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Medicaid and the State Children's Health Insurance Program (SCHIP): FY2009 Budget Issues

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Medicaid and the State Children's Health Insurance Program (SCHIP): FY2009 Budget Issues

Summary

Each year, the President is required to submit a comprehensive federal budget proposal to Congress no later than the first Monday in February. The House and Senate Budget Committees then develop their respective budget resolutions. House and Senate Appropriations committees then reconcile their budget resolutions and file a joint budget agreement. Although not binding, the resolution provides a framework for consideration of the 12 separate appropriations bills that would fund FY2009 government operations.

The President's FY2009 budget contained a number of proposals that would affect Medicaid and the State Children's Health Insurance Program (SCHIP). While certain proposals would require legislative action, others could be implemented administratively (e.g., via regulatory changes, issuance of program guidance, or other possible methods). One of the more notable changes from the Bush Administration's previous budget proposal is an increase in SCHIP funding — increasing federal funding for allotments by $1.5 billion in FY2009 and by $19.7 billion over the five-year period from FY2009 to FY2013. The administration's budget proposed spending reductions to other Medicaid components that would offset much of the additional funding proposed for SCHIP so that total SCHIP and Medicaid spending would increase by $230 million in FY2009 and $1.3 billion from FY2009-FY2013 if the Administration's budget proposal were enacted without changes.

On June 4 and 5, 2008, the Senate and House, respectively, adopted the final version of the budget resolution (H.Rept. 110-659 accompanying S.Con.Res. 70). The conference agreement provides a deficit-neutral reserve fund of up to $50 billion for SCHIP legislation, a variety of other deficit-neutral reserve funds, up to $198 million for health care fraud and abuse control, a sense of the Senate provision on delaying Medicaid administrative regulations, and a sense of the Congress provision on improving access to affordable health coverage.

There were several legislative initiatives during the first part of the second session of the 110th Congress. The Protecting the Medicaid Safety Net Act of 2008 (H.R. 5613), introduced in March, would impose a one-year moratorium on seven recently issued Medicaid regulations. On May 22, 2008, the Senate passed the Supplemental Appropriations Act of 2008 (H.R. 2642), which included a one-year moratorium on implementation of seven Medicaid regulations. Other legislation affecting Medicaid includes the Medicare Improvements for Patients and Providers Act of 2008 (S. 3101), which was introduced June 6, 2008, and an alternative bill, the Preserving Access to Medicare Act of 2008 (S. 3118), introduced June 11, 2008. Although these bills would primarily address Medicare, they contain a number of Medicaid provisions as well.

This report will be updated to reflect relevant activity as the FY2009 budget advances and until the next President's FY2010 budget is released.

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Medicaid and the State Children's Health Insurance Program (SCHIP): FY2009 Budget Issues

Introduction

Each year, the President is required to submit a comprehensive federal budget proposal to Congress no later than the first Monday in February. Once it is submitted, the Congressional Budget Office (CBO) analyzes the proposal using its own economic assumptions and estimation techniques. The House and Senate Budget Committees then develop their respective budget resolutions after reviewing the President's budget, the views of other committees, and information from CBO. Differences between the houses are supposed to be resolved by April 15, but this deadline is rarely met. Although it is not binding, the resolution provides a framework for subsequent legislative action.

This report provides information on Medicaid and the State Children's Health Insurance Program (SCHIP). It will be updated to reflect relevant activity until the FY2009 budget is passed and until the next President's FY2010 budget is released. Congressional Research Service (CRS) staff contact information by topic area is provided in **Table 2** at the end of the report.

Medicaid and SCHIP in the President's FY2009 Budget

The President's FY2009 budget contains a number of proposals that would affect Medicaid and SCHIP. Some are program expansions, and others are designed to reduce federal spending. For each proposal, this report provides:

- background;
- a description of the proposal based on available information;[1] and
- a list of relevant CRS reports.

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[1] Sources include Department of Health and Human Services (HHS), *Fiscal Year 2009 Budget in Brief*, available at [http://www.hhs.gov/budget/docbudget.htm]; the Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2009*, available at [http://www.whitehouse.gov/omb/budget/fy2009/]; and HHS, Centers for Medicare and Medicaid Services, Fiscal Year 2009 Justification of Estimates for Appropriations Committees, available at [http://www.cms.hhs.gov/PerformanceBudget/Downloads/CMSFY09CJ.pdf].

Legislative Versus Administrative Proposals

As shown in **Table 1**, some of the President's proposals would require legislative action, while others would be implemented administratively (e.g., via regulatory changes, issuance of program guidance, etc.).

In their analyses of the President's budget, both CBO and executive branch agencies such as HHS and the Office of Management and Budget (OMB) provide baseline (current law) estimates of Medicaid and SCHIP spending along with estimated costs and savings of proposed changes. However, CBO and the executive branch differ in their treatment of legislative and administrative proposals.

In executive branch documents describing the President's budget, implementation of proposed administrative changes is assumed in estimates of baseline Medicaid and SCHIP[2] spending, and estimates for legislative proposals are presented separately. In general, CBO assesses the likelihood that a particular administrative action will take place before adjusting its baseline,[3] and only provides separate estimates for legislative proposals. For this reason and others, CBO and executive branch estimates of Medicaid and SCHIP spending differ.

Table 1. Cost (Savings) of Medicaid and SCHIP Proposals in the President's FY2009 Budget

Proposal	Outlays in $ millions			
	HHS estimate		CBO estimate	
	FY2009	FY2009-FY2013	FY2009	FY2009-FY2013
Medicaid				
Legislative proposals				
Maintain Substantial Home Equity Amount of $500,000	(80)	(480)	(70)	(440)
Redesign Acute Care Benefits for Optional LTC Groups	(20)	(650)	35	515
Repeal Section 1932(a)(2) Special Rule	(100)	(2,100)	(10)	(390)
Extend Section 1915(b) Waiver Period	—	—	—	—
Replace Best Price with Budget Neutral Rebate	—	—	—	—
Rationalize pharmacy reimbursement	(195)	(1,110)	(375)	(3,025)
Enhance Third Party Liability	(35)	(470)	(65)	(365)
Modify Asset Verification	(82)	(1,200)	(70)	(570)
Publish Annual Actuarial Report	—	—	—	—
Implement Cost Allocation	(280)	(1,770)	(280)	(1,770)

[2] For a description of adjustments made to arrive at baseline Medicaid expenditures, see HHS, Fiscal Year 2008 Justification of Estimates for Appropriations Committees, pp. 135-141 [http://www.cms.hhs.gov/PerformanceBudget/Downloads/CMSFY09CJ.pdf].

[3] CBO, letter to the Honorable John M. Spratt Jr., May 2, 2007, available at [http://www.cbo.gov/ftpdocs/80xx/doc8060/05-02-LetterOnRegs.pdf].

Proposal	Outlays in $ millions			
	HHS estimate		CBO estimate	
	FY2009	FY2009-FY2013	FY2009	FY2009-FY2013
Implement Medicaid Pay-for-Performance Incentives	—	(310)	—	(290)
Require State Participation in PARIS	(5)	(135)	(10)	(65)
Mandate National Correct Coding Initiative	(5)	(105)	(5)	(105)
Align Administrative Match Rates	(950)	(5,485)	(1,220)	(8,720)
Align Family Planning Match Rate	(570)	(3,335)	(635)	(3,955)
Align Case Management Rate	(200)	(1,100)	(240)	(1,470)
Align Qualified Individuals (QI) Program Match Rate	(200)	(200)	(32)	—
Extend QI Program	470	470	75	0
Extend Transitional Medical Assistance (TMA)	485	695	566	1,155
Modify HIPAA	—	—	—	—
Increase Flexibility for Premium Assistance	—	(140)	20	290
Subtotal, Medicaid Legislative Proposals	(1,767)	(17,425)	(2,316)	(19,205)
Other Medicaid Interactions				
Extend Refugee Exemption	32	92	4	10
SCHIP Reauthorization (Medicaid Impact)	130	235	174	2,352
QI Adjustment	(270)	(270)	155	237
Subtotal, Medicaid Interactions	(108)	57	333	2,599
Total, Medicaid Legislative Proposals	(1,875)	(17,368)	(1,983)	(16,606)
SCHIP				
Legislative proposals	2,105	18,685	499	11,936
SCHIP reauthorization	2,105	18,685	499	11,936
[Allotments (non-add)]	[1,500]	[19,740]	—	—
Total Outlays, SCHIP Legislative Proposals	2,105	18,685	499	11,936
Total Medicaid and SCHIP Legislative Proposals	230	1,317	(1,484)	(4,670)
Medicaid, Administrative Actions				
Clarify Inflation Protection in Partnership LTC Programs	—	—	—	—
Issue Regulation Defining 1915(b)(3) Services	(100)	(800)	—	—
Issue Free Care Regulation	—	—	—	—
Total, Medicaid Administrative Actions	(100)	(800)	—	—

Source: Department of Health and Human Services, *Fiscal Year 2009 Budget in Brief*, available at [http://www.hhs.gov/budget/docbudget.htm] and Congressional Budget Office, CBO Estimates of Medicaid and SCHIP Proposals in the President's Budget for Fiscal Year 2009, available at [http://cbo.gov/budget/factsheets/2008b/medicaid.pdf].

