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REPORT
110–600

PROTECTING THE MEDICAID SAFETY NET ACT OF 2008

APRIL 22, 2008.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. DINGELL, from the Committee on Energy and Commerce, submitted the following

R E P O R T

[To accompany H.R. 5613]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 5613) to extend certain moratoria and impose additional moratoria on certain Medicaid regulations through April 1, 2009, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

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AMENDMENTS

The amendments are as follows:

69–006

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Protecting the Medicaid Safety Net Act of 2008".

SEC. 2. MORATORIA ON CERTAIN MEDICAID REGULATIONS.

(a) EXTENSION OF CERTAIN MORATORIA IN PUBLIC LAW 110–28.—Section 7002(a)(1) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (Public Law 110–28) is amended—

(1) by striking "prior to the date that is 1 year after the date of enactment of this Act" and inserting "prior to April 1, 2009";

(2) in subparagraph (A), by inserting after "Federal Regulations)" the following: "or in the final regulation, relating to such parts, published on May 29, 2007 (72 Federal Register 29748)"; and

(3) in subparagraph (C), by inserting before the period at the end the following: ", including the proposed regulation published on May 23, 2007 (72 Federal Register 28930)".

(b) EXTENSION OF CERTAIN MORATORIA IN PUBLIC LAW 110–173.—Section 206 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) is amended—

(1) by striking "June 30, 2008" and inserting "April 1, 2009";

(2) by inserting ", including the proposed regulation published on August 13, 2007 (72 Federal Register 45201)," after "rehabilitation services"; and

(3) by inserting ", including the final regulation published on December 28, 2007 (72 Federal Register 73635)," after "school-based transportation".

(c) ADDITIONAL MORATORIA.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, prior to April 1, 2009, take any action (through promulgation of regulation, issuance of regulatory guidance, use of Federal payment audit procedures, or other administrative action, policy, or practice, including a Medical Assistance Manual transmittal or letter to State Medicaid directors) to impose any restrictions relating to a provision described in subparagraph (A), (B), or (C) of paragraph (2) if such restrictions are more restrictive in any aspect than those applied to the respective provision as of the date specified in paragraph (3) for such provision.

(2) PROVISIONS DESCRIBED.—

(A) PORTION OF INTERIM FINAL REGULATION RELATING TO MEDICAID TREATMENT OF OPTIONAL CASE MANAGEMENT SERVICES.—

(i) IN GENERAL.—Subject to clause (ii), the provision described in this subparagraph is the interim final regulation relating to optional State plan case management services under the Medicaid program published on December 4, 2007 (72 Federal Register 68077) in its entirety.

(ii) EXCEPTION.—The provision described in this subparagraph does not include the portion of such regulation as relates directly to implementing section 1915(g)(2)(A)(ii) of the Social Security Act, as amended by section 6052 of the Deficit Reduction Act of 2005 (Public Law 109–171), through the definition of case management services and targeted case management services contained in proposed section 440.169 of title 42, Code of Federal Regulations, but only to the extent that such portion is not more restrictive than the policies set forth in the Dear State Medicaid Director letter on case management issued on January 19, 2001 (SMDL #01–013), and with respect to community transition case management, the Dear State Medicaid Director letter issued on July 25, 2000 (Olmstead Update 3).

(B) PROPOSED REGULATION RELATING TO REDEFINITION OF MEDICAID OUTPATIENT HOSPITAL SERVICES.—The provision described in this subparagraph is the proposed regulation relating to clarification of outpatient clinic and hospital facility services definition and upper payment limit under the Medicaid program published on September 28, 2007 (72 Federal Register 55158) in its entirety.

(C) PORTION OF PROPOSED REGULATION RELATING TO MEDICAID ALLOWABLE PROVIDER TAXES.—

(i) IN GENERAL.—Subject to clause (ii), the provision described in this subparagraph is the final regulation relating to health-care-related taxes under the Medicaid program published on February 22, 2008 (73 Federal Register 9685) in its entirety.

