAP), provides higher reimbursement to states with lower per capita income relative to the national average (and vice versa). FMAPs have a statutory minimum of 50% and a maximum of 83%, although some Medicaid services receive a higher federal match rate. In February 2009, with the passage of the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5), states received temporary enhanced FMAP rates for nine fiscal quarters beginning with the first quarter of FY2009 and running through the first quarter of FY2011 (December 31, 2010).

Subject to specified requirements, PPACA requires states to make eligible for Medicaid qualifying individuals with income up to 133% of the FPL beginning in 2014, among other mandatory expansions. Under this law, “newly eligible” individuals will be defined as non-elderly, non-pregnant individuals (e.g., childless adults, and certain parents), who are otherwise ineligible for Medicaid under prior law.⁵ As a conforming measure, PPACA also will change the mandatory Medicaid income eligibility level for children age 6 to 19 from 100% FPL to 133% FPL (as previously applied to children under age 6). Income eligibility for individuals in the “newly eligible” population, other non-elderly individuals eligible under prior law (subject to certain exceptions), and certain CHIP eligible individuals will be based on modified gross income (MGI), or in the case of families, the household income. “Newly eligible” individuals will receive either benchmark or benchmark-equivalent coverage consistent with the requirements of Section 1937 of the Social Security Act (SSA)—excluding the “newly eligible” who meet the definition of exempted populations under this section, such as blind or disabled persons, and hospice patients, for example.

Under PPACA, states will receive 100% FMAP for the cost of care provided to “newly eligible” populations, from 2014 through 2016. Beginning in 2017, all states except Nebraska will have an FMAP lower than 100% for “newly eligibles” and will be grouped in the following two categories: (1) expansion states (those that, as of December 1, 2009, had statewide Medicaid coverage⁶ for parents and childless adults up to 100% FPL); and (2) non-expansion states. Subject to a ceiling of 95%, for “newly eligible beneficiaries,” expansion states will receive a 30.3 percentage point increase over their regular FMAP for 2017, a 31.3 percentage point increase over their regular FMAP for 2018, and a 32.3 percentage point increase for 2019, and thereafter. (See **Table 1** for a summary of these annual federal financial participation rates for new eligibles under PPACA and HCERA.)

Expansion states that do *not* get any additional FMAP (because no individuals qualified as “newly eligible” due to the states’ prior Medicaid expansions), and that had not been granted a Secretary-approved diversion of DSH payments toward Medicaid coverage (effective in July 2009) will receive a 2.2 percentage point increase to their regular FMAP for existing Medicaid eligibility groups, between January 1, 2014, and September 30, 2019. Finally, under PPACA, between January 1, 2014, and December 31, 2016, a state can receive a 0.5 percentage point increase to its regular FMAP rate for existing Medicaid eligibility groups if the following two conditions are met: (1) it is a state that did *not* get any additional FMAP (because no individuals qualify as “newly eligible” due to the state’s prior Medicaid expansions); and (2) it ranked as the state with the highest percentage of insured individuals in 2008 based on the Current Population Survey (CPS) (i.e., Massachusetts).

HCERA (Sec. 1201-1202) makes the following modifications to the financing portion of the eligibility provisions in PPACA:⁷

⁵ Like the House health reform bill (H.R. 3962), PPACA will not extend Medicaid eligibility to those also eligible for or enrolled in the Medicare program.

⁶ To be considered an “expansion state,” this Medicaid coverage must include inpatient hospital services and can not be limited to only the following benefits: premium assistance (or Medicaid coverage otherwise dependent on employer coverage or contribution), hospital-only plans, high-deductible health plans or Health Opportunity Accounts.

⁷ Federal financial participation for some of the benefit-related provisions under PPACA (e.g., Adult Preventive Care) are tied to the FMAP rates states would receive for “newly eligible” populations. Federal financial participation for these provisions would also be impacted by the proposed changes to the FMAP rates for “Newly Eligible” populations under the reconciliation bill.

- FMAP rates for the cost of care provided to “newly eligible” populations for *all* states (i.e., expansion and non-expansion states) would be equal to 100% in 2014-2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and beyond (see **Table 1**).
- The provision in PPACA that provides the state of Nebraska with a permanent FMAP rate of 100% for “newly eligibles” was repealed.
- The length of time that specified expansion states would receive a 2.2 percentage point increase to their regular FMAP for existing Medicaid eligibility groups, was shortened from January 1, 2014, through September 30, 2019, to January 1, 2014, through December 31, 2015.
- The Massachusetts-specific 0.5 percentage point increase in FMAP for the period between January 1, 2014, and December 31, 2016 was repealed.
- Expansion states will receive an increase above their regular FMAP rate for the cost of care provided to currently eligible childless adults. The amount of the increase will be a certain percentage (i.e., a transition percentage)⁸ of the difference between the state’s regular FMAP and the FMAP it received for “newly eligibles” (see **Table 1**).