Notes: Numbers in parentheses represent savings. Estimates for proposals that do not show a dollar figure were not provided in the documents cited above. In executive branch documents describing the President's budget, implementation of proposed administrative changes is assumed in estimates of baseline Medicaid and SCHIP spending, and estimates for legislative proposals are presented separately. In general, CBO only adjusts its baseline estimates to account for administrative changes as they are implemented — rather than as they are proposed — and only provides separate estimates for legislative proposals.

Medicaid Legislative Proposals

Medicaid: Maintain Substantial Home Equity Amount of $500,000

Background. The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) amended the Social Security Act to exclude from Medicaid eligibility for nursing facility or other long-term care services, certain individuals with an equity interest in their home of greater than $500,000. Under DRA, the state may elect without regard to Medicaid's requirements concerning statewideness and comparability, to substitute an amount that exceeds $500,000, but does not exceed $750,000. These dollar amounts are increased, beginning in 2011, from year-to-year based on the percentage increase in the consumer price index (CPI) for all urban consumers (all items, United States city average), rounded to the nearest $1,000. The Secretary establishes a process for waiving this provision in the case of a demonstrated hardship. The homes of individuals whose spouse, child under age 21, or child who is blind or disabled (as defined by the Section 1614 of the Social Security Act) and lawfully resides in the individual's home are excluded.

Proposal. The President's budget seeks legislation that would limit the allowable home equity amount to $500,000 for all states by eliminating the state option to increase the equity limit to a number between $500,000 and $750,000. Starting in 2011, this limit would be adjusted by the CPI inflation factor. HHS estimates that the proposal would save $80 million in FY2009, and $480 million over the FY2009-FY2013 period.

Reports. For more information about home equity and Medicaid eligibility, see CRS Report RL33593, *Medicaid Coverage for Long-Term Care: Eligibility, Asset Transfers, and Estate Recovery*, by Julie Stone. For information on DRA's change to eligibility rules for counting home equity, see CRS Report RL33251, *Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005*, by Karen Tritz, Sibyl Tilson, Julie Stone, Chris L. Peterson, Jennifer O'Sullivan, Paulette C. Morgan, Elicia J. Herz, Jean Hearne, Jim Hahn, April Grady, Hinda Chaikind, and Evelyne P. Baumrucker.

Medicaid: Redesign Acute Care Benefits for Optional LTC Groups

Background. Eligibility for Medicaid's long-term care services, such as nursing home care or a range of home- and community-based supportive services, is limited to beneficiaries who meet state-designed assessments for functional need and financial standards. The assessment for functional need examines physical and/or cognitive functioning that evaluates whether applicants would require the level of care provided in an institution (e.g., a nursing facility, intermediate care facility for the mentally retarded, or a hospital). Financial standards refer to a variety of optional eligibility pathways, including pathways that allow states to cover people with long-term care needs who have income above 74% of the federal poverty level, which is equivalent to the level of cash payments under the Supplemental Security income program.

Beneficiaries who are enrolled in Medicaid, because they need long-term care services, also are generally entitled to a range of acute care benefits (e.g., hospital care, physician services, rehabilitation, private duty nursing, home health services, case management, among many others) that a state offers, as long as these services are medically necessary. For dual eligibles, individuals enrolled in both Medicare and Medicaid, Medicaid covers just those acute care services that are not covered by Medicare, often referred to as wrap around services.

Proposal. The President's budget would establish a state plan amendment option to allow states to offer a modified benefit package of acute care services for selected long-term care beneficiaries. States would be given the authority under this provision to expand on the DRA-flexibility to adapt private sector health insurance benefit packages to better meet the needs of specific Medicaid beneficiary groups. The DRA option is modeled on benefit packages available under SCHIP (i.e., FEHBP preferred provider option, coverage for state employees, the largest commercial HMO in a state, or Secretary-approved coverage). HHS estimates that by redesigning acute care benefits, Medicaid would save $20 million in FY2009 and $650 million over the FY2009-FY2013 period.

Reports. Currently, no other CRS reports address this topic.

Medicaid: Repeal Section 1932(a)(2)Special Rules

Background. To control costs and quality of care, many states contract with managed care organizations to deliver services to Medicaid beneficiaries. These arrangements can include contracts with health maintenance organizations (HMOs), primary care case management (PCCM) programs, and pre-paid health plans (PHPs), which vary in the comprehensiveness of services they provide and the degree of financial risk assumed in the managed care contracts. Prior to the Balanced Budget Act of 1997 (BBA, P.L. 105-33), federal Medicaid laws contained provisions that limited states' ability to use managed care, including requirements regarding freedom of choice of provider for beneficiaries, statewideness (i.e., all covered services must be available statewide), and comparability (i.e., the amount, duration and scope of any services available to one individual must be available to all individuals in the same eligibility category). Special waivers were required to override these rules.

BBA added Section 1932 to the Medicaid statute. This provision gave states the option of requiring Medicaid beneficiaries covered under states' Medicaid plans to enroll with a managed care entity without a waiver. Specific groups, identified in Section 1932(a)(2) were exempted from mandatory enrollment in managed care, including children under age 19 with special health care needs, defined as:

- those eligible for the Supplement Security Income or SSI program,
- children eligible for the Title V Maternal and Child Health Block Grant program,
- children under 18 who meet the SSI disability standards who require institutional care, but receive care outside the institution, and for whom the cost of that care does not exceed institutional care (also known as Katie Beckett or TEFRA children), and

- those receiving foster care or adoption assistance under Title IV-E or who are in foster care or otherwise in an out-of-home placement.

Other exempted groups include individuals who are dually eligible for Medicare and Medicaid. Indians are also exempted from mandatory enrollment in Medicaid managed care plans, unless the participating managed care entity is the Indian Health Service, or certain Indian Health Programs operated by Indian tribes, tribal organizations, or urban Indian organizations.

Proposal. The President's FY2009 Budget repeals Section 1932(a)(2). This change would allow states to require the currently exempted populations identified above to enroll in Medicaid managed care programs covered under Medicaid state plans. HHS estimates that by repealing the Section 1932(a)(2) special rules, Medicaid would save $100 million in FY2009 and $2.1 billion over the FY2009-2013 period.

Reports. Currently, no other CRS reports address this topic. For a general overview of managed care under Medicaid, see CRS Report RL33711, *Medicaid Managed Care: An Overview and Key Issues for Congress*, by Elicia J. Herz.

Medicaid: Extend Section 1915(b) Waiver Period

Background. Section 1915(b) of the Social Security Act gives the Secretary of HHS the authority to waive certain Medicaid program requirements (including statewideness, comparability of services, and freedom of choice of provider)[4] to allow states to establish mandatory managed care programs that restrict the providers from whom a beneficiary may obtain covered services, or that create a "carve out" delivery system for specialty care as long as such programs do not reduce beneficiary access and quality of care.[5]

Section 1915(b) waiver programs are generally approved for a two-year period and must be cost effective (cannot cost more than what the Medicaid program would have cost without the waiver). They may not be used to expand eligibility to individuals not otherwise eligible under the Medicaid state plan, but cost savings achieved under the waivers may be used to provide additional services (i.e., those not typically provided under the state plan) to Medicaid beneficiaries.

