



Medicaid: Changes Made by the Reconciliation Act of 2010 to Senate-Passed Patient Protection and Affordable Care Act (H.R. 3590)

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Summary

On December 24, 2009, the Senate passed health reform legislation that would, among other changes, make statutory changes to Medicaid and the Children's Health Insurance Program (CHIP). The Patient Protection and Affordable Care Act (H.R. 3590) is under consideration by the House.

On March 18, 2010, the House Rules Committee issued an amendment in the nature of a substitute to H.R. 4872, the Health Care and Education Affordability Reconciliation Act of 2010, (hereafter referred to as the reconciliation bill). If passed, this reconciliation bill would amend H.R. 3590.

The reconciliation bill 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 to H.R. 3590's Medicaid and CHIP provisions. 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.

This report provides a brief summary of H.R. 3590 followed by a discussion of the modifications that would be made to the Senate-passed bill by the Medicaid and CHIP provisions contained in the reconciliation bill. This report reflects legislative changes contained reconciliation bill published by the House Committee on Rules on March 18, 2010. Selected highlights of the Medicaid and CHIP changes that would be made by the reconciliation bill to H.R. 3590 include provisions that:

- increase primary care physician payment rates for selected patient treatments;
- revise the definition of the average manufacturer price (AMP) to help make AMP more closely reflect the manufacturers' average prices;
- delay the effective date of the Community First Choice Option;
- change state FMAP rates for newly eligible populations;
- provide an increase in the territories' spending rate caps beginning with the second quarter of FY2011;
- provide additional program integrity funding through indexing of the Medicaid Integrity Program for fiscal years beginning with FY2010; and
- modify Medicaid Disproportionate Share Hospital (DSH) payment reductions in H.R. 3590.

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Background

On December 24, 2009, the Senate passed health reform legislation that would, among other changes, make statutory changes to Medicaid and the Children's Health Insurance Program (CHIP).¹ H.R. 3590, the Patient Protection and Affordable Care Act, is under consideration by the U.S. House of Representatives.

On March 18, 2010, the House Committee on Rules issued an amendment in the nature of a substitute to H.R. 4872, The Health Care Education Affordability Reconciliation Act of 2010, (hereafter referred to as the reconciliation bill). If passed, the reconciliation bill would amend H.R. 3590.

The reconciliation bill 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 to H.R. 3590's Medicaid and CHIP provisions. 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.

A preliminary cost estimate from the Congressional Budget Office (CBO) and the Joint Committee on Tax (JTC) indicated that enacting both pieces of legislation, H.R. 3590 and the reconciliation bill, would produce a net reduction in the federal deficits of \$138 billion over the 2010-2019 period as a result of changes in direct spending and revenue.² CBO and JTC previously estimated that enacting 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 H.R. 3590 followed by a discussion of the modifications that would be made to the Senate-passed bill by the Medicaid and CHIP provisions contained in the reconciliation bill. This report reflects legislative language contained in the reconciliation bill published by the House Committee on Rules on March 18, 2010.

Summary of H.R. 3590

H.R. 3590 consists of 10 titles that cover a variety of topics. In general, H.R. 3590 would provide health insurance coverage to many currently uninsured Americans, while attempting to reduce expenditures, and offering mechanisms to increase care coordination, encourage more use of health prevention, and improve quality of care. The bill would reform the private health insurance

¹ For more information on the Medicaid and CHIP provisions contained in H.R. 3590, the Patient Protection and Affordable Care Act, see CRS Report R41037, *Medicaid and the Children's Health Insurance Program (CHIP) Provisions in H.R. 3590, as Passed by the Senate*, coordinated by Kelly Wilkicki. The House also passed H.R. 3962, the Affordable Health Care for America Act, on November 7, 2009. This bill is not currently being considered by the Senate. For more information on the Medicaid and CHIP provisions contained in H.R. 3962, see CRS Report R40900, *Medicaid and Children's Health Insurance Program (CHIP) Provisions in Affordable Health Care for America Act (H.R. 3962)*, coordinated by Elicia J. Herz.