Table 1. FMAP Rates for Required Medicaid Expansions to Newly Eligible Populations Under PPACA and HCERA; FYs 2013-2020

	2013	2014	2015	2016	2017	2018	2019	2020+
PPACA								
Expansion States	NA	100%	100%	100%	FMAP+30.3 (80.3%-95%)	FMAP+31.3 (81.3%-95%)	FMAP+32.3 (82.3%-95%)	FMAP+32.3 (82.3%-95%)
Non-expansion states	NA	100%	100%	100%	FMAP+34.3 (84.3%-95%)	FMAP+33.3 (83.3%-95%)	FMAP+32.3 (82.3%-95%)	FMAP+32.3 (82.3%-95%)
Nebraska	NA	100%	100%	100%	100%	100%	100%	100%
HCERA								
All states	NA	100%	100%	100%	95%	94%	93%	90%
Previously eligible childless adults in expansion states	NA	FMAP+ transition percentage (75%-95%)	FMAP+ transition percentage (80%-92%)	FMAP+ transition percentage (85%-94%)	FMAP+ transition percentage (86%-92%)	FMAP+ transition percentage (90%-92.6%)	FMAP+ transition percentage (93%)	FMAP+ transition percentage (90%)

Source: Table prepared by CRS Specialist in Health Care Financing, Chris L. Peterson, based on provisions in PPACA and HCERA.

Notes: “NA” means not applicable because the mandatory expansions will not take effect under PPACA or HCERA until 2014. FMAP under PPACA refers to the regular Medicaid matching percentage as typically calculated, with additional percentage points as shown, subject to a 95% cap on the FMAP (not shown). For example, in FY2017 the FMAP rate for costs associated with “newly eligible” individuals in an expansion state

⁸ The reconciliation bill defines the transition percentage as 50% in 2014, 60% in 2015, 70% in 2016, 80% in 2017, 90% in 2018, and 100% thereafter.

with a regular FMAP rate of 54% will be increased by 30.3 percentage points for a new FMAP rate of 84.3%. The FMAP ranges (in parentheses) under PPACA and HCERA represent the potential FMAP rate based on regular FMAPs ranging from the statutory minimum (50%) to 80%. 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.

Income Definitions

Generally, Medicaid’s financial 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, certain income disregards (i.e., expenses such as child care costs or block of income disregards where a specified portion of family income is not counted), and assets or resource tests will no longer apply when assessing an individual’s income to determine financial eligibility for Medicaid. Instead, income eligibility for newly eligible individuals, non-elderly individuals eligible under prior law (subject to certain exceptions), as well as certain CHIP eligible individuals will be based on Modified Gross Income (MGI), or in the case of an individual in a family greater than one, the household income of such family.⁹ MGI and household income will also be used to determine applicable premium and cost-sharing amounts under the state plan or waiver. MGI is defined as gross income decreased by trade and business deductions, losses from sale of property, and alimony payments, but including tax-exempt interest and income earned in the territories and by U.S. citizens or residents living abroad. Medicaid enrollees who otherwise would lose coverage because of the change in income-counting will be able to maintain eligibility.

Under HCERA (Sec. 1004), income eligibility for newly eligible individuals, non-elderly individuals eligible under prior law (subject to certain exceptions), as well as certain CHIP eligible individuals will be based on modified adjusted gross income (MAGI),¹⁰ or in the case of an individual in a family greater than one, the household income of such family. MAGI and household income will also be used to determine applicable premium and cost-sharing amounts under the state plan or waiver.

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.

⁹ MGI and household income would also be used for determining the amount of premium credit assistance for the purchase of a qualified health benefits plan under state exchanges, described in Section 1401 of the Senate bill. For more information on MGI and household income see CRS Report R40942, *Private Health Insurance Provisions in Senate-Passed H.R. 3590, the Patient Protection and Affordable Care Act*, by Hinda Chaikind et al.