Proposal. The President's budget seeks legislation to extend the Section 1915(b) waiver renewal period from two years to three years. HHS estimates that the proposal would have no cost impact in FY2009 or over the FY2009-FY2013 period.

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[4] "Freedom of choice" refers to a requirement that Medicaid beneficiaries have the freedom to choose their medical care providers. "Comparability" refers to a requirement that services be comparable in amount, duration, and scope for all persons in each eligibility group. "Statewideness" refers to the requirement that states provide services on a state-wide basis, rather than in only a portion of the state.

[5] Prior to passage of the Balanced Budget Act of 1997 (BBA 97), a state had to obtain a Section 1115 or a Section 1915(b) ("freedom-of-choice") waiver from the Secretary of HHS if it wanted to require Medicaid recipients to enroll in a managed care program.

Reports. For more information on Medicaid managed care, see CRS Report RL33711, *Medicaid Managed Care: An Overview and Key Issues for Congress*, by Elicia J. Herz.

Medicaid: Replace Best Price with Budget Neutral Rebate

Background. Under Medicaid, drug manufacturers that wish to have their drugs available for Medicaid enrollees are required to enter into rebate agreements with the Secretary of HHS, on behalf of the states. Under the agreements, pharmaceutical manufacturers must provide state Medicaid programs with rebates on drugs paid on behalf of Medicaid beneficiaries. The formulas used to compute the rebates are intended to ensure that Medicaid pays the lowest price that the manufacturers offer for the drugs. Rebate calculations depend on the type of drug. For single source and innovator multiple source drugs, basic rebate amounts are determined by comparing the average manufacturer price (AMP) for a drug (the average price paid by wholesalers) to the "best price," which is the lowest price offered by the manufacturer in the same period to any wholesaler, retailer, nonprofit, or public entity. The basic rebate is the greater of 15.1% of the AMP or the difference between the AMP and the best price. Additional rebates are required if the weighted average prices for all of a given manufacturer's single source and innovator multiple source drugs rise faster than inflation. For non-innovator multiple source drugs, basic rebates are equal to 11% of the AMP.

Proposal. The President's budget seeks legislation to eliminate the "best price" from the rebate formula for single source and innovator multiple source drugs, changing the best price-based formula to a flat rebate. This change is intended to be made in a budget neutral manner. HHS explanatory materials describe the proposal as a way to simplify drug rebate calculations and as a way to allow private purchasers to negotiate lower prices without affecting Medicaid drug costs. HHS estimates that the proposal would have no cost impact in FY2009 or over the FY2009-FY2013 period.

Reports. For a general background on Medicaid prescription drug coverage and pricing including a description of drug rebates, see CRS Report RL30726, *Prescription Drug Coverage Under Medicaid*, by Jean Hearne.

Medicaid: Rationalize Pharmacy Reimbursement

Background. Under current law, state Medicaid programs set the prices paid to pharmacies for Medicaid outpatient drugs. Federal reimbursements for those drugs, however, are limited to a federal upper limit (FUL). The Deficit Reduction Act of 2005 (DRA) established that FULs applying to drugs available from multiple sources (generic drugs, for the most part) be re-calculated by CMS to be equal to 250% of the average manufacturer's price (AMP, the average price paid by wholesalers to manufacturers) as reported to CMS by the manufacturers. Those FUL formulas, however, have not yet been reissued based on the DRA provisions and remain calculated by CMS as equal to 150% of the published price for the least costly therapeutic equivalent. At this point, important components of the new FUL formula have been issued in a proposed federal rule. The rule has been contested and

CMS is prohibited from implementing its provisions until the court hears the case and makes a final determination of its legality.

Proposal. The President's budget seeks legislation that would build on changes made by DRA to achieve additional savings in the Medicaid program. The proposal would reduce the FULs on multiple source drugs from 250% of the AMP to 150% of the AMP of the lowest priced drug in the group. HHS estimates that the proposal would save $195 million in FY2009, and $1.1 billion over the FY2009-FY2013 period.

Reports. For more information on the Medicaid provisions of DRA 2005, see CRS Report RL33131, *Budget Reconciliation FY2006: Medicaid, Medicare, and State Children's Health Insurance Program (SCHIP) Provisions*, by Evelyne P. Baumrucker, et al. and CRS Report RL33251, *Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005*, by Karen Tritz et al. Additional background information on Medicaid prescription drugs can be found in CRS Report RL30726, *Prescription Drug Coverage Under Medicaid*, by Jean Hearne.

Medicaid: Enhance Third Party Liability

Background. Third party liability (TPL) refers to the legal obligation of third parties — individuals, entities, or programs — to pay all or part of the expenditures for medical assistance furnished under Medicaid. In general, federal law requires Medicaid to be the payer of last resort, meaning that all other available third parties must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual.

States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state Medicaid plan. If a state has determined that probable liability exists at the time a claim for reimbursement is filed, it generally must reject the claim and return it to the provider for a determination of the amount of third-party liability (referred to as "cost avoidance"). If probable liability has not been established or the third party is not available to pay the individual's medical expenses, the state must pay the claim and then attempt to recover the amount paid (referred to as "pay and chase").

States are generally required to cost avoid claims unless they have an approved waiver that allows them to use the pay-and-chase method. However, there are two statutory exceptions to this rule. In the case of prenatal and preventive pediatric care, states are required to use pay and chase. In the case of a Medicaid beneficiary whose parent provides medical support (e.g., health insurance coverage via an employer) as part of a child support order being enforced by the state, the state must use pay and chase if a provider has not been paid under the medical support arrangement within 30 days.

In some cases, a Medicaid beneficiary may be required to reimburse the state for Medicaid expenses paid on his or her behalf. To facilitate such reimbursement, the state may place a lien on the Medicaid beneficiary's property. With certain exceptions, federal law generally prohibits states from imposing Medicaid liens on

the property of living beneficiaries. In contrast, federal law permits Medicaid liens on the estates of deceased beneficiaries in a wider variety of situations.

Proposal. The President's budget seeks legislation to allow states to avoid costs for prenatal and preventive pediatric claims where a third party is responsible; collect for medical child support where health insurance is derived from a non-custodial parent's obligation to provide coverage; and recover Medicaid expenditures from beneficiary liability settlements. HHS estimates that the proposal would save $35 million in FY2009 and $470 million over the FY2009-FY2013 period.

Reports. Currently, no other CRS reports address this topic.

Medicaid: Modify Asset Verification

Background. The Social Security Administration is piloting a financial account verification system (in field offices located in New York and New Jersey) that uses an electronic asset verification system to help confirm that individuals who apply for Supplemental Security Income (SSI) benefits are eligible. The process permits automated paperless transmission of asset verification requests between SSA field offices and financial institutions. Part of this demonstration involved a comprehensive study to measure the value of such a system for SSI applicants as well as recipients already on the payment rolls. The study identified a small percentage (about 5 percent) of applicants and recipients who were overpaid based on this financial account verification system. The TMA, Abstinence Education, and QI Programs Extension Act of 2007 (P.L. 110-90) applied the SSA demonstration to Medicaid for the period of October 1, 2007 through September 30, 2012.

Proposal. The President's budget seeks legislation to provide technical corrections to the demonstration and extend it permanently. HHS estimates that the proposal would save $82 million in FY2009, and $1.2 billion over the FY2009-FY2013 period.

Reports. Currently, no other CRS reports address this topic.

Medicaid: Publish Annual Actuarial Report

Background. As required by the Social Security Act, a Medicare Board of Trustees oversees the financial operations of the Hospital Insurance trust fund that covers Medicare Part A services and the Supplementary Medical Insurance trust fund that covers Medicare Parts B and D. The act requires that the Board report annually to Congress on the financial and actuarial status of the funds. No such requirement exists for the Medicaid program, which does not have a trust fund and is financed with state dollars and federal general revenues.

Proposal. The President's budget seeks legislation to increase transparency through the publication of an annual actuarial report. HHS estimates that the proposal would have no cost impact in FY2009 or over the FY2009-FY2013 period.

Reports. Currently, no other CRS reports address this topic.