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.

market, impose a mandate for most legal U.S. residents to obtain health insurance, establish health insurance “Exchanges” that would subsidize health insurance coverage for eligible individuals; expand Medicaid eligibility; create programs to improve quality of care and encourage more use of preventive services; address healthcare workforce issues; and propose a number of other Medicaid and Medicare program and federal tax code changes. Key Medicaid and CHIP provisions in H.R. 3590 are summarized below.

- *Eligibility-related reforms.* The Senate bill would 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 would expand eligibility to a group who is not currently eligible for Medicaid (low income childless adults), but also would raise Medicaid’s mandatory income eligibility level for certain existing groups from 100% to 133% of the FPL.
- *Maintenance of effort provisions.* The Senate bill would require states to maintain current Medicaid and CHIP coverage levels—through 2013 for adults and 2019 for children.
- *Outreach and enrollment provisions.* The Senate bill includes provisions to encourage states to improve outreach, streamline enrollment, and coordinate with the proposed American Health Benefit Exchanges (Exchange).⁴
- *Benefit reforms.* The Senate bill would add new mandatory and optional benefits. Mandatory benefit additions would include premium assistance for employer-sponsored health insurance, coverage of free-standing birth clinics, and tobacco cessation services for pregnant woman. The bill also would authorize states to offer new optional benefits such as preventive services for adults, health homes 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.* The bill would introduce measures to reduce the growth of Medicaid expenditures and would increase federal matching payments for the eligibility expansions.
- *Cost control reforms.* Some of the proposal’s cost control measures include (1) proposed reductions in Medicaid disproportionate share hospital (DSH) payments, (2) expenditure reductions for prescription drugs, (3) payment reforms to reduce inappropriate hospital expenditures for health-care acquired conditions.
- *Program integrity reforms.* The bill would create enforcement and monitoring tools and would impose new data reporting and oversight requirements on states and providers. States would also be required to implement initiatives used by the Medicare program, such as a national correct coding initiative and a recovery audit contract program.
- *Nursing home accountability.* The Senate bill would add a number of requirements to improve the transparency of information within facilities and chains, as well as provide 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.* These proposals would provide the Secretary of the Department of Health and Human Services (the Secretary) and state Medicaid and CHIP programs with opportunities to test models for improving the delivery, quality, and payment of services.
- *CHIP-related provisions.* The Senate bill would require states to maintain the current CHIP structure through FY2019, but would not provide federal CHIP appropriations beyond FY2013.
- *Miscellaneous Medicaid and CHIP reforms.* These proposals would add 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 would be dedicated to improving coordination for beneficiaries eligible for both Medicare and Medicaid (dual eligibles). Another would add a Medicare and Medicaid innovation center, which could permit states to better control expenditures for dual eligibles across both Medicare and Medicaid.

Modifications to H.R. 3590 as Proposed by The Health Care Education Affordability Reconciliation Act of 2010

The health care-related provisions in Title I of the reconciliation bill would modify the Senate bill. 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 the Senate bill, and an explanation of the changes proposed by the Health Care Education and Affordability Reconciliation Act of 2010 to the Senate provision.

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 federal match minimum of 50% and a federal match 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, the Senate bill would require states to make eligible for Medicaid qualifying individuals with income up to 133% of the FPL beginning in 2014, among other mandatory expansions. Under the Senate bill, “newly eligible” individuals would be defined as non-elderly, non-pregnant individuals (e.g., childless adults, and certain parents), and otherwise ineligible for Medicaid under current law.⁵ As a conforming measure, the Senate bill also would change the mandatory Medicaid income eligibility level for children ages 6 to 19 from 100% FPL to 133% FPL (as currently applies to children under age 6). Income eligibility for individuals in the “newly eligible” population would be based on modified gross income (MGI), or in the case of families, the household income. “Newly eligible” individuals would 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 currently exempted populations under SSA Section 1937, such as blind or disabled persons, and hospice patients, for example.

