



American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5): Title V, Medicaid Provisions

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Summary

The economy officially was considered in a recession in December 2008, but many forecasters had long recognized the downturn and some believed this economic contraction would be more severe than other post-World War II slowdowns. A combination of factors combined to present policymakers with difficult decisions on how best to stimulate the economy. Troubling instability in the housing and financial services sectors, weak auto manufacturing demand, and high energy costs earlier in 2008 had slowed growth dramatically and forced millions into unemployment. With declining tax revenue and increasing costs to provide unemployment and other benefits to unemployed workers, states were implementing measures to rein in spending, including restricting Medicaid eligibility and services.

Congress considered legislation aimed at stimulating economic activity in selected industrial sectors to save existing and create new jobs, reduce taxes, invest in future technologies, and fund infrastructure improvements. In addition to reducing some taxes and funding infrastructure projects, ARRA provisions were designed to provide: temporary support to families and individuals by increasing unemployment compensation benefits; financial assistance for individuals to maintain their health coverage under provisions in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA); temporary increases in Medicaid matching rates; and increases in disproportionate share hospital allotments.

The House approved the American Recovery and Reinvestment Act of 2009 (H.R. 1) on January 28, 2009. The Senate passed an amendment (S.Amdt. 570) as a replacement for the House-approved version of ARRA on February 10, 2009. ARRA was referred to a joint House and Senate conference committee. The joint Senate and House Conference Committee reached agreement, and ARRA was passed by the House and Senate on February 13, 2009. President Obama signed ARRA (P.L. 111-5) into law on February 17, 2009. This report is a summary of ARRA's Medicaid provisions.

For more information on the Medicaid provisions included in House and Senate versions of ARRA, see CRS Report R40158, *Medicaid Provisions in the House and Senate American Recovery and Reinvestment Act of 2009 (ARRA, H.R. 1, S.Amdt. 570)*, coordinated by Cliff Binder. This report will not be updated.

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Background

In December 2008, the National Bureau of Economic Research (NBER) announced that the economy was in a recession and that the recession had begun a year earlier in December 2007.¹ However, some economists and forecasters had been concerned that a combination of factors might make this economic contraction much worse than other post-war slowdowns.² At first, economic instability seemed limited to the housing sector as housing values decreased in many markets, forcing some subprime and highly leveraged home owners into foreclosure. The problems that began in housing, quickly spread to banking and financial services and were compounded earlier in 2008 by spikes in energy prices. The solvency of automobile manufacturers rapidly deteriorated, possibly due in part to tight credit policies, rising unemployment, and high fuel costs. National unemployment rose steadily throughout 2008 reaching 7.2% in December.³

Due to slower economic activity caused by the recession, many states also faced large tax revenue decreases, forcing them to reduce Medicaid eligibility and spending, just when the demand for additional public sector health care was expanding to fill the gap left when unemployed individuals no longer could afford employer-based health insurance for their families. Although by themselves the problems in housing, financial services, manufacturing, and energy sectors might not have forced the economy into recession, taken together these problems had contributed to the emergence of a recession and, if the underlying fundamentals have changed as some forecasters suspect, perhaps a prolonged, global economic slow down that could have widespread impact on living standards here and abroad.

In response, policymakers quickly moved to prevent the instability in housing and financial services from spilling over into the broader economy. Looking to the future, members of Congress and the Obama Administration sought additional mechanisms to stimulate economic activity. Various approaches were considered to ensure that an economic stimulus package could reach many different segments of the economy, provide a sustained economic boost, and wide spread job growth. Some economic stimulus proposals included infrastructure spending, revenue sharing with states, middle class tax cuts, business tax cuts, unemployment benefits, and food stamps. On January 22, 2009 the House Committee on Energy and Commerce marked-up selected health components and approved a stimulus bill, the American Recovery and Reinvestment Act of 2009 (ARRA, H.R. 1). The full House amended and approved H.R. 1 on January 28, 2009.