Medicaid: Implement Cost Allocation

Background. Because of the overlap in eligible populations, states often undertake administrative activities that benefit more than one program. Under the former Aid to Families with Dependent Children (AFDC) cash welfare program, AFDC and Medicaid program eligibility were linked, and many AFDC families also qualified for food stamps. As a result, states often collected necessary information for all three programs during a single eligibility interview or performed other shared administrative tasks and charged the full amount of the cost to AFDC as a matter of convenience. Since the federal government reimbursed states for 50% of administrative expenditures for all three programs, total federal spending was not affected by the way in which states allocated the programs' common administrative costs.

When Congress replaced AFDC with the Temporary Assistance for Needy Families (TANF) block grant program in 1996, the 50% federal match for expenditures related to cash welfare assistance ended and the automatic link between cash welfare and Medicaid eligibility was severed. Later, HHS clarified that states are required to allocate common administrative costs for TANF, Medicaid, and food stamps based on the relative benefits derived by each program. A remaining issue of controversy stems from the fact that TANF block grants are calculated in part on the basis of pre-1996 federal welfare spending, including any amounts received by states as reimbursement for common administrative costs. As a result, TANF block grants are higher in many states than they would be if common administrative costs attributable to Medicaid and food stamps were excluded from block grant calculations. To compensate, Congress has permanently reduced federal reimbursement for food stamp administrative costs in most states by a flat dollar amount that reflects the administrative costs attributable to food stamps that are included in states' TANF block grants (the annual reductions total about $200 million). Congress has not reduced federal reimbursement for Medicaid administrative costs in a similar manner.

Proposal. The President's budget seeks legislation to recoup Medicaid administrative costs included in states' TANF block grants. HHS estimates that the proposal would save $280 million in FY2009, and approximately approximately $1.8 billion over the FY2009-FY2013 period.

Reports. See CRS Report RS22101, *State Medicaid Program Administration: A Brief Overview*, by April Grady.

Medicaid: Implement Medicaid Pay-for-Performance Incentives

Background. The Budget Act of 1997 mandated performance monitoring as a tool for ensuring the delivery of quality services in Medicaid and SCHIP. Among several initiatives, the Centers for Medicare and Medicaid Services (CMS) formed the Performance Measurement Partnership Project to select a common set of measures that can be used by Medicaid and SCHIP programs on a voluntary basis to assess the quality of care.

Proposal. The President's budget proposal would seek legislation to require states to monitor and report on Medicaid performance measures aimed at improving quality of care, program integrity, and efficiency, and would link performance to federal Medicaid grant awards. Reporting would begin in FY2009 with a three-year phase-in for the performance measures. Beginning in 2012, states that fail to meet performance thresholds would be subject to Federal Medical Assistance Percentage (FMAP) or Medicaid grant award reductions, depending on the performance measure. These reductions would remain in effect until the state meets the designated thresholds for specific performance measures. Budget documents further indicate that performance measures currently being considered include increasing estate recovery collection rates and reducing the prevalence of daily physical restraints in nursing homes. HHS estimates that this proposal will have no cost impact in FY2009, but will produce $310 million savings over the FY2009-FY2013 period.

Reports. Currently, no other CRS reports address this topic.

Medicaid: Require State Participation in the Public Assistance Reporting Information System (PARIS)

Background. The Administration on Children and Families (ACF) began a program that coordinated with state public assistance agencies (SPAA) and other federal agencies in 1993, which became the Public Assistance Reporting Information System (PARIS) PARIS is an information-sharing project used by SPAAs and federal agencies (e.g., Medicaid, Department of Defense, Department of Veterans Affairs) to help in verifying clients' public assistance circumstances — - PARIS data-matching enables agencies to determine if public assistance clients are receiving benefits from other agencies. ACF assisted a number of states with start-up funds to establish PARIS demonstrations through a grant program. Although grant funding was exhausted, 42 states, the District of Columbia and Puerto Rico participate in PARIS in some form. PARIS is a voluntary program and commitment to the project by states varies considerably. The voluntary nature of the PARIS program and differing levels of state adherence to common approaches and use of matching data may decrease the program's effectiveness in neighboring states and nationally.

Proposal. This proposal would require states to participate in PARIS. States might receive guidance in rules or regulations from the Secretary of Health and Human Services on how best to collect and use the PARIS data-matching information, as well as other program participation issues. HHS estimates a PARIS program mandate would reduce Medicaid spending by $5 million in FY2009 and $135 million over the five year period from FY2009-FY2013.

Reports. Currently, no other CRS reports address this topic.

Medicaid: Mandate National Correct Coding Initiative

Background. The Centers for Medicare and Medicaid Services (CMS) administers the Medicare program. Working through contractors, primarily health insurance companies, CMS processes Part B Medicare claims which include

payments for physician, laboratory, and radiology claims. To ensure correct payment for claims, CMS implemented the correct coding initiative (CCI) in 1996. Under CCI CMS' contractors use automated edits to review Medicare claims submitted by Part B providers. Medicare contracts use software to scan claims using CCI edits to detect duplicate services delivered to the same beneficiary on the same date of service. In addition, by using pairs of matched Healthcare Common Procedure Coding System (HCPCS) codes[6] which generally are not billed together, CCI software identifies individual services billed erroneously as service bundles (when individual services are grouped together, but cheaper comprehensive codes are available to describe the same services) or in other cases as separate services which should have been billed individually and not as bundled services.

Proposal. This proposal would mandate Medicaid participate in a National Correct Coding Initiative, presumably similar to Medicare's correct coding initiative. HHS estimates that CCI would reduce Medicaid spending in FY2009 by $5 million and would decrease Medicaid spending by $105 million for the period FY2009-FY2013.

Reports. Currently, no other CRS reports address this topic.

Medicaid: Align Administrative Match Rates

Background. The federal government pays a share of every state's spending on Medicaid services and program administration. For most Medicaid services, this share is based on the federal medical assistance percentage (FMAP). The FMAP is based on a formula that provides higher reimbursement to states with lower per capita incomes (and vice versa); it has a statutory minimum of 50% and maximum of 83%. The federal match for administrative expenditures does not vary by state and is generally 50%, but certain administrative functions have a higher federal match. Functions with a 75% federal match include:

- compensation or training of skilled professional medical personnel (and their direct support staff) of the state Medicaid or other public agency;
- preadmission screening and resident review for individuals with mental illness or mental retardation who are admitted to a nursing facility;
- survey and certification of nursing facilities;
- operation of an approved Medicaid Management Information System (MMIS) for claims and information processing;
- performance of medical and utilization review activities or external independent review of managed care activities; and
- operation of a state Medicaid fraud control unit (MFCU).

In the case of MMISs and MFCUs, the federal match is 90% for startup expenses. There is a 100% match for the implementation and operation of immigration status verification systems. Section 1903(a)(7) of the Social Security

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[6] HCPCS codes are used to bill for physicians' services and outpatient procedures.

Act specifies that a 50% match will be provided for remaining expenditures that are found necessary by the Secretary of HHS for the proper and efficient administration of the state Medicaid program.

Proposal. The President's budget seeks legislation to set the federal reimbursement rate for all Medicaid administrative activities at 50%. HHS estimates that the proposal would save $950 million in FY2009, and approximately $5.5 billion over the FY2009-FY2013 period.

Reports. See CRS Report RS22101, *State Medicaid Program Administration: A Brief Overview*, by April Grady.

Medicaid: Align Family Planning Match Rate

Background. The federal government's share of most Medicaid service costs is based on the FMAP (see background on "Medicaid: Align Administrative Match Rates" proposal above). However, certain Medicaid services receive a higher federal match, including family planning services (which receive 90%) and those provided through an Indian Health Service facility (which receive 100%) or to certain women with breast or cervical cancer (which receive the enhanced FMAP used for SCHIP).

Proposal. The President's budget seeks legislation that would provide federal reimbursement for family planning services based on the FMAP. HHS estimates that the proposal would save $570 million in FY2009, and $3.3 billion over the FY2009-FY2013 period.

Reports. See CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by April Grady.

Medicaid: Align Case Management Match Rate

Background. Under current law, case management is an optional Medicaid service that assists Medicaid beneficiaries in gaining access to needed medical, social, educational and other services. The term targeted case management refers to situations in which the service is provided only to specific classes of beneficiaries (e.g., those with AIDS, tuberculosis, chronic physical or mental illness, developmental disabilities, or children in foster care) or to those who reside in a specific area. When case management is claimed as a service, the federal government's share of the cost is based on the FMAP (see background on "Medicaid: Align Administrative Match Rates" proposal above).

