Title V—STATE FISCAL RELIEF

Sec. 5000. Purposes (Sec. 5000 of the Senate Bill)

Current Law

No provision.

House Bill

No provision.

Senate bill

The Senate bill sets forth the purposes of the State Fiscal Relief title as: (1) to provide fiscal relief to states in a period of economic downturn, and (2) to protect and maintain state Medicaid programs during a period of economic downturn, including by helping to avert cuts to provider payment rates and benefits or services, and to prevent constrictions of income eligibility requirements for such programs, but not to promote increases in such requirements.

Conference Agreement

The conference agreement follows the Senate bill.

Sec. 5001. Temporary increase of Medicaid FMAP (Sec. 5001 of the House Bill; Sec. 5001 of the Senate Bill)

Current Law

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed by the federal government for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. Exceptions to the FMAP formula have been made for certain states and situations. For example, the District of Columbia's Medicaid FMAP is set in statute at 70%, and the territories have FMAPs set at 50% (they are also subject to federal spending caps). During the last economic downturn under the Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L. 108-27), all states 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. In addition to Medicaid, the FMAP is used in determining the federal share of certain other programs (e.g., foster care and adoption assistance under Title IV-E of the Social Security Act) and serves as the basis for calculating an enhanced FMAP that applies to the Children's Health Insurance Program.

House Bill

The House bill provides a temporary adjustment FMAP during a recession adjustment period that begins with the first quarter of FY2009 and runs through the first quarter of FY2011. The House provision would hold all states harmless from any scheduled decline in their regular FMAPs, provide all states with an across-the-board increase of 4.9 percentage points, and provide high unemployment states with an additional increase. It would also allow each territory to choose between an FMAP increase of 4.9 percentage points along with a 10% increase in its spending cap, or its regular FMAP along with a 20% increase in its spending cap. It is estimated that the House provision would provide about half of its spending via the hold harmless and across-the-board increases, and about half via the unemployment-related increase which is targeted to the states hit hardest by job loss.

States would be evaluated on a quarterly basis for the additional unemployment-related FMAP increase, which would equal a percentage reduction in the state share. The percentage reduction would be applied to the state share after the hold harmless increase and before the 4.9 percentage point increase. For example, after applying the 4.9 point increase provided to all states, a state with a regular FMAP of 50% (state share of 50%) would have an FMAP of 54.90%. If the state share were further reduced by 6%, the state would receive an additional FMAP increase of 3 points (50 * 0.06 = 3). The state's total FMAP increase would be 7.9 points (4.9 + 3 = 7.9), providing an FMAP of 57.90%.

The additional unemployment-related FMAP increase would be based on a state's unemployment rate in the most recent 3-month period for which data are available (except for the first two and last two quarters of the recession adjustment period, for which the 3-month period would be specified) compared to its lowest unemployment rate in any 3-month period beginning on or after January 1, 2006. The criteria would be as follows:

- unemployment rate increase of at least 1.5 but less than 2.5 percentage points = 6% reduction in state share;
- unemployment rate increase of at least 2.5 but less than 3.5 percentage points = 12% reduction in state share; and
- unemployment rate increase of at least 3.5 percentage points = 14% reduction in state share.

If a state qualifies for the additional unemployment-related FMAP increase and later has a decrease in its unemployment rate, its percentage reduction in state share could not decrease until the fourth quarter of FY2010 (for most states, this corresponds with the first quarter of SFY2011). If a state qualifies for the additional unemployment-related FMAP increase and later has an increase in its unemployment rate, its percentage reduction in state share could increase.

The full amount of the temporary FMAP increase would only apply to Medicaid (excluding disproportionate share hospital payments). A portion of the temporary FMAP increase (hold harmless plus 4.9 percentage points) would apply to Title IV-E foster care and adoption assistance. States would be required to maintain their Medicaid eligibility standards, methodologies, and procedures as in effect on July 1, 2008, in order to be eligible for the increase. They would be prohibited from depositing or crediting the additional federal funds paid

as a result of the temporary FMAP increase to any reserve or rainy day fund. States would also be required to ensure that local governments do not pay a larger percentage of the state's nonfederal Medicaid expenditures than otherwise would have been required on September 30, 2008.