Under H.R. 3590, states would receive 100% FMAP for the cost of care provided to “newly eligible” populations, from 2014 through 2016. Beginning in 2017, all states but Nebraska would have an FMAP lower than 100% for “newly eligibles” and would be grouped in 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 eligibles,” expansion states would receive a 30.3 percentage point increase over their regular FMAP for 2017, a 31.3 percentage point increase over their regular FMAP for 2017, a 32.3 percentage point increase for 2018, and a 32.3 percentage point increase thereafter. (see **Table 1** for a summary of these proposed annual federal financial assistance rates for new eligibles under the Senate bill and reconciliation bill.)

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) would 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 the Senate bill, between January 1, 2014, and December 31, 2016, a state could receive a 0.5 percentage point increase to its regular FMAP rate for existing Medicaid eligibility groups if two conditions are met: (1) it was a state that did *not* get any additional FMAP (because no individuals qualified as “newly eligible” due to the state’ 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).

The reconciliation bill (Sec. 1201-1202) would make the following modifications to the financing portions of the eligibility provisions in the Senate bill:⁷

⁵ Like the House bill, the Senate Bill would 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 could 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 the Senate bill (e.g., Adult Preventive (continued...))

- 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 2**).
- The H.R. 3590 provision that would provide the state of Nebraska with a permanent FMAP rate of 100% for “newly eligibles” was removed.
- 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 reduced from January 1, 2014 through September 30, 2019 to from January 1, 2014 through December 31, 2015.
- The Massachusetts-specific 0.5 increase in FMAP for the period between January 1, 2014, and December 31, 2016 was removed.
- Expansion states would receive an increase above their regular FMAP rate for the cost of care provided to currently eligible childless adults. The amount of the increase would 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 2**).

Table 1. Proposed FMAP Rates for Required Medicaid Expansions to Newly Eligible Populations, Under H.R. 3590 and the Reconciliation Bill; FYs 2013-2020

	2013	2014	2015	2016	2017	2018	2019	2020+
Senate								
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%
Reconciliation Bill								
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%)

(...continued)

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 proposal.

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.

Source: Table prepared by CRS Specialist in Health Care Financing, Chris L. Peterson, based on provisions in Senate-passed H.R. 3590, and the Amendment in the Nature of a Substitute to H.R. 4872 (i.e., the Reconciliation bill).

Notes: “NA” means not applicable because the mandatory expansions would not take effect under the Senate or reconciliation bill until 2014. FMAP under the Senate bill 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 with a regular FMAP rate of 54% would be increased by 30.3 percentage points for a new FMAP rate of 84.3%. The FMAP ranges (in parentheses) under the Senate bill and the reconciliation bill represent the potential FMAP rate based on regular FMAPs ranging from the statutory minimum (50%) to 80%. Although HHS would make the official determination of which states would be considered “expansion states” under the Senate bill and reconciliation bill, 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 H.R. 3590, 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 would no longer apply when assessing an individual’s income to determine financial eligibility for Medicaid. Instead, income eligibility for a newly eligible (or certain CHIP eligible individuals) would 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 would also be used to determine applicable premium and cost sharing amounts under the state plan or waiver. MGI was 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 would otherwise lose coverage because of the change in income-counting would be able to maintain eligibility.

Under the reconciliation bill (Sec. 1004), income eligibility for a newly eligible (or certain CHIP eligible individuals) would 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

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.

household income would 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. citizens or residents living abroad. Although H.R. 3590 prohibited any continued use of income disregards under Medicaid once the new income definitions would be in place, the reconciliation bill (Sec. 1004(e)) would require states determining individuals' Medicaid eligibility under MAGI to reduce their countable income by a certain amount. That amount would 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.

H.R. 3590 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. The reconciliation bill adds similar language to H.R. 3590 (Sec. 1202). States would 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 would need to be paid at the Medicare rate for these services or higher (or if greater, the Medicare 2009 payment rate that would be applicable).

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

For services furnished in 2013 and 2014, the federal government would 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 would equal 100%.

Disproportionate Share Hospital Payments

The Medicaid statute requires that states make disproportionate share hospital (DSH) adjustments to the payment rates of hospitals treating large numbers of low-income and Medicaid patients. The current law 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 will be 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.