Case management can also be claimed as a Medicaid administrative activity, in which case the federal match is 50%. Thirty-eight states will have an FMAP that exceeds 50% in FY2009, meaning that the federal government would pick up a larger share of the cost in these states when case management is claimed as a Medicaid service.

Proposal. The President's budget seeks legislation that would set the federal reimbursement rate for all case management activities at 50%. HHS estimates that

the proposal would save $200 million in FY2009, and $1.1 billion over the FY2009-FY2013 period.

Reports. See CRS Report RL34426, *Medicaid Targeted Case Management Benefits*, by Cliff Binder; CRS Report RS22101, *State Medicaid Program Administration: A Brief Overview*, by April Grady; and CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by April Grady.

Medicaid: Align Qualified Individuals (QI) Program Match Rate

Background. Congress requires state Medicaid programs to pay monthly Medicare Part B premiums on behalf of certain low-income Medicare beneficiaries, including Qualifying Individuals (QI-1s) whose income is between 120% and 135% of the federal poverty level. Unlike the reimbursement procedure used for most Medicaid costs (see background on "Medicaid: Align Administrative Match Rates" proposal above), each state is allocated a fixed amount of federal funds to pay for the Medicare Part B premium costs of QI-1s and no state share is required. At the federal level, Medicaid amounts allocated to the states for QI-1s are offset by a reimbursement from Medicare Part B.

Proposal. The President's budget seeks legislation that would provide federal reimbursement to state Medicaid programs for the Medicare Part B premium costs of QI-1s based on the FMAP, thereby requiring a state share. HHS estimates that the proposal would save $200 million in FY2009, and $200 million over the FY2009-FY2013 period. As explained in the next section, "Extend QI Program," under this budget proposal the QI-1 program is re-authorized only for one year. Thus, funding to align the QI match rate also is only for one year at $200 million.

Reports. For more information about the QI-1 program, see CRS Report RL32977, *Dual Eligibles: A Review of Medicaid's Role in Providing Services and Assistance*, by Karen Tritz.

Medicaid: Extend QI Program

Background. Congress requires state Medicaid programs to cover the Medicare Part B premiums for certain groups of low-income Medicare beneficiaries. The Qualifying Individual (QI-1) program is one of these groups and includes individuals who have Medicare Part A benefits and whose income is between 120% and 135% of the federal poverty level. Medicaid already covers premiums for individuals below 120% of FPL. The Balanced Budget Act of 1997 established this group of eligibles for a temporary period between January 1998 and December 2002. Congress has extended eligibility for this group several times since its expiration. The most recent extension was authorized under the Medicare, Medicaid, and SCHIP Extension Act of 2007 ((P.L. 110-173), which extended the QI-1 program from January 1, 2008 through June 30, 2008. The prior extension, authorized the QI-1 Program through December 31, 2007 (P.L. 110-90). Without changes to current law, eligibility for this group would expire in September 2008.

Proposal. The President's budget seeks legislation to extend premium assistance for QI-1s through September 30, 2009. HHS estimates that the proposal would cost Medicaid $470 million in FY2009 and $470 million over the FY2009-FY2013 period, but that the net cost to Medicaid would be zero because the amounts paid are offset by state dollars obtained under the "Align QI Program Match Rate" proposal described earlier and a continued reimbursement from Medicare Part B.

Reports. For more information about the QI-1 program, see CRS Report RL32977, *Dual Eligibles: A Review of Medicaid's Role in Providing Services and Assistance*, by Karen Tritz.

Medicaid: Extend Transitional Medical Assistance

Background. 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 of benefits is known as 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. It also permanently requires four months of TMA for families who lose Medicaid eligibility due to an increase in earned income or hours of employment.

However, Congress expanded work-related TMA benefits in 1988, requiring states to provide at least six, and up to 12, months of TMA coverage to families losing Medicaid eligibility due to increased hours of work or income from employment, as well as to families who lose eligibility due to the loss of a time-limited earned income disregard (such disregards allow families to qualify for Medicaid at higher income levels for a set period of time). Congress has acted on numerous occasions to extend these expanded TMA requirements (which are outlined in Section 1925 of the Social Security Act) beyond their original sunset date of September 30, 1998. They are currently set to expire on June 30, 2008.

Proposal. The President's budget seeks legislation to extend expanded TMA requirements through September 30, 2009. HHS estimates that the President's proposal would cost Medicaid $35 million in FY2008, $485 million in FY2009, and $695 million over the FY2009-FY2013 period (the budgetary effects extend beyond FY2009 because families are still entitled to up to 12 months of TMA if they qualify on or before the expiration date).

Reports. See CRS Report RL31698, *Transitional Medical Assistance (TMA) Under Medicaid*, by April Grady.

Medicaid: Modify HIPAA

Background. The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) established a number of rules for employer-based health insurance plans to improve access to and portability of plans for people enrolled or enrolling into those plans. One of those provisions requires employer-based health plans to allow for new enrollment into the plan during periods outside of the typical annual open enrollment period for certain special reasons. Examples of those reasons

include when an eligible employee (or their dependent) exhausts COBRA continuation coverage, or when an employee gains a new dependent through birth or adoption. Another HIPAA provision limits the ability of private health insurance plans to exclude coverage for pre-existing conditions during what are known as "pre-existing condition exclusion periods." The allowable length of such pre-existing condition exclusion periods depends on the amount of time the new enrollee had been covered by prior "creditable" health insurance coverage.[7] A beneficiary can prove they have had prior creditable coverage by providing certificates issued by insurers at the end of each year. Because HIPAA was created in law before SCHIP was established, SCHIP was not included on the list of types of health insurance that can be considered as prior creditable coverage.

Proposal. The President's budget seeks several legislative changes relating to HIPAA. The first would define a determination of Medicaid or SCHIP eligibility as a qualifying event allowing for a special enrollment period into employer-based health insurance plans. This provision is intended to improve Medicaid and SCHIP programs' ability to coordinate coverage with private employer-offered coverage. The second proposal would require SCHIP programs to issue certificates of creditable coverage. This provision is intended to improve the reach of HIPAA's portability provisions by recognizing SCHIP coverage as prior creditable coverage. Both of these interpretations have previously been promulgated in a final regulation implementing HIPAA's portability for group health plan provisions.[8] HHS estimates that the proposal would have no cost impact in FY2009 or over the FY2009-FY2013 period.

Reports. For general information on HIPAA, see CRS Report RL31634, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*, by Hinda Chaikind, Jean Hearne, Bob Lyke, and C. Stephen Redhead.

Medicaid: Increase Flexibility for Premium Assistance

Background. Under Medicaid, states may pay a Medicaid beneficiary's share of costs for group (employer-based) health coverage for any Medicaid enrollee for whom coverage is available, comprehensive, and cost-effective for the state. An individual's enrollment in an employer plan is considered cost effective if paying the premiums, deductibles, coinsurance and other cost sharing obligations of the employer plan is less expensive than the state's expected cost of directly providing Medicaid-covered services. States must also provide coverage for those Medicaid covered services that are not included in the private plans.

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[7] Not all prior health insurance coverage is considered to be creditable. For a discussion of creditable coverage, see CRS Report RL31634, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*, by H. Chaikind, J. Hearne, B. Lyke, and C. Redhead.

[8] 69 Federal Register 78720, *Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers Under HIPAA Titles I and IV*, December 30, 2004.

Proposal. The President's budget seeks legislation and administrative action to provide states with greater flexibility in determining cost effectiveness and information sharing with employers. Reportedly, the administration also seeks to align Medicaid Employer-Sponsored Insurance options with open enrollment periods for group (employer-based) health coverage in an effort to streamline the implementation of these programs.[9] HHS estimates that the proposal would have no cost impact in FY2009 and would generate $140 million in savings over the FY2009-FY2013 period.

Reports. Currently, no other CRS reports address this topic.

Medicaid: Extend Refugee Exemption

Background. Under current law, most legal immigrants who entered the country on or after August 22, 1996, and some who entered prior to that date, are not eligible for Supplemental Security Income (SSI) benefits — and thus, SSI-related Medicaid — until they have resided in the country for five years or have obtained citizenship. Refugees and asylees are currently exempted from this ban for the first seven years they reside in the United States.