Senate Bill

Similar to the House provision, the Senate provision would hold all states harmless from any decline in their regular FMAPs. However, it would provide a larger across-the-board increase of 7.6 percentage points and a smaller unemployment-related increase. It would apply the 7.6 percentage point increase and raise the territories' spending caps in the territories by 15.2%. It is estimated that the Senate provision would provide about 80% of its spending via the hold harmless and across-the-board increases, and about 20% via the unemployment-related increase.

As in the House provision, the Senate provision would calculate the unemployment-related increase as a percentage reduction in the state share. However, the percentage reduction would be applied to the state share *after* both the hold harmless increase and the across-the-board increase of 7.6 percentage points. The Senate provision would evaluate states based on the same unemployment data, except that it would not specify the three-month period to be used for the first two and last two quarters of the temporary FMAP increase. The criteria would be as follows: unemployment rate increase of at least 1.5 but less than 2.5 percentage points = 2.5% reduction in state share; increase of at least 2.5 but less than 3.5 percentage points = 4.5% reduction; increase of at least 3.5 percentage points = 6.5% reduction. Like the House provision, a state's percentage reduction could increase over time as its unemployment rate increases, but it would not be allowed to decrease until the last quarter of FY2010.

Unlike the House provision, the Senate provision would not apply the temporary FMAP increase to expenditures for individuals who are eligible for Medicaid because of an increase in a state's income eligibility standards above what was in effect on July 1, 2008. It would also prohibit states from receiving the temporary increase if they are not in compliance with existing requirements for prompt payment of health care providers under Medicaid and would extend this requirement to nursing facilities. States would be required to report to the Secretary of HHS on their compliance with such requirements. Otherwise, the Senate provision is similar to the House provision.

Conference Agreement

The conference agreement follows the Senate bill with modifications. The across-the-board increase in FMAP would be 6.2 percentage points. The reductions in state share for states with increases in unemployment rates would be 5.5%, 8.5%, and 11.5%. These percent reductions would be applied against the state share after the hold harmless reduction and after an across-the-board increase of 3.1 percentage points. Each territory would be allowed to choose between an FMAP increase of 6.2 percentage points along with a 15% increase in its spending cap, or its regular FMAP along with a 30% increase in its spending cap. It is estimated that the conference agreement would provide about 65% of its spending via the hold harmless and across-the-board increases, and about 35% via the unemployment-related increase.

The conference agreement would also prohibit states from receiving the temporary increase if they are not in compliance with existing requirements for prompt payment of practitioners under Medicaid and would extend this requirement to nursing facilities and hospitals. States would be required to report to the Secretary of HHS on their compliance with such requirements.

Sec. 5001(f)(2). Compliance with prompt pay requirements (Sec. 3304 of the Senate Bill)

Current Law

Under SSA Sec. 1902(a)(37)(A) states are to reimburse providers for services within 30 days of the receipt of a reimbursement claim. State Medicaid programs are to reimburse providers for 90% of claims submitted for payment within 30 days of receipt of the claim. Medicaid also is to process and pay 99% of claims within 90 days from the date of receipt of such claims. These requirements allow states additional time to process claims that are inaccurate, incomplete, or otherwise can not be processed in a timely manner.

House Bill

No provision.

Senate Bill

Under this provision, for states to qualify for the temporary enhanced FMAP funding under section 5001, states would have to meet current prompt payment requirements under section 1902(a)(37)(A), as well as a temporary extension of those requirements to nursing facilities, which are not currently subject to the prompt pay requirements in title XIX.

Conference Agreement

The conference agreement follows the Senate bill with modifications to the reporting requirements, to temporarily extend application of the prompt pay requirements to hospitals, and to provide a grace period before states become ineligible for increased FMAP as a result of failure to comply with the requirements as relate to nursing facilities and hospitals.

Sec. 5002. Temporary increase in DSH allotments during recession (Sec. 5006 of the House Bill; Sec. 5002 of the Senate Bill)

Current Law

Medicaid law requires that states make Medicaid payment adjustments for hospitals that serve a disproportionate share of low-income patients with special needs. Payments to these hospitals known as disproportionate share hospital (DSH) payments, are specifically defined in Medicaid law. They are subject to aggregate annual state-specific limits on federal financial participation. States are required to provide an annual report to the Secretary describing the payment adjustments made to each DSH hospital.