Similar legislation to H.R. 1 was introduced in the Senate (ARRA, S. 350) and referred to the Committee on Finance, among others, where provisions were approved on January 27.⁴ An amendment in the nature of a substitute (S.Amdt. 570) was offered as a substitute for H.R. 1 and

¹ See CRS Report R40052, *What is a Recession and Who Decided When It Started?*, by Brian W. Cashell, for more information on how business cycles are defined and measured.

² For more information see CRS Report R40104, *Economic Stimulus: Issues and Policies*, by Jane G. Gravelle, Thomas L. Hungerford, and Marc Labonte.

³ U.S. Bureau of Labor Statistics, Press Release dated January 9, 2009. Available on the internet at <http://www.bls.gov/> for more information (accessed January 22, 2009).

⁴ See the Senate Committee on Finance website for S.Amdt. 98 <http://finance.senate.gov/sitepages/leg/LEG%202009/020209%20complete%20legislative%20text%20of%20American%20Recovery%20and%20Reinvestment%20Act.pdf>.

was approved by the full Senate on February 10, 2009. The Senate version of ARRA was referred to a joint Senate and House conference committee. The conference committee reached agreement and referred ARRA to the House and Senate, where it was passed on February 13, 2009. President Obama signed ARRA (P.L. 111-5) on February 17, 2009. This report is a summary the Medicaid provisions in P.L. 111-5. For more information on the Medicaid provisions included in House and Senate versions of ARRA, see CRS Report R40158, *Medicaid Provisions in the House and Senate American Recovery and Reinvestment Act of 2009 (ARRA, H.R. 1, S.Amdt. 570)*, coordinated by Cliff Binder.

ARRA, P.L. 111-5: Medicaid Provisions

Table 1 displays a summary of the Medicaid provisions in P.L. 111-5. Although **Table 1** displays 14 Medicaid provisions, ARRA included only eight provisions.

Table 1 Summary: Medicaid Provisions in P.L. 111-5

Medicaid Provision	Senate	House	P.L. 111-5
Temporary FMAP Increase	X	X	X
Coverage of the Unemployed Under Medicaid		X	
Medicaid Regulation Moratoria		X	X
DSH Allotment Increases	X	X	X
Medicare Liability for Special Disability Workload	X		
Medicaid Indian Protections ^a			X
Premiums and Cost Sharing	X	X	X
Eligibility Determinations	X	X	X
Estate Recovery	X	X	X
Medicaid Consultation with Indian Health Programs	X	X	X
Medicaid Managed Care for Indians	X		X
TMA Extension	X	X	X
QI Extension	X		X
OIG Oversight and Implementation Funding ^b	X		X
GAO Study on Recession Effects on Medicaid	X		X
Nursing Home Prompt Pay Requirement ^c	X		X
Selected Medicaid Provisions Sunset	X		

Source: CRS Analysis of ARRA Conference Agreement and Senate and House versions.

- There were five Indian protection components included in one provision in P.L. 111-5. Some of these components were presented as separate provisions in the Senate or House versions, so they are shown separately on **Table 1**.
- Funding (\$5M) for implementation of the Temporary FMAP Increase was added to the OIG Oversight provision.
- Nursing home prompt pay requirements were a separate provision in the Senate Bill, but were integrated into the FMAP provision in P.L. 111-5 and expanded to apply to all providers.

Some provisions presented separately in the Senate or House Bills were aggregated under one provision in P.L. 111-5. For instance, there was one provision for Medicaid Indian protections in the Conference Agreement that included five provisions from the earlier House and Senate versions (premiums and cost sharing, eligibility determinations, estate recovery, consultation with

Indian health programs, and managed care protections). In addition, the nursing home prompt payment provision from the Senate bill was integrated into the Temporary Federal Medical Assistance Percentage (FMAP) Increase provision in P.L. 111-5, but \$5 million in funding to implement the FMAP provision was added to ARRA in the Conference Agreement under the OIG Oversight provision from the Senate Bill. Thus, there are eight Medicaid provisions included in Title V of the Conference Agreement. An additional provision providing funding for Medicaid Health Information Technology (HIT) is in Title IV of P.L. 111-5.