Proposal. The President's budget seeks legislation to extend the exemption for refugees and asylees from seven years to eight years, allowing additional time for individuals to complete the citizenship process without penalty. HHS estimates that the proposal would cost $32 million in FY2009, and $92 million over the FY2009-FY2013 period.

Reports. For general background information, see CRS Report RL31269, *Refugee Admissions and Resettlement Policy*, by Andorra Bruno; CRS Report RL31630, *Federal Funding for Unauthorized Aliens' Emergency Medical Expenses*, by Alison M. Siskin; and CRS Report RL33809, *Noncitizen Eligibility for Federal Public Assistance: Policy Overview and Trends*, Ruth Ellen Wasem.

Medicaid Administrative Proposals

Medicaid: Clarify Inflation Protection in Partnership Programs

Background. The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) added new requirements to the Social Security Act that specify, among other things, minimum inflation protection standards for long-term care (LTC) insurance policies to qualify under Medicaid's LTC Insurance Partnership program. Under this program, states with approved Medicaid state plan amendments may extend Medicaid coverage, including LTC benefits (i.e., nursing home and home- and community-based services), to certain persons who have purchased private LTC insurance policies without requiring them to meet the same means-testing

[9] HHS Budget Briefing for House Staff, February 4, 2008.

requirements applicable to other groups of Medicaid eligibles. During the eligibility determination for Medicaid, these states may disregard either a portion, or all assets, of the Medicaid applicant to the extent that payments have been made under a LTC insurance policy or because an individual has received (or is entitled to receive) benefits under a LTC insurance policy.

Under current law, the inflation protection standards required for a LTC Insurance Partnership policy specify that if, at the date of purchase, the purchaser is younger than age 61, the policy must provide for compound inflation; if the purchaser is at least age 61 but not older than age 76, the policy must provide some level of inflation protection; and if the purchaser is age 76 or older, the policy may, but is not required to, provide some level of inflation protection.

Some LTC insurance policies offer consumers a choice to purchase a feature known as a Future Purchase Option. This feature allows a purchaser to choose to increase the plan's benefits periodically, such as every second or third year, with a premium increase and no new underwriting. For purchasers who decline to take up the Future Purchase Option when it is offered, access to an inflation protection increase likely would be accompanied by new medical underwriting.

Proposal. The President's proposal seeks to take regulatory or sub-regulatory action to prohibit LTC Insurance policies that contain Future Purchase Option inflation protection from qualifying as state-approved LTC Partnership policies. HHS estimates that there would be neither no cost to Medicaid for this administrative change in FY2009 nor over the FY2009-FY2013 period.

Reports. For more information on the Medicaid LTC insurance program see, CRS Report RL33251, *Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005,* by Karen Tritz, Sibyl Tilson, Julie Stone, Chris L. Peterson, Jennifer O'Sullivan, Paulette C. Morgan, Elicia J. Herz, Jean Hearne, Jim Hahn, April Grady, Hinda Chaikind, and Evelyne P. Baumrucker; and CRS Report RL32610, *Medicaid's Long-Term Care Insurance Partnership Program*, by Julie Stone.

Medicaid: Issue Regulation Defining 1915(b)(3) Services

Background. Section 1915(b) of the Social Security Act gives the Secretary of HHS the authority to waive certain Medicaid program requirements (see above) to allow states to establish mandatory managed care programs that restrict the providers from whom a beneficiary may obtain covered services, or that create a "carve out" delivery system for specialty care as long as such programs do not negatively impact beneficiary access and quality of care of services. Under Section 1915(b)(3) states also have the option to use savings achieved by using managed care to provide additional health-related services (i.e., those not typically provided under the state plan) to Medicaid beneficiaries.

Section 1915(b) waiver programs are generally approved for a two-year period and must be cost effective (cannot cost more than what the Medicaid program would have cost without the waiver).

Proposal. The President's budget would, through administrative action, clarify which additional services may be provided under Section 1915(b)(3) out of cost savings achieved under Section 1915(b) waiver programs. HHS estimates that the proposal would generate $100 million in savings in FY2009 and $800 million over the FY2009-2013 period.

Reports. For more information on Medicaid managed care, see CRS Report RL33711, *Medicaid Managed Care: An Overview and Key Issues for Congress*, by Elicia J. Herz.

Medicaid: Issue Free Care Regulation

Background. Generally, Medicaid pays for covered benefits provided to Medicaid beneficiaries by Medicaid participating providers. However, third party payer and "free care" rules limit Medicaid's liability. For example, when private insurance is available, Medicaid must pay only the remainder of allowable costs for covered services after other third party coverage has been taken into account. This may result in no Medicaid payments. In addition, the "free care" principle precludes Medicaid from paying for Medicaid-covered services which are generally available without charge, and for which no other sources for reimbursement are pursued.

Both the Clinton and current Bush Administrations provided guidance on these payment principles in the context of school-based services. Services would not be considered to be "free" if certain conditions are met. Providers must: (1) establish a fee schedule for the services provided, (2) determine whether other third parties are liable for every individual served, and (3) bill the beneficiary and/or any liable third parties.

According to Administration guidance, there are exceptions to the "free care" principle. Covered services provided to children with an Individualized Education Plan (IEP) or an Individualized Family Service Plan (IFSP) pursuant to the Individuals with Disabilities Education Act (IDEA) are reimbursable under Medicaid. Also, Medicaid-covered services provided to individuals who qualify for benefits provided under the Title V Maternal and Child Health Services Block Grant, and the Women, Infants and Children's (WIC) program are also exempt from the free care principle. School providers can bill Medicaid for these services even when such services are provided to non-Medicaid eligible children free of charge. But in each case, the requirement to pursue all other liable third parties would still apply.

Proposal. The Administration proposes to codify through regulation, the long-standing Medicaid "free care" policy. Under this policy, providers cannot bill Medicaid for services furnished to the public and other payers at no cost. HHS estimates that the free-care regulation would not have a cost impact in FY2009 or over the five-year budget forecast period, FY2009-FY2013.

Reports. Currently, no other CRS reports address this topic.

SCHIP Legislative Proposals

SCHIP: SCHIP Reauthorization

Background. The Balanced Budget Act of 1997 (BBA, P.L.105-33) established SCHIP. In general, this program allows states to cover targeted low-income children with no health insurance in families with income that is above Medicaid eligibility levels. States may choose among three benefit options when designing their SCHIP programs. They may enroll targeted low-income children in Medicaid, create a separate state program, or devise a combination of both approaches. All states, the District of Columbia, and the five territories have SCHIP programs.

BBA appropriated nearly $40 billion for SCHIP for the period FY1998 through FY2007. The formula for determining annual state allotments is based on the estimated number of low-income children and low-income uninsured children in the state, adjusted by a state health cost factor. In FY2008, while reauthorization of the SCHIP program was under consideration, there were four continuing resolutions that maintained appropriations through December 31, 2007. For SCHIP allotments in FY2008, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173, enacted December 29, 2007, appropriated funds to ensure that no state's exhausted their federal SCHIP program funds before March 31, 2009, but did not make other changes to the program.

States that established SCHIP programs are entitled to federal reimbursement, up to a cap, for a percentage of the incurred costs of covering enrolled individuals. This percentage, which varies by state, is called the enhanced federal medical assistance percentage (E-FMAP). E-FMAP is based on states' Medicaid program matching rates (FMAPs), but is higher in SCHIP. In other words, the federal government contributes more toward the coverage of individuals in SCHIP (ranging from 65% to 83.09% in FY2009) than it does for those covered under Medicaid (50% to 75.4% in FY2009).[10]

States have three years to spend their annual allotment (e.g., states have until the end of FY2007 to spend their FY2005 allotments). At the end of the applicable three-year period, unspent funds are reallocated among states based on year-specific rules. In the early years of SCHIP, both states that did and did not fully exhaust their original allotments received unspent funds. In more recent years, only those states that fully exhausted their original allotments received unspent funds. Some states have experienced shortfalls in SCHIP funds, meaning at the end of a given fiscal year, they have spent all federal SCHIP funds available to them at that point in time, including original allotments and reallocations of unspent funds from other states.

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[10] Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the State Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2008 through September 30, 2009," *Federal Register*, Vol. 72, No. 228 / Wednesday, November 28, 2007 / Notices.