House Bill

This provision would increase states' FY2009 annual Disproportionate Share Hospital (DSH) allotments by 2.5% above the allotment they would have received in FY2009 under current law. In addition, states' DSH allotments in FY2010 would be equal to the FY2009 DSH allotment (with the adjustment) increased by 2.5%. After FY2010, states' annual DSH allotments would be determined as under current law. If, under current law, states' annual DSH allotments are higher in either FY 2009 or FY 2010 than they would have been with the 2.5% adjustment, then states would receive the higher DSH allotments without the recession adjustment.

Senate Bill

Under this provision, states that reported to the Health and Human Services Secretary, as of August 31, 2009, FY2006 total (federal and state) DSH allotments of less than 3% of the state's total state plan medical assistance expenditures would receive special DSH allotments established under the Medicare Modernization Act of 2003 (MMA, P.L. 108-391). This new provision may affect the number of states that are determined to be low-DSH states since the provision would rely on a different base year than that used under MMA. Under this provision, low-DSH states would receive the following revised DSH allotments:

- for FY2009, the DSH allotment would be the FY2008 DSH allotment increased by 16%;
- for FY2010, the DSH allotment would be the FY2009 DSH allotment increased by 16%;
- for the first quarter of FY2011(through December 31, 2010), the DSH allotment would be ¼ of the DSH allotment for FY2010 increased by 16%;
- for the remainder of FY2011 (January 1, 2011-September 30, 2011), the DSH allotment would be ¾ of the FY2010 DSH allotment for each qualified state without the changes contained in this provision;
- for FY2012, qualified states' DSH allotments would be FY2010 DSH allotment (as if this provision had not been enacted);
- for FY2013 and subsequent years, qualified states would receive the DSH allotment for the previous fiscal year with an inflation adjustment, as described in the Social Security Act (SSA), Section 1923(f)(5).

Conference Agreement

The conference agreement follows the House provision.

Sec. 5003. Moratoria on certain Medicaid final regulations (Sec. 5002 of the House Bill; Sec. 5002 of the Senate Bill)

Current Law

In 2007 and 2008, the Centers for Medicare and Medicaid Services (CMS) issued seven Medicaid regulations that generated controversy during the 110th Congress. To address concerns with the impact of the regulations, Congress passed a law that imposed moratoria on six of the Medicaid regulations until April 1, 2009 (excluding the rule on outpatient hospital facility and clinic services). The seven Medicaid regulations covered the following Medicaid areas:

- Graduate Medical Education,
- Cost Limit for Public Providers,
- Rehabilitation Services,
- Targeted Case Management,
- School-Based Services,
- Provider Taxes, and
- Outpatient Hospital Services.

House Bill

This provision would extend the moratoria on the first six regulations beyond April 1, 2009, when the current moratoria expire, to July 1, 2009. The regulations covered under the extension would include: (1) Graduate Medical Education, (2) Cost Limit for Public Providers, (3) Rehabilitative Services, (4) Targeted Case Management, (5) School-Based Services, and (6) Provider Taxes. In addition, this provision would specifically prohibit the Health and Human Services Secretary from taking any action until after June 30, 2009 (through regulation, regulatory guidance, use of federal payment audit procedures, or other administrative action, policy, or practice, including Medical Assistance Manual transmittal or state Medicaid director letter) to implement a final regulation covering Outpatient Hospital facility services.

Senate Bill

No provision.

Conference Agreement

The conference agreement follows the House bill with a modification limiting the application of the moratoria to the four regulations that have been published as final: (1) Targeted Case Management, (2) School-Based Services, (3) Provider Taxes, and (4) Outpatient Hospital

Services. The conference agreement also states the sense of the Congress that the Secretary of HHS should not promulgate as final the proposed regulations relating to Graduate Medical Education, Cost Limit for Public Providers, and Rehabilitative Services.

Sec. 5004. Extension of transitional medical assistance (TMA) (Sec. 5003 of the House Bill; Sec. 3101 of the Senate Bill)

Current Law

States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation is called transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families who lose Medicaid eligibility due to increased child or spousal support collections, as well as those who lose eligibility due to an increase in earned income or hours of employment. However, Congress expanded work-related TMA under Section 1925 of the Social Security Act in 1988, requiring states to provide at least six, and up to 12, months of coverage. Since 2001, these work-related TMA requirements have been funded by a series of short-term extensions, most recently through June 30, 2009.