The Senate bill would reduce federal DSH allotments to states based on changes (reductions) in state-specific uninsurance rates over time. State DSH allotments would remain intact as under current law until a state uninsurance level is reached. This level would be initially reached the first fiscal year after FY2012 for which a state’s uninsured rate, as measured by the Census Bureau’s American Community Survey, decreases by at least 45%, compared to an initial baseline uninsured rate for FY2009. Once this level is reached, reductions in DSH allotments would depend on a state’s status as a low DSH state and spending patterns vis-à-vis 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 would 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 would 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 would 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.

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

Table 2. DSH Provision in the Senate Bill (H.R. 3590)

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%)
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 the reconciliation bill, the provision (Sec. 1203) would strike the language in H.R. 3590 and require states to make aggregate reductions in Medicaid DSH allotments that would equal \$500 million in FY2014, \$600 million in FY2015, and \$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 would be required to:

- (1) impose the largest percentage reduction on states that
 - (a) 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
 - (b) do not target their DSH payments to hospitals with high volumes of Medicaid patients, and
 - (c) 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 would be applied on a quarterly basis. For states with a DSH allotment of \$0 in the 2nd, 3rd and 4th quarters of FY2012, the provision would set states' DSH allotments at \$72.2 million, and for states with a DSH allotment of \$0 in FY2013, the provision would set states' DSH allotments 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 would not count against the Medicaid caps.

H.R. 3590 would increase spending caps for the territories by 30% for the second, third and fourth quarters of FY2011, and for each full fiscal year thereafter. The measure also would increase the applicable FMAP by five percentage points—to 55%—beginning January 1, 2011 and for each full fiscal year thereafter. Beginning in fiscal year 2014, payments made to the territories for medical assistance for “newly eligible” individuals would not count towards territories’ applicable Medicaid spending caps. In the case of the territories, the provision defines “newly eligible” individuals as non-pregnant childless adults who are eligible under the new Medicaid mandatory eligibility group and whose modified gross income or household income does not exceed the income eligibility level in effect for parents under each such commonwealth or territory’s state plan or waiver as of the date of enactment of the bill.

The reconciliation bill (Sec. 1204) would strike the Medicaid provisions related to Payment of the Territories in the Senate-passed bill, and would permit the territories to establish an Exchange (in accordance with the Exchange-related provisions also included in the proposal), not later than October 13, 2013. Out of funds not otherwise appropriated, \$1.0 billion would be 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 would allocate \$925 million for Puerto Rico, and a portion (as specified by the Secretary of the Department of Health and Human Services of the remaining \$75 million for any other territory that chooses establish an Exchange. Under this provision, territories would be treated as states and would be required to structure their Exchange in a manner so there is no gap in assistance between individuals eligible for Medicaid and those eligible for premium and cost sharing assistance.

Under the reconciliation bill, territories that do *not* elect to establish an Exchange as of the specified date, would be 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 would be 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 would apply, and the provision would be 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, shopping for groceries, among others. Under current law, states have the option to cover personal care services, including personal care attendant services, under a variety of optional state plan benefits.

Under H.R. 3590, states could 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. Under the Senate bill, this provision would become effective beginning October 1, 2010. Under the reconciliation bill (Sec. 1205), it would become 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.

H.R. 3590 would require 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 would pay the additional rebate based on a new formula. Similar to the House health reform bill, H.R. 3962, the reconciliation bill (Sec. 1206) would limit the definition of line extension drugs to oral solid dosage forms of single source or innovator multiple source drugs.

H.R. 3590 also would modify the definition of Average Manufacturer Price (AMP). Among other changes to AMP, H.R. 3590 would specifically exclude 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 would 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 would be make the calculation of AMP more closely reflect the actual real average cost of outpatient prescription drugs.

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.

H.R. 3590 would increase 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. The reconciliation bill, (Sec. 1304) would further increase those funds, bringing them up to the levels proposed in the H.R. 3962. In addition, the reconciliation bill would increase Medicaid Program Integrity funds by indexing those resources to annual changes in the Consumer Price Index beginning with fiscal year 2010.

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