The Congressional Budget Office (CBO) estimated that ARRA's Medicaid provisions (under TITLE V—State Fiscal Relief) would increase federal expenditures by \$33.96 billion in FY2009 and \$89.74 billion from FY2009 to FY2013, although one provision, a temporary FMAP increase, accounts for \$87.2 billion of the five-year increase.

Sec. 5001. Temporary Increase of Medicaid FMAP

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed 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). 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 State Children's Health Insurance Program. (For more details, see CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by April Grady.)

During a recession adjustment period that begins with the first quarter of FY2009 and runs through the first quarter of FY2011, the provision holds all states harmless from any decline in their regular FMAPs, provides all states with an across-the-board increase of 6.2 percentage points, and provides qualifying states with an additional unemployment-related increase. It allows each territory 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.

States are evaluated on a quarterly basis for the unemployment-related FMAP increase, which equals a percentage reduction in the state share. The percentage reduction is applied to the state share after the hold harmless increase and after one-half of the 6.2 percentage point increase (i.e., 3.1 percentage points). For example, after applying the across-the-board increase, a state with a regular FMAP of 50% would have an FMAP of 56.20%. If the state share (after the hold harmless and one-half of the across-the-board increase) were further reduced by 5.5%, the state would receive an additional FMAP increase of 2.58 percentage points (46.9 state share * 0.055 reduction in state share = 2.58). The state's total FMAP increase would be 8.78 points (6.2 + 2.58 = 8.78), providing an FMAP of 58.78%.

The unemployment-related FMAP increase is 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 is specified) compared to its

lowest unemployment rate in any 3-month period beginning on or after January 1, 2006. The criteria are as follows:

- unemployment rate increase of at least 1.5 but less than 2.5 percentage points = 5.5% reduction in state share;
- unemployment rate increase of at least 2.5 but less than 3.5 percentage points = 8.5% reduction in state share;
- unemployment rate increase of at least 3.5 percentage points = 11.5% reduction in state share.

If a state qualifies for the 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 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 only applies to Medicaid, excluding disproportionate share hospital payments and 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. A portion of the temporary FMAP increase (hold harmless plus across-the-board) applies to Title IV-E foster care and adoption assistance. To receive the increase, states are:⁵

- required to maintain their Medicaid eligibility standards, methodologies, and procedures as in effect on July 1, 2008;⁶
- prohibited from receiving the increase if they are not in compliance with requirements for prompt payment of health care providers under Medicaid, and required to report to the Secretary of HHS on their compliance;⁷
- prohibited from depositing or crediting the additional federal funds paid as a result of the increase to any reserve or rainy day fund;
- 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; and
- required to submit a report to the Secretary regarding how the additional federal funds paid as a result of the temporary FMAP increase were expended.

⁵ For the requirements related to rainy day funds and local governments' share of nonfederal expenditures, the law was written such that states would be denied the across-the-board and unemployment-related FMAP increases (and territories would be denied cap increases) if they are out of compliance; however, they would not be denied the hold harmless FMAP increase. In contrast, for the requirements related to maintenance of eligibility and prompt payment, states would be denied all of the temporary FMAP increases (including hold harmless) if they are out of compliance.

⁶ States that have restricted their eligibility standards, procedures, or methodologies can reinstate them in any quarter to begin receiving the temporary FMAP increase. In addition, those that reinstate them prior to July 1, 2009, can receive the increase for the first three quarters of FY2009.

⁷ More specifically, the temporary FMAP increase would not be available for any claim received by the state from a health care practitioner subject to prompt pay requirements for such days during any period in which the state has failed to pay claims in accordance with those requirements.

CBO estimated that ARRA's FMAP provision would increase federal spending by \$87.2 billion over the five-year period from FY2009-2013.

Sec. 5002. Temporary Increase in DSH Allotments During Recession

Medicaid law requires states to make Medicaid payment adjustments for hospitals that serve a disproportionate number of low-income patients with special needs. Payments to these hospitals that serve a large number of low-income individuals, disproportionate share hospital (DSH) payments, are specifically defined in Medicaid law, including, aggregate annual state-specific limits on federal financial participation and hospital-specific limits on DSH payments.