To qualify for work-related TMA under Section 1925, a family must have received Medicaid in at least three of the six months preceding the month in which eligibility is lost and have a dependent child in the home. During the initial 6-month period of TMA, states must provide the same benefits the family was receiving, although this requirement may be met by paying a family's premiums, deductibles, coinsurance, and similar costs for employer-based health coverage. An additional 6-month extension of TMA (for a total of up to 12 months) is available for families who continue to have a dependent child in the home, who meet reporting requirements, and whose average gross monthly earnings (less work-related child care costs) are below 185% of the federal poverty line. States may impose a premium, limit the scope of benefits, and use an alternative service delivery system during the second six months of TMA.

House Bill

The provision would extend work-related TMA under Section 1925 for 18 months through December 31, 2010. The provision also would give States the flexibility to extend an initial eligibility period of 12 months of Medicaid coverage to families transitioning from welfare to work, in which case the additional 6-month extension would not apply. The House bill also gives states the option of waiving the requirement that a family must have received Medicaid in at least three of the last six months in order to qualify.

Under the House provision, states would be required to collect and submit to the Secretary of Health and Human Services (and make publicly available) information on average monthly enrollment and participation rates for adults and children under work-related TMA; states would also be required to collect and submit information on the number and percentage of children who become ineligible for work-related TMA, but who continue to be eligible under another Medicaid eligibility category or who are enrolled in the Children's Health Insurance Program.

Senate Bill

The Senate bill is the same as the House bill.

Conference Agreement

The conference agreement follows the House and Senate bills.

Sec. 5005. Extension of the qualifying individual (QI) program (Sec. 3201 of the Senate Bill)

Current Law

Certain low-income individuals who are aged or have disabilities, as defined under the Supplemental Security Income (SSI) program, and who are eligible for Medicare, are also eligible to have their Medicare Part B premiums paid for by Medicaid under the Medicare Savings Program (MSP). Eligible groups include Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs). QMBs have incomes no greater than 100% of the federal poverty level (FPL) and assets no greater than $4,000 for an individual and $6,000 for a couple. SLMBs meet QMB criteria, except that their incomes are greater than 100% of FPL but do not exceed 120% FPL. QIs meet the QMB criteria, except that their income is between 120% and 135% of FPL. Further, they are not otherwise eligible for Medicaid. The QI program is currently slated to terminate December 2009.

In general, Medicaid payments are shared between federal and state governments according to a matching formula. Unlike the QMB and SLMB programs, the QI program is paid 100% by the federal government from the Part B Trust fund. The total amount of federal QI spending is limited each year and allocated among the states. States are required to cover only the number of people that would bring their annual spending on these population groups to their allocation levels. For the period beginning on January 1, 2009 and ending on September 30, 2009, the total allocation amount for all states was $350 million. For the period that begins on October 1, 2009 and ends on December 31, 2009, the total allocation is $150 million.

House Bill

No provision.

Senate Bill

This provision would extend the QI program an additional year from December 2009 to December 2010. It establishes specific funding limits:

- from January 1, 2010, through September 30, 2010, the total allocation amount would be $412.5 million, and
- from October 1, 2010, through December 31, 2010, the total allocation amount would be $150 million.

Conference Agreement

The conference agreement follows the Senate bill.

Sec. 5006(a), (b), (c). Protections for Indians under Medicaid and CHIP (Sec. 5004 of the House Bill; Sec. 3301 of the Senate Bill)

Current Law

Premiums and Cost Sharing. In Medicaid, premiums and enrollment fees generally are prohibited for most beneficiaries. Nominal premiums and enrollment fees specified in regulations may be imposed on selected groups (e.g., medically needy, certain families qualifying for transitional Medicaid, pregnant women and infants with income over 150% FPL). Premiums and enrollment fees can exceed these nominal amounts for other selected groups (e.g., certain workers with disabilities and individuals covered under Section 1115 demonstrations).

Service-related cost-sharing (e.g., deductibles, copayments, co-insurance) is prohibited for selected groups (e.g., children under 18, pregnant women) and for selected benefits (e.g., hospice care, emergency services, family planning services and supplies). For most other groups and services, nominal cost-sharing amounts specified in regulations may be applied at state option. For other selected groups (e.g., workers with disabilities and individuals covered under Section 1115 demonstrations), cost-sharing can exceed nominal amounts.

The Deficit Reduction Act of 2005 (P.L. 109-171) added a new Medicaid state option for alternative premiums and cost-sharing for certain subgroups. Applicable maximum amounts vary by income level (as a percent of the federal poverty level). Special rules apply to prescription drugs and to non-emergency services provided in hospital emergency rooms.