¹⁰ MAGI and household income would also be used for determining the amount of premium credit assistance for the purchase of a qualified health benefits plan under state exchanges, as described in Section 1401 of the Senate bill. For more information on MAGI and household income, see CRS Report R40942, *Private Health Insurance Provisions in Senate-Passed H.R. 3590, the Patient Protection and Affordable Care Act*, by Hinda Chaikind et al.

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 bill (Sec. 1004(e)) will require 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.

Payments to Primary Care Providers

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

PPACA 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. HCERA (Sec. 1202) will add similar language to PPACA. States will be required to set Medicaid payments for primary care services (i.e., evaluation and management or 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 that will be applicable).

With respect to Medicaid managed care, the bill also will require 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%.

Disproportionate Share Hospital Payments

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. In claiming federal matching dollars, states cannot exceed their state-specific allotment amounts, calculated for each state based on a statutory formula. 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 determining federal DSH 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.

PPACA reduces federal DSH allotments to states based on changes (reductions) in state-specific uninsurance rates over time. State DSH allotments will remain intact as under current law until a state uninsurance level is reached. This level will be initially reached the first fiscal year after FY2012 for which a state’s uninsured rate, as measured by the Census Bureau’s American Community Survey, decreases by at least 45%, compared to an initial baseline uninsured rate for FY2009. Once this level is reached, reductions in DSH allotments will depend on a state’s status as a low DSH state and spending patterns in comparison to a benchmark (over or under 99.90% of the state’s average DSH allotments) during a base five-year period (FY2004 through FY2008).

These reductions will be 17.5% (over the spending benchmark) or 25% (under the spending benchmark) for low DSH states versus 35% (over the spending benchmark) or 50% (under the spending benchmark) for all other states. For subsequent years, if a state’s uninsurance rate decreases further, the state’s DSH allotment will be further reduced, again depending on a state’s status as a low DSH state and its spending patterns during the base five-year period. In general, these reductions will be equal to the product of the percentage reduction in uncovered individuals and 20% (over the spending benchmark) or 27.5% (under the spending benchmark) for low DSH states versus 40% (over the spending benchmark) or 55% (under the spending benchmark) for all other states.

For FY2013 forward, in no case will a state’s DSH allotment be less than 50% of the state’s FY2012 allotment, increased by the percentage change in the CPI-U for each previous year occurring before the fiscal year. **Table 2** summarizes the DSH provisions in PPACA.

Table 2. DSH Provisions in P.L. 111-148

Trigger Year of DSH Allotment Changes	DSH Allotment Reductions by Type of State (Based on Spending Patterns)	
When a state’s rate of uninsurance decreases by at least 45% compared to its 2009 rate, then:	States with annual DSH spending of >99.90% of average DSH spending for FY2004-FY2008	States with annual DSH spending <=99.90% of average DSH spending for FY2004-FY2008
First Fiscal Year After FY2012		
Low DSH States	(DSH Allotment)*(17.5%)	(DSH Allotment)*(25%)
All Other States	(DSH Allotment)*(35%)	(DSH Allotment)*(50%)
Subsequent Years		
Low DSH States	(Reduced DSH Allotment) * (% Annual Reduction in Uninsured)*(20%)	(Reduced DSH Allotment) * (% Annual Reduction in Uninsured)*(27.5%)

Trigger Year of DSH Allotment Changes	DSH Allotment Reductions by Type of State (Based on Spending Patterns)	
All Other States	(Reduced DSH Allotment) * (% Annual Reduction in Uninsured)*(40%)	(Reduced DSH Allotment) * (% Annual Reduction in Uninsured)*(55%)

Notes: For FY2013 forward, in no case would a state's DSH allocation be less than 50% of the state's FY2012 DSH allotment (increased by the CPI-U for each previous fiscal year). "*" means "multiplied by."

Under HCERA, the provision (Sec. 1203) strikes the language in PPACA and requires the Secretary to make aggregate reductions in Medicaid DSH allotments that would equal \$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 Section 1115 as of July 31, 2009.

For each fiscal year, these reductions in DSH allotments will be applied on a quarterly basis. 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.

Funding for the Territories

The federal share for most Medicaid service costs is determined by the FMAP, which is based on a formula that provides higher reimbursement to states with lower per capita income relative to the national average (and vice versa). FMAPs have a statutory minimum of 50% and maximum of 83%. In the territories, the FMAP is typically set at 50%.