Under those hospital specific limits, a hospital's DSH payments may not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid beneficiaries and the uninsured, less other Medicaid payments made to the hospital, and payments made by uninsured patients ("uncompensated care costs"). States are required to provide an annual report to the Secretary describing the payment adjustments made to each DSH.

This provision increases states' FY2009 annual DSH allotments by 2.5% above the allotment they would have received in FY2009 (in FY2009, DSH allotments increased by 4% over FY2008 allotment levels). 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 will return to 100% of the annual DSH allotments as determined under current law. Under this provision, if states' annual DSH allotments grew at a greater rate than what they would have received without the 2.5% adjustment, then states will receive the higher DSH allotments without the recession adjustment. CBO estimated that the temporary increase in DSH allotments would increase federal expenditures by \$228 million in FY2009 and \$456 million for the period FY2009-FY2013.

Sec. 5003. Extension of Moratoria on Certain Medicaid Final Regulations

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, several laws passed during the 110th Congress imposed moratoriums on six of the Medicaid regulations until April 1, 2009 (excluding a rule on outpatient hospital facility and clinic services). CBO estimated that the extension of the Medicaid moratoria would increase federal expenditures by \$105 million in FY2009, but would not have an additional spending increase beyond FY2009. The seven Medicaid regulations issued during the most recent Congress covered the following areas:

Graduate Medical Education

Most states make Medicaid payments to help cover the costs of training new doctors in teaching programs. The proposed rule would eliminate federal reimbursement for graduate medical education and change how Medicaid upper payment limits for hospital services are calculated. For more information on GME, see CRS Report RS22842, *Medicaid and Graduate Medical Education*, by Elicia J. Herz and Sibyl Tilson.

Cost Limit on Public Providers

Intergovernmental transfers (IGTs) are used by some states to finance the non-federal share of Medicaid costs. Certain IGTs are specifically allowed for funding the state share of program costs. Some states have instituted programs where the state shares of Medicaid spending is paid by hospitals or nursing homes that are public providers, but not units of government, or are units of government, but the state share is returned to the provider sometimes through Medicaid payments. Both a proposed and final regulation were issued, however, a federal court held that the rule had been improperly promulgated and remanded the rule back to CMS for further action. This regulation would clarify the types of IGTs allowable for financing a portion of Medicaid costs, impose a limit on Medicaid reimbursement for government-owned hospitals and other institutional providers, and require certain providers to retain all Medicaid reimbursement. For more information on cost limits on public providers, see CRS Report RS22848, *Medicaid Regulation of Governmental Providers*, by Elicia J. Herz.

Rehabilitative Services

Medicaid rehabilitative services include a full range of treatments designed to reduce physical or mental disability or restore eligible beneficiaries to their best possible functional levels. There has been enough misunderstanding about when Medicaid pays for and what constitutes rehabilitative services that both the executive and legislative branches have addressed this benefit repeatedly. The proposed rule defines the scope of the rehabilitation benefit and identifies services that could be claimed under Medicaid. For more information on rehabilitative services, see CRS Report RL34432, *Medicaid Rehabilitation Services*, by Cliff Binder.

Case Management

Case management services assist Medicaid beneficiaries in obtaining needed medical and related services. Targeted case management (TCM) refers to case management for specific beneficiary groups or for individuals residing in state-designated geographic areas. There has been considerable ambiguity about what services are covered and what is legitimately considered TCM. The case management regulation addresses a provision of the Deficit Reduction Act of 2005 (DRA; P.L. 109-171) that clarifies and narrows the case management definition and directs the Secretary of HHS to issue regulations to guide states' claims for federal matching funds for case management. For more information on case management and targeted case management, see CRS Report RL34426, *Medicaid Targeted Case Management (TCM) Benefits*, by Cliff Binder.