Indians are not explicitly exempted from cost-sharing and premium charges in Medicaid. When an Indian Medicaid beneficiary receives services from a contract health services (CHS) provider, Medicaid pays for the service. Any copayment that Medicaid does not pay must be paid by the Indian Health Service (IHS) or the Tribe from its CHS budget, since the CHS provider may not bill the Indian patient. The practical effect of this is simply to reduce the amount of appropriated funds available for health care from IHS or CHS for Tribes that already lack sufficient resources. CHIP programs are already prohibited from imposing cost-sharing on eligible Indians.

Eligibility Determinations under Medicaid and CHIP. The federal Medicaid statute defines more than 50 eligibility pathways. For some pathways, states are required to apply an assets test. For other pathways, assets tests are a state option. When assets tests apply, some pathways give states flexibility to define specific assets that are to be counted and which can be disregarded. For other pathways, primarily for people qualifying on the basis of having a disability or who are elderly, assets tests are required. States generally follow asset guidelines specified for the Supplementary Security Income (SSI) program. Medicaid also defines the rules for the counting of certain assets. Under SSI law, several types of assets are excluded, including: (1) any land

held in trust by the United States for a member of a federally-recognized tribe, or any land held by an individual Indian or tribe and which can only be sold, transferred, or otherwise disposed of with the approval of other individuals, his or her tribe, or an agency of the federal government; and (2) certain distributions (including land or an interest in land) received by an individual Alaska Native or descendant of an Alaska Native from an Alaska Native Regional and Village Corporation pursuant to the Alaska Native Claims Settlement Act. Most other property is required to be counted. There is no similar provision in current CHIP law.

Estate Recovery. The Omnibus Budget Reconciliation Act of 1993 requires all states to recover property and assets of deceased Medicaid beneficiaries for the cost of certain services provided by Medicaid. At a minimum, states must seek recovery for certain services provided, including nursing home care, services provided by an intermediate care facility for the mentally retarded or other similar medical institutions, and Medicaid payments to Medicare for cost-sharing related benefits. The state has discretion to recover further assets to cover the costs for all Medicaid services provided to the beneficiary. The state also has the authority to grant an exemption if the recovery would place undue hardship against the estate. The Secretary specifies the standards for a state hardship waiver for Medicaid estate recovery purposes.

House Bill

Premiums and Cost Sharing. The provision would specify that no enrollment fee, premium or similar charge, and no deduction, co-payment, cost-sharing, or similar charge shall be imposed against an Indian who receives Medicaid-coverable services or items directly from the Indian Health Service (IHS), an Indian Tribe (IT), Tribal Organization (TO), or Urban Indian Organization (UIO), or through referral under the contract health services (CHS) program. In addition, Medicaid payments due to the IHS, an IT, TO, or UIO, or to a health care provider through referral under the CHS program for providing services to a Medicaid-eligible Indian, could not be reduced by the amount of any enrollment fee, premium or similar charge, as well as any cost-sharing or similar charge that would otherwise be due from an Indian, if such charges were permitted. A rule of construction would specify that nothing in this provision could be construed as restricting the application of any other limitations on the imposition of premiums or cost-sharing that may apply to a Medicaid-enrolled Indian. This language would also add Indians receiving services through Indian entities to the list of individuals exempt from paying premiums or cost-sharing under the DRA option for alternative premiums and cost-sharing under Medicaid. The effective date of this provision would be October 1, 2009.

Eligibility Determinations under Medicaid and CHIP. The provision would prohibit consideration of four different classes of property from resources in determining Medicaid eligibility of an Indian. These classes include: (1) property, including real property and improvements, that is held in trust (subject to federal restrictions or otherwise under the supervision of the Secretary of the Interior), located on a reservation, including any federally recognized Indian Tribes reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act (ANCSA), and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs; (2) for any federally recognized Tribe not described in the first class, property located within the most recent boundaries of a prior federal reservation; (3) ownership interests in rents, leases, royalties, or usage rights related to natural resources, including extraction of natural resources or harvesting of timber, other plants and plant products, animals,

fish, and shellfish, resulting from the exercise of federally protected rights; and (4) ownership interest in or usage rights to items not covered in the previous classes that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional life style according to applicable tribal law or custom. This provision is modeled on the provisions of the Centers for Medicare & Medicaid Services (CMS) State Medicaid Manual that exempt the same type of Indian property from Medicaid estate recovery. The House bill would also apply this new language to CHIP in the same manner in which it applies to Medicaid.