Proposal. Through a legislative proposal, the President's FY2009 Budget would increase SCHIP state allotments by $19.7 billion through FY2013, on top of the assumed $5 billion per year in the baseline.

As reported at a Health and Human Services (HHS) press conference on the budget, a CMS FY2009 budget briefing for House staff on February 4, 2008, and discussions with HHS' staff, the Administration proposes to target SCHIP funds at children and pregnant women with annual family income under 200% of the federal poverty level (FPL). The SCHIP proposal also sets a "hard cap" upper income eligibility threshold at 250% FPL based on families' gross annual incomes. HHS estimates that the proposed SCHIP allotments will cover eligible children below 200% FPL as well as enrollees with income between 200% and 250% FPL.[11] The enhanced SCHIP matching rate would apply to children in families with income below 250% FPL.

The Administration's policy assumes no new children would be enrolled in SCHIP if their annual family income exceeds the 250% "hard cap." However, children currently enrolled in SCHIP whose annual family income exceeds 250% FPL would be "grandfathered in" under current eligibility rules, and state expenditures on their behalf would be matched at the regular Medicaid FMAP. Under the SCHIP budget proposal, children in higher-income families (above 250% FPL) who lose eligibility based on current eligibility policies, but later wish to re-enroll in SCHIP would, after a continuous year off of SCHIP, be subject to the new 250% FPL "hard-cap" based on gross family income.

Further, under the SCHIP budget proposal, HHS plans to continue efforts to prevent the substitution of SCHIP for private insurance. The proposed "crowd-out" policy would apply to states seeking to exceed 200% FPL for SCHIP eligibility, rather than 250% FPL as stipulated in an August 17, 2007, letter from CMS's Center for State Operations to state health officials. States would be required to have the "crowd-out" strategies in place and meet the assurances listed in the August 17 letter, or face penalties for non-compliance. For example, states with SCHIP income eligibility thresholds greater than 200% FPL would be required to enroll 95% of their Medicaid- and SCHIP-eligible children with annual family income less than 200% FPL. States that do not comply with the 95% enrollment target would be subject to a one percentage point reduction in their federal matching rate (i.e., enhanced SCHIP FMAP for children in families with income between 200-250% FPL, and regular Medicaid FMAP for "grandfathered" children in families with income above 250% FPL), subject to annual matching rate changes, but capped at 5 percentage points. States that enroll 95% or more of the SCHIP eligible population below the 200% FPL target would be permitted to expand their SCHIP income eligibility threshold up to 250% FPL.

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[11] HHS estimates that the proposed federal SCHIP allotments also would be adequate to cover eligible, but not enrolled, children in families with annual income between 200%-250% FPL in the states that also meet the Administration's criteria for the proposed "crowd-out" policy (described below).

Moreover, the Administration proposes to transition adults out of SCHIP into the Medicaid program by December 31, 2008. Finally, the administration proposes to work with Congress to create a new allotment distribution formula that emphasizes enrollment of children in families with income under 200% FPL. HHS estimates that the proposal would increase SCHIP outlays by $2.1 billion in FY2009, and $18.7 billion over the FY2009-FY2013 period, and also will increase Medicaid outlays by $130 million in FY2009 and $235 million over the FY2009-FY2013 period.

Through a separate grant initiative, annual outreach grants in the amount of $50 million in FY2009, and $100 million in each of FY2010 through FY2013, would be available to states to identify and enroll uninsured children who are eligible for Medicaid and SCHIP.

Reports. For more information on the SCHIP, see CRS Report RL30473, *State Children's Health Insurance Program (SCHIP): A Brief Overview* by Elicia J. Herz, Chris L. Peterson, and Evelyne P. Baumrucker, and CRS Report RS22739, *FY2008 Federal SCHIP Financing*, by Chris L. Peterson.

Congressional Budget Action

The House and Senate adopted their respective budget resolutions for FY2009 in March of 2008. A conference agreement on the budget was adopted by both chambers on May 20. In early June, the Senate and House approved the FY2009 budget federal budget resolution (S.Con.Res. 70 — conference report: H. Rept 110-659). The budget agreement includes a trigger mechanism that would apply to bills or conference reports that would reduce revenue over a five-year period below CBO's baseline. Although the budget resolution does not become law, it establishes spending and revenue targets for discretionary spending. The resolution also creates a framework for the budget subcommittees to follow in developing 12 annual appropriations bills that will fund FY2009 (discretionary) federal programs and operations. With adoption of the budget proposal, Appropriations subcommittees will begin to mark up appropriations bills. House Appropriations subcommittees will start markups first, and the Senate will begin their markups later in June.

Senate

On March 3, 2008, the Senate Budget Committee reported a budget resolution (S.Con.Res 70), which was amended and passed by the Senate March 6. The Senate budget resolution includes 36 deficit-neutral reserve fund and sense of the Senate provisions, including a number of provisions that specifically could affect Medicaid and SCHIP:

- **SCHIP.** Would reserve up to $50 billion in outlays over five years for reauthorization of SCHIP.

- **Medicaid rules or administrative actions.** Would reserve funding to impose moratoria on federal rules covering aspects of the Medicaid or SCHIP programs, including targeted case management,

rehabilitation, school-based transportation and administration, and graduate medical education; transitional medical assistance. In addition, a sense of the Senate provision adds more discussion on how the administrative rules and actions should not undermine Medicaid nor shift Medicaid expenditures to states.

- **Other improvements in health.** Would reserve funds to make health insurance coverage more affordable; improve health care and provide quality health insurance coverage for under- and uninsured; improve and re-balance LTC; increase parity between health insurance coverage for mental health and medical-surgical services; and improve access to pediatric dental care for children from low-income families.

- **Pilot project on LTC provider background checks.** Provides up to $160 million for a three-year extension of a pilot program for national and state background checks for direct patient access employees of LTC facilities or providers.

- **State Internet sites to disclose Medicaid payments.** Would authorize creation of state internet sites for the disclosure of information on providers that participate in and receive payment from state Medicaid programs.

- **Demonstration waivers for low-income individuals with HIV.** Would provide for a demonstration project to use 1115 waivers for extending Medicaid coverage to low-income HIV-infected individuals.

House

The House Budget Committee reported a budget resolution (H.Con.Res. 312) on March 7, which was passed by the House on March 13. The House's budget resolution contained 17 deficit-neutral provisions and 12 sense of the House provisions. The budget-neutral and sense of the House provisions that would affect Medicaid and SCHIP include the following:

- **SCHIP.** The House budget resolution would reserve up to $50 billion in outlays over five years for reauthorization of SCHIP.

- **Health care quality, effectiveness, and efficiency.** This provision would include incentives and other support for health care information technology and electronic prescribing to protect privacy and improve quality. The provision also would include a public-private initiative for comparative effectiveness research, as well as mental health parity with medical surgical services including public programs, such as Medicaid.

- **Medicaid regulations and administrative actions.** The House budget would provide deficit-neutral reserve funds to prevent or

delay Medicaid regulations such as case management/targeted case management, rehabilitation, graduate medical education, and intergovernmental transfers.

- **Program integrity.** Up to an additional $198 million in FY2009 discretionary funding could be appropriated for the health care fraud and abuse control program.

- **Waste, fraud, and abuse, and health coverage affordability.** Sense of the House provisions describe the need for additional initiatives to identify and reduce health care waste, fraud, and abuse, as well as funding and programs to increase affordable health insurance coverage.

Conference Agreement

On May 20, the House and Senate filed a conference agreement on the budget resolution (H.Rept. 110-659 accompanying S.Con.Res. 70). On June 4, the Senate adopted a conference report (S.Con.Res. 70, accompanying H.Rept 110-659). The House adopted the same measure on June 5. Medicaid provisions in the Senate and House conference agreement include:

- A reserve fund up to $50 billion in outlays over five years for reauthorization of SCHIP that is deficit-neutral in the Senate and House.
- Deficit-neutral reserve funds for: (1) Medicaid and SCHIP regulations and administrative actions; (2) a demonstration project to provide Medicaid health coverage for low-income HIV-infected individuals; (3) increasing access for low-income families to pediatric dental care services; (4) extending transitional medical assistance; (5) health information technology, including e-prescribing; (6) comparative effectiveness research; (7) parity between health insurance coverage for mental health and medical surgical services, including public programs, such as Medicaid; (8) providing quality health insurance for uninsured/underinsured individuals; and (9) the use of Medicare data to evaluate health care issues (i.e., quality, safety, effectiveness, and resource utilization) in federal programs and the private health care system.
- Up to an additional $198 million in FY2009 discretionary funding could be appropriated for the health care fraud and abuse control program.
- Sense of the Senate provision on Medicaid administrative regulations. The conference agreement would prevent Medicaid administrative regulations from undermining the role of Medicaid, capping federal medicaid spending or shifting costs to states or beneficiaries, undermining the federal guarantee of safety net health coverage.
- Sense of the Congress resolutions on seeking opportunities to reduce health care waste fraud and abuse and increasing public access to affordable health coverage.