School-Based Services

As a condition of accepting funds under the Individuals with Disabilities Education Act (P.L. 108-446, IDEA), public schools must provide special education and related services necessary for children with disabilities to benefit from public education. States can finance only a portion of these costs with federal IDEA funds. Medicaid may cover IDEA required health-related services for enrolled children as well as related administrative activities. According to federal investigations and congressional hearings, Medicaid payment to schools have sometimes been improper. To address these problems, CMS issued a regulation that would restrict federal Medicaid payments for school-based administrative activities (e.g., outreach, service coordination, referrals performed by school employees or contractors), and certain transportation services (e.g., from home to school and back for certain school-age children). For more

information on school-based services under Medicaid, see CRS Report RS22397, *Medicaid and Schools*, by Elicia J. Herz.

Provider Taxes

States use provider-specific taxes to help finance their share of the Medicaid program. Under these funding methods, states collect funds (through taxes or other means) from providers and pay the money back to those providers as Medicaid payments, and claim the federal matching share of those payments. Once the state share has been subtracted, the federal matching funds may be used to raise provider payment rates, to fund other portions of the Medicaid program, or for other non-Medicaid purposes. Provider taxes must be consistent with federal laws and regulations, which may have been ambiguous or changing. CMS issued a provider tax regulation to address these issues. For more information on Medicaid provider taxes, see CRS Report RS22843, *Medicaid Provider Taxes*, by Elicia J. Herz.

Outpatient Hospital Services

Under Medicaid, outpatient hospital (OPH) services are a mandatory benefit for most beneficiaries. OPH services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided under the direction of a physician or a dentist in the hospital. States use a number of different reimbursement methods for different types of services provided in OPH departments and clinics. CMS issued a regulation that would limit the definition and scope of Medicaid-covered OPH services. For more information on outpatient hospital services, see CRS Report RS22852, *Medicaid and Outpatient Hospital Services*, by Elicia J. Herz and Sibyl Tilson.

P.L. 111-5 extends the existing moratoria on the final regulations on case management services, provider taxes, and school-based administrative and transportation services beyond April 1, 2009, when these moratoria expire, to July 1, 2009. In addition, this provision prohibits the Secretary of HHS 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 the final regulation on OPH facility services (published November 7, 2008 and effective on December 8, 2008).

Under current law, moratoria on further administrative action until April 1, 2009 for the regulations on cost limits for public providers, graduate medical education, and rehabilitative services. A Sense of the Congress clause in this ARRA provision indicates that the Secretary of HHS should not promulgate final regulations for rehabilitative services, cost limits on public providers, or graduate medical education. For more information on Medicaid regulations, see CRS Report RL34764, *Medicaid Regulatory Issues*, by Elicia J. Herz and Vanessa K. Burrows.

Sec. 5004. Extension of Transitional Medical Assistance (TMA)

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. (For more details, see CRS Report RL31698, *Transitional Medical Assistance (TMA) Under Medicaid*, by April Grady.)

The provision extends work-related TMA under Section 1925 through December 31, 2010. States can opt to treat any reference to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months) for purposes of the initial eligibility period for work-related TMA, in which case the additional 6-month extension does not apply. States can opt to waive the requirement that a family have received Medicaid in at least three of the last six months in order to qualify. Under the TMA provision, states are 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, and on the number and percentage of children who become ineligible for work-related TMA and whose eligibility is continued under another Medicaid eligibility category or who are enrolled in the Children's Health Insurance Program (CHIP).

CBO estimated that the TMA provision would increase federal spending by \$1.3 billion over the five-year period from FY2009-2013.

Sec. 5005. Extension of the Qualifying Individual (QI) Program.

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 (QI-1s). 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. QI-1s meet the QMB criteria, except that their income is between 120% and 135% of poverty and they are not otherwise eligible for Medicaid. The QI-1 program is currently slated to terminate December 2009. This provision of P.L. 111-5 extends authorization for the QI-1 program through December 2010.