Estate Recovery. The provision would provide that certain income, resources, and property would remain exempt from Medicaid estate recovery if they were exempted under Section 1917(b)(3) of the Social Security Act (allowing the Secretary to specify standards for a state hardship waiver of asset criteria) under instructions regarding Indian tribes and Alaskan Native Villages as of April 1, 2003. The provision also would allow the Secretary to provide for additional estate recovery exemptions for Indians under Medicaid.

Senate Bill

Same as House bill, except that these provisions would sunset on December 31, 2010. The Senate bill did not specify an effective date for the premiums and cost sharing provision, meaning those provisions would take effect upon enactment.

Conference Agreement

The conference agreement follows the Senate bill with modifications for the provisions to be permanently effective July 1, 2009.

Sec. 5006(d). Rules applicable under Medicaid and CHIP to managed care entities with respect to Indian enrollees and Indian health care providers and Indian managed care entities (Sec. 3302 of the Senate Bill)

Current Law

Section 1903(m)(1) of Title XIX defines: (1) the term Medicaid managed care organization (MCO), (2) requirements regarding accessibility of services for Medicaid MCO beneficiaries vis-a-vis non-MCO Medicaid beneficiaries within the area served by the MCO; (3) solvency standards in general and specific to different types of organizations; and (4) the duties and functions of the Secretary with respect to the status of an organization as a Medicaid MCO.

Section 1905(t) of Title XIX defines another type of managed care arrangement called primary care case management (PCCM). Under such arrangements, states contract with primary care case managers who are responsible for locating, coordinating and monitoring covered primary care (and other services stipulated in contracts) provided to all individuals enrolled in such PCCM programs.

Title XIX contains a number of additional provisions regarding managed care under Medicaid. Section 1932(a)(5) specifies rules regarding the provision of information about managed care to

beneficiaries and potential enrollees. Such information must be in an easily understood form, and must address the following topics: (1) who providers are and where they are located, (2) enrollee rights and responsibilities, (3) grievance and appeal procedures, (4) covered items and services, (5) comparative information for available MCOs regarding benefits, cost-sharing, service area and quality and performance, and (6) information on benefits not covered under managed care arrangements. In addition, Section 1932(d)(2)(B) requires managed care entities to distribute marketing materials to their entire service areas.

Sections 1903(m) and 1932 provide cross-referencing definitions for the term "Medicaid managed care organization." Under Title XIX, section 1932(a)(2)(C) stipulates the rules regarding Indian enrollment in Medicaid managed care. A state may not require an Indian (as defined in Section 4(c) of the Indian Health Care Improvement Act (IHCIA) to enroll in a managed care entity unless the entity is one of the following (and only if such entity is participating under the plan): (1) the IHS, (2) an IHP operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS pursuant to the Indian Self-Determination Act, or (3) an urban IHP operated by a UIO pursuant to a grant or contract with the IHS pursuant to Title V of IHCIA.

In general, Federally Qualified Health Centers (FQHCs) are paid on a per visit basis, using a prospective payment system that takes into account costs incurred and changes in the scope of services provided. Per visit payment rates are also adjusted annually by the Medicare Economic Index applicable to primary care services. When an FQHC is a participating provider with a Medicaid managed care entity (MCE), the state must make supplemental payments to the center in an amount equal to any difference between the rate paid by the MCE and the per visit amount determined under the prospective payment system.

House Bill

No provision.

Senate Bill

Under this provision, Medicaid managed care contracts with Managed Care Entities (MCEs) and Primary Care Case Management (PCCMs) companies would be required to meet certain conditions relating to access for Indian Medicaid beneficiaries in order to receive Medicaid payments, including:

- MCEs and PCCMs would need to demonstrate that the number of participating Indian health care providers was sufficient to ensure timely access to covered Medicaid managed care services for eligible enrollees, and
- MCEs and PCCMs would need to agree to pay Indian health care providers (IHPs) at rates equal to the rates negotiated between these organizations and the provider involved, or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which the MCE or PCCM would make for services rendered by a participating non-Indian health care provider.

In addition, this provision would specify that MCEs and PCCMs must agree to make prompt payment, as required under Medicaid rules for all providers, to participating Indian health care providers, and states would be prohibited from waiving requirements relating to assurance that payments are consistent with efficiency, economy, and quality.