(ii) EXCEPTION.—The provision described in this subparagraph does not include the portions of such regulation as relate to the following:

(I) REDUCTION IN THRESHOLD.—The reduction from 6 percent to 5.5 percent in the threshold applied under section 433.68(f)(3)(i) of

title 42, Code of Federal Regulations, for determining whether or not there is an indirect guarantee to hold a taxpayer harmless, as required to carry out section 1903(w)(4)(C)(ii) of the Social Security Act, as added by section 403 of the Medicare Improvement and Extension Act of 2006 (division B of Public Law 109–432).

(II) CHANGE IN DEFINITION OF MANAGED CARE.—The change in the definition of managed care as proposed in the revision of section 433.56(a)(8) of title 42, Code of Federal Regulations, as required to carry out section 1903(w)(7)(A)(viii) of the Social Security Act, as amended by section 6051 of the Deficit Reduction Act of 2005 (Public Law 109–171).

(3) DATE SPECIFIED.—The date specified in this paragraph for the provision described in—

(A) subparagraph (A) of paragraph (2) is December 3, 2007;

(B) subparagraph (B) of such paragraph is September 27, 2007; or

(C) subparagraph (C) of such paragraph is February 21, 2008.

SEC. 3. FUNDS TO REDUCE MEDICAID FRAUD AND ABUSE.

(a) IN GENERAL.—For purposes of reducing fraud and abuse in the Medicaid program under title XIX of the Social Security Act, there is appropriated to the Secretary of Health and Human Services, out of any money in the Treasury not otherwise appropriated, $25,000,000, for each fiscal year (beginning with fiscal year 2009). Amounts appropriated under this section shall remain available for expenditure until expended and shall be in addition to any other amounts appropriated or made available to the Secretary for such purposes with respect to the Medicaid program.

(b) ANNUAL REPORT.—Not later than September 30 of 2009 and of each subsequent year, the Secretary of Health and Human Services shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on the activities (and the results of such activities) funded under subsection (a) to reduce waste, fraud, and abuse in the Medicaid program under title XIX of the Social Security Act during the previous 12 month period, including the amount of funds appropriated under such subsection (a) for each such activity and an estimate of the savings to the Medicaid program resulting from each such activity.

SEC. 4. STUDY AND REPORTS TO CONGRESS.

(a) SECRETARIAL REPORT IDENTIFYING PROBLEMS.—Not later than July 1, 2008, the Secretary of Health and Human Services shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report that—

(1) outlines the specific problems the Medicaid regulations referred to in the amendments made by subsections (a) and (b) of section 2 and in the provisions described in subsection (c)(2) of such section were intended to address;

(2) detailing how these regulations were designed to address these specific problems; and

(3) cites the legal authority for such regulations.

(b) INDEPENDENT COMPREHENSIVE STUDY AND REPORT.—

(1) IN GENERAL.—Not later than July 1, 2008, the Secretary of Health and Human Services shall enter into a contract with an independent organization for the purpose of—

(A) producing a comprehensive report on the prevalence of the problems outlined in the report submitted under subsection (a);

(B) identifying strategies in existence to address these problems; and

(C) assessing the impact of each regulation referred to in such subsection on each State and the District of Columbia.

(2) ADDITIONAL MATTER.—The report under paragraph (1) shall also include—

(A) an identification of which claims for items and services (including administrative activities) under title XIX of the Social Security Act are not processed through systems described in section 1903(r) of such Act;

(B) an examination of the reasons why these claims for such items and services are not processed through such systems; and

(C) recommendations on actions by the Federal government and the States that can make claims for such items and services more accurate and complete consistent with such title.

(3) DEADLINE.—The report under paragraph (1) shall be submitted to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate not later than March 1, 2009.

(4) COOPERATION OF STATES.—If the Secretary of Health and Human Services determines that a State or the District of Columbia has not cooperated with the

independent organization for purposes of the report under this subsection, the Secretary shall reduce the amount paid to the State or District under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) by $25,000 for each day on which the Secretary determines such State or District has not so cooperated. Such reduction shall be made through a process that permits the State or District to challenge the Secretary's determination.

(c) FUNDING.—

(1) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Secretary without further appropriation, $5,000,000 to carry out this section.

(2) AVAILABILITY; AMOUNTS IN ADDITION TO OTHER AMOUNTS APPROPRIATED FOR SUCH ACTIVITIES.—Amounts appropriated pursuant to paragraph (1) shall—

(A) remain available until expended; and

(B) be in addition to any other amounts appropriated or made available to the Secretary of Health and Human Services with respect to the Medicaid program.