Medicaid programs in the five territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands) are subject to annual federal spending caps that are set in statute. The Congress has increased the levels of federal Medicaid funding in the territories in recent years. For FY2008 and subsequent fiscal years, the total annual cap on federal funding for the Medicaid programs in the territories is calculated by increasing the FY2007 ceiling for inflation. The territories also benefited from a temporary 30% increase in their Medicaid spending caps as a result of the FMAP assistance provided under ARRA.

The territories also have access to other sources of federal matching funds; for example, they may be eligible for enhanced federal match (90% or 75%) that is available under Medicaid for improvements in data reporting systems. Beginning with FY2009, funds spent on specified administrative activities will not count against the Medicaid caps.

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

HCERA (Sec. 1204) strikes the Medicaid provisions related to payment of the territories in PPACA, and permits territories to establish an Exchange (in accordance with the Exchange-related provisions also included 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 territory to obtain health insurance coverage through the Exchange. 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 an Exchange. 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.

Also under HCERA, territories that do *not* elect to establish an Exchange 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 dollars in total additional payments are available for distribution among each territory across each such year 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.

Delay in Community First Choice Option

A personal care attendant provides assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) to persons with a significant disability. ADLs and IADLs include activities such as eating, bathing and showering, using the toilet, preparing meals, managing money, and shopping for groceries, among others. States have the option to cover personal care services, including personal care attendant services, under a variety of optional state plan benefits.

Under PPACA, states can offer home and community-based attendant services as an optional state plan benefit to Medicaid beneficiaries whose income does not exceed 150% of poverty, or if greater, the income level applicable for an individual who has been determined to require the level-of-care offered in an institution. This provision would be effective beginning October 1, 2010. However, under HCERA (Sec. 1205), this provision becomes effective on October 1, 2011.

Financing: Payment for 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 agree to pay rebates to states for outpatient drugs purchased on behalf of Medicaid beneficiaries. Medicaid differentiates between the following two types of drugs when determining rebates:

1. single source innovator drugs (generally, those still under patent) and innovator multiple source drugs (originally marketed under a patent or an original new drug application, but for which there now are therapeutically or pharmaceutically equivalent products); and
2. all other, non-innovator, multiple source drugs.

Rebates for 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 a drug's quarterly Average Manufacturer Price (AMP) compared to the best price for the same period, or a percentage (15.1%) of the drug's quarterly AMP. Drug manufacturers owe an additional rebate on single source innovator drugs (the first drug category mentioned above) when their unit prices for individual products increase faster than inflation.

PPACA requires manufacturers to pay additional rebates to Medicaid for certain new formulations of existing single source or innovator multiple source drugs. For these new drug formulations, referred to as line extensions, drug manufacturers will pay the additional rebate based on a new formula. Similar to the House health reform bill, H.R. 3962, HCERA (Sec. 1206) will limit the definition of line extension drugs to oral solid dosage forms of single source or innovator multiple source drugs.

PPACA also modifies the definition of Average Manufacturer Price (AMP). Among other changes to AMP, this law specifically excludes a wide range of rebates, discounts, price concessions, and service fees extended by manufacturers to wholesalers, retail community pharmacies, and other large volume purchasers. Under the reconciliation bill, the definition of AMP will be further modified to exclude discounts paid by manufacturers to Medicare Part D plans. The effect of excluding the Medicare Part D discounts, as well as other price concessions will be make the calculation of AMP more closely reflect the actual real average cost of outpatient prescription drugs. HCERA did not amend the Medicaid prescription drug provisions.

Program Integrity

Program integrity (PI) initiatives are designed to combat waste, fraud, 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.

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 increased funding to the Health Care Fraud and Abuse Control (HCFAC) account. HCFAC funds are used for a number of health care fraud and abuse activities, but the majority of the funding goes to Medicare activities. HCERA (Sec. 1304) further increases those HCFAC account funds, bringing them up to the levels proposed in the House health care reform bill (H.R. 3962). In addition, HCERA increases Medicaid Program Integrity funds by indexing MIP funds to annual changes in the consumer price index, beginning with fiscal year 2010.

Author Contact Information

Evelyne P. Baumrucker, Coordinator
Analyst in Health Care Financing
ebaumrucker@crs.loc.gov, 7-8913

Cliff Binder, Coordinator
Analyst in Health Care Financing
cbinder@crs.loc.gov, 7-7965

Julie Stone
Specialist in Health Care Financing
jstone@crs.loc.gov, 7-1386

Elicia J. Herz
Specialist in Health Care Financing
eherz@crs.loc.gov, 7-1377

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