Further, this provision would apply special payment provisions to certain Indian health care providers that are Federally Qualified Health Centers (FQHCs). For non-participating Indian FQHCs that provide covered Medicaid managed care services to Indian MCE enrollees, the MCE must pay a rate equal to the payment that would apply to a participating non-Indian FQHC. When payments to such participating and non-participating providers by an MCE for services rendered to an Indian enrollee with the MCE are less than the rate under the state plan, the state must pay such providers the difference between the rate and the MCE payment. Likewise, if the amount paid to a non-FQHC Indian provider (whether or not the provider participates with the MCE) is less than the rate that applies under the state plan, the state must pay the difference between the applicable rate and the amount paid by MCEs. Under this provision, Indian Medicaid MCEs would be permitted to restrict enrollment to Indians and to members of specific tribes in the same manner as IHPs may restrict the delivery of services to such Indians and tribal members.

Finally, the provision would apply specific sections affecting Medicaid to the CHIP program, including (1) Section 1932(a)(2)(C) in current law regarding enrollment of Indians in Medicaid managed care (e.g., states cannot require Indians to enroll in a MCE unless the entity is the IHS, certain IHPs operated by tribes or tribal organizations, or certain urban IHPs operated by Urban Indian Organizations (UIOs), and (2) the new Section 1932(h) as described above.

Conference Agreement

The conference agreement follows the Senate bill with a modification deleting the sunset date clarifying that Indian Medicaid MCEs would be permitted to restrict enrollment to Indians but not to members of specific tribes, and clarifying access standards in states where there are no Indian providers. The provision would be effective July 1, 2009.

Sec. 5006(e). Consultation on Medicaid, CHIP, and other health care programs funded under the Social Security Act involving Indian Health Programs and Urban Indian Organizations (Sec. 5005 of the House Bill; Sec. 3303 of the Senate Bill)

Current Law

There are no provisions in current Medicaid or CHIP statutes regarding a Tribal Technical Advisory Group (TTAG) within the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicare, Medicaid and CHIP programs. CMS currently maintains a TTAG for consultation on matters relating to Indian health care, but it is not codified in law.

House Bill

The provision would require the Secretary to maintain within CMS a Tribal TAG, previously established in accordance with requirements of a charter dated September 30, 2003. The provision also would require that the TAG include a representative of the UIOs and IHS. The UIO representative would be deemed an elected official of a tribal government for the purposes of applying Section 204(b) of the Unfunded Mandates Reform Act of 1995, which exempts elected tribal officials from the Federal Advisory Committee Act for certain meetings with federal officials.

The provision would also require states in which one or more IHPs or UIOs provide health services to establish a process for obtaining advice on a regular, on-going basis from designees of IHPs and UIOs regarding Medicaid law and its direct effects on those entities. This process must include seeking advice prior to submission of state Medicaid plan amendments, waiver requests or proposed demonstrations likely to directly affect Indians, IHPs, or UIOs. This process may include appointment of an advisory panel and of a designee of IHPs and UIOs to the Medicaid medical care advisory committee advising the state on its state Medicaid plan. The provision would also apply this new language to CHIP in the same manner in which it applies to Medicaid. Finally, the provision would prohibit construing these amendments as superseding existing advisory committees, working groups, guidance or other advisory procedures established by the Secretary or any state with respect to the provision of health care to Indians.

Senate Bill

This provision is similar to the House provision. Both versions would require the Secretary to maintain within CMS a Tribal Technical Advisory Group (TTAG), previously established in accordance with requirements of a charter dated September 30, 2003. The provision also would require that the TTAG include a IHS representative. Unlike the House bill, however, under this provision in S.Amdt. 570, the TTAG also would include a representative of a national urban Indian Health organization, rather than a representative of the UIOs. The non-application of Federal Advisory Committee Act (FACA) would still hold for a representative of a national UIO.

Conference Agreement

The conference agreement follows the Senate bill with a modification deleting the sunset date. The provision would be effective July 1, 2009.

Sec. 5007. Funding for oversight and implementation (Sec. 5004 of the Senate Bill)

Current Law

The Office of Inspector General (OIG) of the Department of Health and Human Services is responsible for ensuring program integrity of over 300 programs in the Department, including the Medicaid program. The OIG's program integrity activities are funded through a combination of discretionary appropriations and mandatory funding through the Health Care Fraud and Abuse Control Program. The Centers for Medicare & Medicaid Services (CMS) in the Department of

Health and Human Services administers the Medicaid program at the federal level. These administrative activities are funded through discretionary appropriations.