SEC. 5. ASSET VERIFICATION THROUGH ACCESS TO INFORMATION HELD BY FINANCIAL INSTITUTIONS.

(a) ADDITION OF AUTHORITY.—Title XIX of the Social Security Act is amended by inserting after section 1939 the following new section:

"ASSET VERIFICATION THROUGH ACCESS TO INFORMATION HELD BY FINANCIAL INSTITUTIONS

"SEC. 1940. (a) IMPLEMENTATION.—

"(1) IN GENERAL.—Subject to the provisions of this section, each State shall implement an asset verification program described in subsection (b), for purposes of determining or redetermining the eligibility of an individual for medical assistance under the State plan under this title.

"(2) PLAN SUBMITTAL.—In order to meet the requirement of paragraph (1), each State shall—

"(A) submit not later than a deadline specified by the Secretary consistent with paragraph (3), a State plan amendment under this title that describes how the State intends to implement the asset verification program; and

"(B) provide for implementation of such program for eligibility determinations and redeterminations made on or after 6 months after the deadline established for submittal of such plan amendment.

"(3) PHASE-IN.—

"(A) IN GENERAL.—

"(i) IMPLEMENTATION IN CURRENT ASSET VERIFICATION DEMO STATES.—The Secretary shall require those States specified in subparagraph (C) (to which an asset verification program has been applied before the date of the enactment of this section) to implement an asset verification program under this subsection by the end of fiscal year 2009.

"(ii) IMPLEMENTATION IN OTHER STATES.—The Secretary shall require other States to submit and implement an asset verification program under this subsection in such manner as is designed to result in the application of such programs, in the aggregate for all such other States, to enrollment of approximately, but not less than, the following percentage of enrollees, in the aggregate for all such other States, by the end of the fiscal year involved:

"(I) 12.5 percent by the end of fiscal year 2009.

"(II) 25 percent by the end of fiscal year 2010.

"(III) 50 percent by the end of fiscal year 2011.

"(IV) 75 percent by the end of fiscal year 2012.

"(V) 100 percent by the end of fiscal year 2013.

"(B) CONSIDERATION.—In selecting States under subparagraph (A)(ii), the Secretary shall consult with the States involved and take into account the feasibility of implementing asset verification programs in each such State.

"(C) STATES SPECIFIED.—The States specified in this subparagraph are California, New York, and New Jersey.

"(D) CONSTRUCTION.—Nothing in subparagraph (A)(ii) shall be construed as preventing a State from requesting, and the Secretary approving, the implementation of an asset verification program in advance of the deadline otherwise established under such subparagraph.

"(4) EXEMPTION OF TERRITORIES.—This section shall only apply to the 50 States and the District of Columbia.

"(b) ASSET VERIFICATION PROGRAM.—

"(1) IN GENERAL.—For purposes of this section, an asset verification program means a program described in paragraph (2) under which a State—

"(A) requires each applicant for, or recipient of, medical assistance under the State plan under this title on the basis of being aged, blind, or disabled to provide authorization by such applicant or recipient (and any other person whose resources are material to the determination of the eligibility of the applicant or recipient for such assistance) for the State to obtain (subject to the cost reimbursement requirements of section 1115(a) of the Right to Financial Privacy Act but at no cost to the applicant or recipient) from any financial institution (within the meaning of section 1101(1) of such Act) any financial record (within the meaning of section 1101(2) of such Act) held by the institution with respect to the applicant or recipient (and such other person, as applicable), whenever the State determines the record is needed in connection with a determination with respect to such eligibility for (or the amount or extent of) such medical assistance; and

"(B) uses the authorization provided under subparagraph (A) to verify the financial resources of such applicant or recipient (and such other person, as applicable), in order to determine or redetermine the eligibility of such applicant or recipient for medical assistance under the State plan.

"(2) PROGRAM DESCRIBED.—A program described in this paragraph is a program for verifying individual assets in a manner consistent with the approach used by the Commissioner of Social Security under section 1631(e)(1)(B)(ii).