In general, Medicaid payments are shared between federal and state governments according to a matching formula. Unlike the QMB and SLMB programs, federal spending under the QI-1 program is subject to annual limits. Expenditures under the QI-1 program are paid 100% by the federal government (from the Part B trust fund) up to a state's allocation level. States are required to cover only the number of people which 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 was \$350 million. For the period beginning on October 1, 2009 and ending on December 31, 2009, the total allocation is \$150 million. This provision allocates \$412.5 million for the period that begins January 1, 2010, and ends September 30, 2010; and allocates \$150 million for the period that begins October 1, 2010 and ends on December 31, 2010.

Sec. 5006. Protections for Indians Under Medicaid and CHIP

P.L. 111-5 combined a number of provisions presented separately or together as protections for Indians under Medicaid and the Children's Health Insurance Program (CHIP). Five provisions from either the Senate or House Bills were combined in P.L. 111-5, including premiums and cost sharing, eligibility determinations, estate recovery, managed care protections, and consultation with Indian health providers (IHP). CBO estimated that the Indian protections under Medicaid and CHIP would increase federal expenditures by \$6 million in FY2009 and by \$54 million from FY2009-FY2013.

Premiums and Cost-Sharing

Under Medicaid, premiums and enrollment fees generally are prohibited for most beneficiaries. Nominal amounts specified in federal regulations may be imposed on selected groups (e.g., certain families qualifying for transitional Medicaid, medically needy). Service-related cost-sharing (e.g., coinsurance, copayments) is prohibited for selected groups (e.g., children under 18, pregnant women) and selected benefits (e.g., hospice care, emergency services, family planning services and supplies). For most other groups and services, states may impose nominal cost-sharing amounts specified in federal regulations at state option. Premiums and cost-sharing may exceed nominal amounts for selected groups (e.g., workers with disabilities and individuals covered under Section 1115 waivers). The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) added a Medicaid state option for alternative premiums and cost-sharing for certain subgroups. Applicable maximum amounts vary by income level. Special rules apply to prescription drugs and non-emergency services provided in hospital emergency rooms.

P.L. 111-5 specifies that no premiums, service-related cost-sharing or similar charges can be imposed on Indians who receive Medicaid services directly from the Indian Health Service (IHS), an Indian tribe (IT), a tribal organization (TO), an urban Indian organization (UIO), or through referral under the contract health service. Medicaid payments due to such providers for services rendered to a Medicaid-eligible Indian cannot be reduced by the amount of such cost-sharing that would otherwise apply to such an Indian. The new law also adds Indians receiving services through Indian entities to the list of individuals exempt from paying premiums or cost-sharing under the DRA option. The effective date of this provision is July 1, 2009.

Treatment of Certain Property from Resources for Medicaid and CHIP Eligibility

The federal Medicaid statute identifies more than 50 eligibility pathways. For some pathways, asset tests are required and for other pathways, such tests are optional. When asset tests apply, some pathways give states flexibility to define specific assets to be counted and which can be disregarded. For other pathways, primarily for people qualifying on the basis of a disability or who are elderly, asset tests are required. States generally follow asset guidelines specified in the Supplemental Security Income (SSI) Program. Medicaid also defines the rules for counting certain assets. Under SSI law, several types of assets related to certain Indian-related lands held in trust by the U.S., certain other Indian held lands, and certain distributions (including land or an interest in land) received by certain Alaskan Natives or their descendants are excluded. There is no similar provision in prior CHIP law.

P.L. 111-5 prohibits consideration of four different classes of property from resources in determining Medicaid eligibility of an Indian. These include certain properties held in trust, certain other properties within the boundaries of a prior reservation, certain ownership interests

related to natural resources, and certain other ownership interests not otherwise specified that have unique religious, traditional or cultural significance that support subsistence or a traditional lifestyle. The new law also applies this provision to CHIP in the same manner that it applies to Medicaid. The effective date of this provision is July 1, 2009.

Continuation of Protections of Certain Indian Property from Medicaid Estate Recovery

Under Medicaid, all states are required to recover property and assets of deceased Medicaid beneficiaries for outstanding 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. States may grant an exemption if the recovery would place an undue hardship on the estate. The Secretary of HHS specifies the standards for a state hardship waiver for Medicaid estate recovery purposes.