House Bill

No provision.

Senate Bill

Under this provision, the Health and Human Services Office of the Inspector General (HHS OIG) is to receive $31.25 million to ensure the proper expenditure of federal Medicaid funds. These funds are appropriated from any money in the Treasury not otherwise appropriated and are available throughout the recession period (defined as October 1, 2008 through December 31, 2010). Amounts appropriated under this provision would be available until September 30, 2012, without further appropriation, and would be in addition to any other amounts appropriated or made available to HHS OIG.

Conference Agreement

The conference agreement follows the Senate bill with a modification. The funds for the HHSOIG would be appropriated in FY2009 and would be available for expenditure until September 30, 2011. The conference agreement would also appropriate $5 million in FY2009 to CMS for the implementation and oversight of the state fiscal relief provisions relating to Medicaid. These funds would remain available until expended.

Sec. 5008. GAO study and report regarding state needs during periods of national economic downturn (Sec. 5005 of the Senate Bill)

Current Law

No provision.

House Bill

No provision.

Senate Bill

Under this provision, the Comptroller General of the United States, would study the current (as of the date of enactment of the legislation) economic recession as well as previous national economic downturns since 1974. GAO would develop recommendations to address states' needs during economic recessions, including the past and projected effects of temporary increases in the federal medical assistance percentage (FMAP) during these recessions. By April 1, 2011, GAO would submit a report to appropriate congressional committees that would include the following:

- Recommendations for modifying the national economic downturn assistance formula for temporary Medicaid FMAP adjustments (a "countercyclical FMAP," as described in GAO report number, GAO-07-97), to improve the effectiveness of the countercyclical FMAP for addressing states' needs during national economic downturns:

    - what improvements are needed to identify factors to begin and end the application of a countercyclical FMAP;
    - how to adjust the amount of a countercyclical FMAP to account for state and regional variations; and
    - how a countercyclical FMAP could be adjusted to better account for actual Medicaid costs incurred by states during economic recessions.

- Analysis of the impact on states of recessions, including declines in private health insurance benefits coverage; declines in state revenues; and maintenance and growth of caseloads under Medicaid, CHIP, or any other publicly funded programs that provide health benefits coverage to state residents.

Conference Agreement

The conference agreement follows the Senate bill.

Payment of Medicare liability to States as a result of the Special Disability Workload Project (Sec. 5003 of the Senate Bill)

Current Law

No provision.

House Bill

No provision.

Senate Bill

Under this provision, within three months after enactment of this law, the Secretary, in consultation with the Commissioner of Social Security, would negotiate an agreement on a payment amount to be made to each state for the Medicare Special Disability Workload (SDW) project. Payments to states would be subject to certain conditions:

- states would waive the right to file or be a part of any civil action in any federal or state court where payment was sought for liability related to the Medicare SDW project;
- states would release the federal government from any further claims for reimbursement of state expenditures arising from the SDW project;

- states that are parties to civil actions in any federal or state court seeking reimbursement for the SDW project, would be ineligible to receive payment under this provision while such action is pending or if it is resolved in a state's favor.

In negotiating with states, the Secretary and SSA Commissioner would use the most recent federal data available, including estimates, to determine the amount of payment to be offered to each state that elects to enter into an agreement with the Secretary. The payment methodology would consist of the following factors:

- the number of SDW cases that were eligible for benefits under Medicare and the month when these cases initially became eligible;
- the applicable non-federal share of Medicaid expenditures made by states during the period these cases were eligible; and
- other factors determined appropriate by the Secretary and the SSA Commissioner in consultation with states.

However, as a condition of payment under a negotiated agreement for SDW cases, states would not be required to submit individual paid Medicaid claims data.

To make payments to states for the SDW project, $3 billion would be appropriated for FY2009 from money in the treasury not otherwise appropriated. Aggregate payments to states could not exceed $3 billion. Payments to states would be provided within four months from the date of enactment of ARRA.

An SDW case would be defined as an individual determined by the SSA Commissioner to have been eligible for benefits under Title II of the SSA for a period during which such benefits were not provided to the individual and who was, during all or part of such period, enrolled in Medicaid.

Conference Agreement

The conference agreement follows the House bill.