"(c) DURATION OF AUTHORIZATION.—Notwithstanding section 1104(a)(1) of the Right to Financial Privacy Act, an authorization provided to a State under subsection (b)(1) shall remain effective until the earliest of—

"(1) the rendering of a final adverse decision on the applicant's application for medical assistance under the State's plan under this title;

"(2) the cessation of the recipient's eligibility for such medical assistance; or

"(3) the express revocation by the applicant or recipient (or such other person described in subsection (b)(1), as applicable) of the authorization, in a written notification to the State.

"(d) TREATMENT OF RIGHT TO FINANCIAL PRIVACY ACT REQUIREMENTS.—

"(1) An authorization obtained by the State under subsection (b)(1) shall be considered to meet the requirements of the Right to Financial Privacy Act for purposes of section 1103(a) of such Act, and need not be furnished to the financial institution, notwithstanding section 1104(a) of such Act.

"(2) The certification requirements of section 1103(b) of the Right to Financial Privacy Act shall not apply to requests by the State pursuant to an authorization provided under subsection (b)(1).

"(3) A request by the State pursuant to an authorization provided under subsection (b)(1) is deemed to meet the requirements of section 1104(a)(3) of the Right to Financial Privacy Act and of section 1102 of such Act, relating to a reasonable description of financial records.

"(e) REQUIRED DISCLOSURE.—The State shall inform any person who provides authorization pursuant to subsection (b)(1)(A) of the duration and scope of the authorization.

"(f) REFUSAL OR REVOCATION OF AUTHORIZATION.—If an applicant for, or recipient of, medical assistance under the State plan under this title (or such other person described in subsection (b)(1), as applicable) refuses to provide, or revokes, any authorization made by the applicant or recipient (or such other person, as applicable) under subsection (b)(1)(A) for the State to obtain from any financial institution any financial record, the State may, on that basis, determine that the applicant or recipient is ineligible for medical assistance.

"(g) USE OF CONTRACTOR.—For purposes of implementing an asset verification program under this section, a State may select and enter into a contract with a public or private entity meeting such criteria and qualifications as the State determines appropriate, consistent with requirements in regulations relating to general contracting provisions and with section 1903(i)(2). In carrying out activities under such contract, such an entity shall be subject to the same requirements and limitations on use and disclosure of information as would apply if the State were to carry out such activities directly.

"(h) TECHNICAL ASSISTANCE.—The Secretary shall provide States with technical assistance to aid in implementation of an asset verification program under this section.

"(i) REPORTS.—A State implementing an asset verification program under this section shall furnish to the Secretary such reports concerning the program, at such times, in such format, and containing such information as the Secretary determines appropriate.

"(j) TREATMENT OF PROGRAM EXPENSES.—Notwithstanding any other provision of law, reasonable expenses of States in carrying out the program under this section shall be treated, for purposes of section 1903(a), in the same manner as State expenditures specified in paragraph (7) of such section.".

(b) STATE PLAN REQUIREMENTS.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (69) by striking "and" at the end;

(2) in paragraph (70) by striking the period at the end and inserting "; and"; and

(3) by inserting after paragraph (70), as so amended, the following new paragraph:

"(71) provide that the State will implement an asset verification program as required under section 1940.".

(c) WITHHOLDING OF FEDERAL MATCHING PAYMENTS FOR NONCOMPLIANT STATES.—Section 1903(i) of such Act (42 U.S.C. 1396b(i)) is amended—

(1) in paragraph (22) by striking "or" at the end;

(2) in paragraph (23) by striking the period at the end and inserting "; or"; and

(3) by adding after paragraph (23) the following new paragraph:

"(24) if a State is required to implement an asset verification program under section 1940 and fails to implement such program in accordance with such section, with respect to amounts expended by such State for medical assistance for individuals subject to asset verification under such section, unless—

"(A) the State demonstrates to the Secretary's satisfaction that the State made a good faith effort to comply;

"(B) not later than 60 days after the date of a finding that the State is in noncompliance, the State submits to the Secretary (and the Secretary approves) a corrective action plan to remedy such noncompliance; and

"(C) not later than 12 months after the date of such submission (and approval), the State fulfills the terms of such corrective action plan.".

(d) REPEAL.—Section 4 of Public Law 110–90 is repealed.

SEC. 6. ADJUSTMENT TO PAQI FUND.