Appropriations

In general, Medicaid and SCHIP spending are not controlled through the annual appropriations process. As an entitlement program, Medicaid's spending level is based on the underlying benefit and eligibility criteria established in law. Federal Medicaid expenditures vary depending on the amount of services required and the number of beneficiaries that enroll in any federal fiscal year. SCHIP is a grant program, so federal spending is capped, with annual SCHIP appropriations specified by law. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) provides FY2008 and FY2009 SCHIP allotments through March 31, 2009, and enough additional funding to cover every state's currently projected federal SCHIP spending through March 31, 2009. As noted above, the administration's FY2009 budget proposal includes additional funding for SCHIP through FY2013.

Even though annual Medicaid and SCHIP appropriations are not controlled through the appropriations process, Congress can exercise some authority over Medicaid and SCHIP spending through the appropriations process by limiting funds for specified activities. For example, the Labor, Health and Human Services, and Education appropriations bill regularly contains restrictions that limit circumstances when federal funds may be used to pay for abortions.

Other Legislation

A bill, Protecting the Medicaid Safety Net Act of 2008 (H.R. 5613), was introduced in March that would impose a one-year moratorium on seven recently issued Medicaid regulations. On April 16, 2008, the House Energy and Commerce Committee voted to send H.R. 5613 to the full House. The House referred H.R. 5613 to the Senate after passing the measure on April 23, 2008. Among other things, H.R. 5613 would require the Secretary to submit a report by July 1, 2008, to the House Energy and Commerce and the Senate Finance Committees. The Secretary's report would be required to address three topics: (1) an outline of specific problems the Medicaid regulations were intended to correct, (2) an explanation of how the regulations would address these problems, and (3) the legal authority for the regulations.

In addition, H.R. 5613 would require the Secretary to retain an independent contractor to prepare a comprehensive report to be completed by March 1, 2009, which also would be submitted to the House Energy and Commerce and the Senate Finance Committees. The independent contractor's report would describe the prevalence of the specific problems identified in the Secretary's report, identify existing strategies to address these problems, and assess the impact of the Medicaid regulations on each state and the District of Columbia. In the Senate, a similar measure to H.R. 5613, the Economic Recovery in Health Care Act of 2008 (S. 2819), was introduced in April. Like H.R. 5613, S. 2819, would impose a one-year moratorium on seven Medicaid regulations until April 1, 2009, but also included moratoria on two additional Medicaid issues. One of the moratoriums in S. 2819 would suspend the rule arising from an August 17, 2007, letter from CMS to State Health Officials (07-001) that limited states' ability to expand coverage under the State Children's Health Insurance Program to families with incomes above certain

poverty levels. Another moratorium would suspend the rules governing Department Appeals Board (DAB) hearings, which would give expanded authority to the Secretary of HHS to review DAB decisions involving disagreements between the federal government and states and give the Secretary the authority to overturn DAB decisions.

On May 22, 2008, the Senate passed the Supplemental Appropriations Act of 2008 (H.R. 2642). H.R. 2642 included a one-year moratorium on implementation of seven Medicaid regulations. The provision in H.R. 2642 covering Medicaid regulations included requirements, similar to H.R. 5613, for the Secretary to submit reports to the House Energy and Commerce and the Senate Finance Committees. In addition, H.R. 2642 included provisions requiring states to implement a program to verify assets held by financial institutions to assess applicants' eligibility for medical assistance benefits (Medicaid). These asset verification programs would be phased in, so that all states and the District of Columbia, but excluding U.S. territories, would have programs by 2013.

The Medicare Improvements for Patients and Providers Act of 2008 (S. 3101) was introduced in the Senate on June 6, 2008. Although this legislation would primarily address Medicare issues, it contains several related Medicaid provisions as well. There are new requirements for Medicare Advantage plans that serve Medicaid beneficiaries through Special Needs Plans (SNPs). Under S. 3101, SNPs would need to nearly exclusively serve beneficiaries with the types of conditions the plans were organized to offer; namely, those with chronic or disabling conditions, institutionalized beneficiaries, or Medicaid-eligible individuals. Plans would also be subject to new quality monitoring and reporting requirements. S. 3101 also would extend transitional medical assistance and abstinence education programs at their current levels through FY2009, as well as continuing special disproportionate share hospital (DSH) allotment arrangements for Tennessee and Hawaii through a portion of FY2010. Other Medicaid provisions of S. 3101 include new rules that address administrative review of federal financial participation dis-allowances under Medicaid, as well as retaining through September 30, 2009, federal upper payment formulas for certain multiple source (mostly generic) drugs.

A similar but alternative bill, Preserving Access to Medicare Act of 2008 (S. 3118), was introduced June 11, 2008. S. 3118 would address Medicare Advantage SNPs, but unlike S. 3101, more closely follows rules from a recently released CMS regulation on SNPs and would remove a moratorium on SNPs. In addition, like S. 3101, S. 3118 would extend transitional medical assistance and abstinence education programs at their current levels through FY2009, as well as continuing special DSH allotment arrangements for Tennessee and Hawaii through a portion of FY2010. Other provisions of S. 3118 would include creation of a requirement, similar to H.R. 2642, that states and the District of Columbia implement systems to verify assets held in financial institutions when assessing individuals' eligibility for Medicaid; reduce administrative payments to prevent duplication of administrative payments under the Temporary Assistance for Needy Families program; and require a state plan amendment to limit inpatient hospital payment rates when certain conditions were acquired during beneficiaries' hospital stays.

Table 2. CRS Staff Contact Information, by Medicaid and SCHIP Topic Area

Topic	Staff member	Phone number
Medicaid		
Administration	April Grady	7-9578
Benefits and eligibility		
Aged	Julie Stone	7-1386
Children, families, immigrants, other non-disabled adults	Evelyne Baumrucker Jean Hearne Elicia Herz	7-8913 7-7362 7-1377
Individuals with disabilities, medically needy	Cliff Binder Julie Stone	7-7965 7-1386
Dual eligibles	Julie Stone	7-1386
Expenditures	April Grady	7-9578
Financing		
Disproportionate share hospital payments	Jean Hearne	7-7362
Federal medical assistance percentage	April Grady	7-9578
General issues	April Grady Jean Hearne Elicia Herz	7-9578 7-7362 7-1377
Intergovernmental transfers	Jean Hearne Elicia Herz	7-7362 7-1377
Upper payment limits	Elicia Herz	7-1377
HCBS & Section 1915(i) SPAs	Cliff Binder	7-7965
Integrity (waste, fraud, and abuse)	April Grady	7-9578
Long-term care	Cliff Binder Julie Stone	7-7965 7-1386
Managed care	Elicia Herz	7-1377
Prescription drugs	Jean Hearne	7-7362
Provider payment issues	Jean Hearne	7-7362
Regulations		
Case and targeted case management (TCM)	Cliff Binder	7-7965
Graduate medical assistance (GME)	Elicia Herz	7-1377
Outpatient hospital services	Elicia Herz	7-1377
Rehabilitation	Cliff Binder	7-7965
School-based services/administration	Elicia Herz	7-1377
Territories	Evelyne Baumrucker	7-8913
Waivers		
Section 1115	Evelyne Baumrucker	7-8913
Section 1915(c)	Cliff Binder Julie Stone	7-7965 7-1386
SCHIP		
Financing	Evelyne Baumrucker Chris Peterson	7-8913 7-4681
General issues	Evelyne Baumrucker Elicia Herz	7-8913 7-1377
Section 1115 waivers	Evelyne Baumrucker	7-8913