P.L. 111-5 stipulates that certain income, resources, and property 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 new law also allows the Secretary to provide for additional estate recovery exemptions for Indians under Medicaid. The effective date of this provision is July 1, 2009.

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

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 or IHICIA) 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 the IHICIA.

In general under Medicaid, 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.

P.L. 111-5 requires that Indians enrolled in a non-Indian MCE with an IHP or UIO participating as a primary care provider be allowed to choose such an IHP or UIO as their primary care provider when (1) the Indian is otherwise eligible to receive services from such a provider and (2) the IHP or UIO has the capacity to provide primary care services to that Indian. Contracts between the state and such MCEs must include this requirement, and Medicaid payments to these entities would be conditional on meeting this requirement.

Under P.L. 111-5, Medicaid managed care contracts with MCEs and Primary Care Case Management (PCCMs) companies will be required to meet certain conditions to receive Medicaid payments, including:

- MCEs and PCCMs must demonstrate that the number of participating Indian health care providers is sufficient to ensure timely access to covered Medicaid managed care services for eligible Indian enrollees, and
- MCEs and PCCMs must agree to pay both participating and non-participating IHPs for services rendered to Indians 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, P.L. 111-5 specifies that MCEs and PCCMs must agree to make prompt payment, as required under Medicaid rules for all providers, to 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, ARRA applies special payment provisions to certain Indian health care providers that are 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 are 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, P.L. 111-5 applies specific sections affecting Medicaid to the CHIP program, including (1) Section 1932(a)(2)(C) 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 provisions described above. The effective date of this provision is July 1, 2009.

Consultation on Medicaid, CHIP and Other Health Care Programs Funded under the Social Security Act Involving Indian Health Programs and Urban Indian Organizations

There are no provisions in prior Medicaid or CHIP law regarding a Tribal Technical Advisory Group (TTAG) within CMS, the federal agency that oversees the Medicare, Medicaid and CHIP programs.

P.L. 111-5 requires the Secretary to maintain within CMS a TTAG, previously established in accordance with requirements of a charter dated September 30, 2003. ARRA also requires that the TTAG include a representative of a national urban Indian Health organization and the IHS. The representative of a national urban Indian Health organization will be exempt from the Federal

Advisory Committee Act for certain meetings with federal officials. The P.L. 111-5 also requires certain states 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. Applicable states include those in which one or more IHPs or UIOs provide health care services. 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 also applies this new language to CHIP in the same manner in which it applies to Medicaid. Finally, the new law prohibits 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. The effective date of this provision is July 1, 2009.

Sec. 5007. Funding for Oversight and Implementation.

Oversight

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

Implementation of Increased FMAP

This provision also includes a \$5 million appropriation for FY2009 to be used by the Health and Human Services Secretary to implement the temporary increased FMAP provision described in the Conference Agreement under Sec. 5001. The implementation funding is available to the Secretary until the end of FY2011 (September 30, 2011).

CBO estimated that the funding for the HHS Secretary for implementation of the temporary FMAP increase provision would increase federal expenditures by \$5 million in FY2009, with no financial impact beyond FY2009. CBO also estimated that federal expenditures would increase by \$31 million in FY2009 for the additional funds provided under this provision for the OIG to monitor the increased recession spending. There would be no financial impact beyond FY2009 for the OIG funding.

Sec. 5008. GAO Study and Report Regarding State Needs During Periods of National Economic Downturn.

Under this provision of P.L. 111-5, the Comptroller General of the United States and the Government Accountability Office (GAO), are to study the current (on the date of enactment of the legislation) economic recession as well as previous national economic downturns since 1974. GAO is required to develop recommendations to address states' needs during economic recessions, including the past and projected effects of temporary increases in FMAP during these

recessions. By April 1, 2011, GAO is required to submit a report to appropriate congressional committees that is to 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. The report should address:
 - 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 publically funded programs that provide health benefits coverage to state residents.
- Identification of and recommendations for addressing the effects on states of any other specific economic indicators GAO determines appropriate.

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