Section 1848(l)(2) of the Social Security Act (42 U.S.C. 1395w-4(l)(2)), as amended by section 101(a)(2) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173), is amended—

(1) in subparagraph (A)(i)—

(A) in subclause (III), by striking "$4,960,000,000" and inserting "$3,790,000,000"; and

(B) by adding at the end the following new subclause:

"(IV) For expenditures during 2014, an amount equal to $3,690,000,000.";

(2) in subparagraph (A)(ii), by adding at the end the following new subclause:

"(IV) 2014.—The amount available for expenditures during 2014 shall only be available for an adjustment to the update of the conversion factor under subsection (d) for that year."; and

(3) in subparagraph (B)—

(A) in clause (ii), by striking "and" at the end;

(B) in clause (iii), by striking the period at the end and inserting "; and"; and

(C) by adding at the end the following new clause:

"(iv) 2014 for payment with respect to physicians' services furnished during 2014.".

Amend the title so as to read:

A bill to extend certain moratoria and impose additional moratoria on certain Medicaid regulations through April 1, 2009, and for other purposes.

PURPOSE AND SUMMARY

The purpose of H.R. 5613, the "Protecting the Medicaid Safety Net Act of 2008", is to place a one-year moratorium on the U.S. Department of Health and Human Services (HHS) implementation of seven Medicaid regulations recently issued by, and for other purposes. These proposed regulations have the potential to adversely affect the Medicaid program, title XIX of the Social Security Act. The regulations would eliminate Medicaid payment for certain out-

patient hospital services; redefine the rules for how States may use provider taxes to fund Medicaid; restrict Medicaid payments to governmental healthcare providers such as critical safety net hospitals and nursing homes; restrict Medicaid coverage of rehabilitative services which are essential for people with disabilities; eliminate Medicaid payment for Medicaid administrative activities in schools, such as outreach and enrollment, and specialized medical transportation for school-age children who receive a medical service in school; restrict the coverage of case management services under the Medicaid program; and eliminate Medicaid payment for graduate medical education costs, used to train medical residents who care for Medicaid beneficiaries and others with special needs. The legislation ensures that Secretary will take no action, regulatory or otherwise, to advance the specified policies of these proposed regulations before April 2009.

The purpose of H.R. 5613, the "Protecting the Medicaid Safety Net Act of 2008," is to place a 1-year moratorium on the Department of Health and Human Services implementation of 7 Medicaid regulations issued by the Department over the past 14 months, and for other purposes. These proposed regulations have the potential to adversely affect the Medicaid program. The regulations affected by this legislation would restrict the use of intergovernmental transfers, limit Medicaid payments to governmental providers, clarify and narrow payment policy for certain provisions in target case management final regulation, prohibit Federal Medicaid payments for certain school-based administration and transportation services, narrow the definition of rehabilitative services, prohibit Federal Medicaid payment for graduate medical education, clarify the definition of outpatient clinic and hospital services, and prohibit elements of regulation related to permissible taxes on healthcare providers. The legislation ensures that Secretary will take no action, regulatory or otherwise, to advance the specified policies of these proposed regulations before April 2009.

BACKGROUND AND NEED FOR LEGISLATION

Beginning in 2007, the Centers for Medicare and Medicaid Services (CMS) began issuing rules that made significant programmatic changes to the Medicaid program. Only two of the regulations were issued in response to recent Congressional legislation, the provider tax rule, and the case management rule. This reshaping of the Medicaid program by Administrative action raised significant concern in Congress, as well as with the Nation's governors, Medicaid directors, State legislators, beneficiary advocates, providers, schools, and others affected by the proposed changes.

Throughout 2007, Congress acted to place moratoria on a number of the regulations targeted by H.R. 5613. In the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (P.L. 110–28) Congress placed a one-year ban on the regulation restricting payments to public providers (intergovernmental transfers) and the rule eliminating Medicaid payment for graduate medical education (GME). This moratorium expires on May 25, 2008.

In the Children's Health Insurance Program Reauthorization Act (CHIPRA), Congress placed a moratorium on the rule restricting rehabilitation care and school-based administration and transpor-

tation services. This legislation, however, was vetoed twice by the President.

In the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110–173), Congress placed a six-month moratorium on the implementation of the rule restricting rehabilitation care under Medicaid and the rule eliminating Medicaid payment for specialized medical transportation for school children with disabilities and Medicaid outreach and enrollment conducted by schools. This moratorium expires on June 30, 2008.

In addition, Senators Mikulski (D–MD) and Coleman (R–MN) offered an amendment to S. 1200, the Indian Health Care Improvement Act (ICHIA), which placed a one-year moratorium on the targeted case management rule, which was adopted by voice vote. The House, however, has not yet completed action on ICHIA.

Both the House and Senate-passed budget resolutions include a reserve fund that would allow for deficit-neutral action to place a moratorium on the regulations. These funds would allow Committee allocations to be appropriately adjusted in the event such legislation was enacted. Differences between the two bills are currently being negotiated by the House and Senate Budget Committees.

In response to the concerns raised by Medicaid stakeholders about the looming expiration of the existing moratoria and the need for a moratorium on the remaining regulations, Rep. John D. Dingell (D–MI), Chairman of the Committee on Energy and Commerce, along with Representative Tim Murphy (R–PA), introduced H.R. 5613. This legislation would place a one-year moratorium, but not a permanent ban, on all seven regulations. This will allow Congress time to better understand the nature and extent of the problems that the regulations propose to address, whether the solution identified in the regulation is appropriate and within the authority of CMS, and how each regulation would affect States, beneficiaries, and providers.

This legislation received broad bipartisan support by the Nation's 50 governors and Medicaid directors. More than 2,000 organizations, including national organizations such as the American Hospital Association, the American Health Care Association, and the American Association of School Administrators, and the American Association of People with Disabilities, as well as local organizations such as the Wayne County Public Schools in Michigan, have come forward in support of H.R. 5613.

REGULATIONS DELAYED BY H.R. 5613

Regulation	Date issued/Status	Summary
Optional Case Management Services.	Interim final rule issued December 4, 2007; no current moratorium, regulation effective March 3, 2008.	Medicaid's case management benefit is intended to help people with disabilities, chronic illnesses, or special needs to gain access to the full spectrum of health care and support services by arranging for and coordinating care. The rule would eliminate Federal reimbursement to States for all payments for certain case management activities (such as those done by child welfare workers); limit Federal reimbursement for other case management activities (such as assistance with transitioning out of a nursing home); and eliminate Federal reimbursement for case management as an administrative activity.

REGULATIONS DELAYED BY H.R. 5613—Continued

Regulation	Date issued/Status	Summary
Rehabilitation services 72 Fed. Reg. 45201.	Proposed rule issued August 13, 2007; current moratorium (sec. 206 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, P.L. 110–173) through June 30, 2008.	Medicaid's rehabilitation benefit provides an array of care and services to allow individuals with disabilities to attain, maintain, or regain maximum function. The rule would prohibit Federal Medicaid reimbursement to States for services that allow a beneficiary to maintain current functional status and rehabilitative services furnished through a non-medical program (e.g., foster care, adoption services, education, juvenile justice)
School-based administration and transportation services 72 Fed. Reg. 73635.	Final rule issued December 28, 2007; current moratorium (sec. 206 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, P.L. 110–173) through June 30, 2008.	Under current law, States may receive Federal Medicaid reimbursements for payments to schools for both administrative activities associated with the Medicaid program (such as outreach and enrollment) and specialized medical transportation services of a child to and from school. The rule prohibits Federal Medicaid reimbursements for (1) administrative activities by school employees or contractors and (2) specialized medical transportation of school-aged children from home to school and back when receiving a medical service at the school.
Payments to public providers 72 Fed. Reg. 29748.	Final rule issued May 29, 2007; current moratorium (sec. 7002 of P.L. 110–28) through May 25, 2008.	This rule changes existing policy to eliminate a major source of supplemental payments to healthcare providers such as public hospitals and nursing homes. Since 1991 the Federal law has explicitly allowed States to use certain intergovernmental transfers and certified public expenditures to help States pay their share of Medicaid costs. This rule would limit the amount States can pay to governmentally-operated healthcare providers. It would also restrict the types of entities authorized to provide non-Federal share funding and the rule determines which healthcare providers would be subject to the new cost limit.
Provider taxes 72 Fed. Reg. 13726.	Final rule issued February 22, 2008; no current moratorium.	Under current law, States are allowed to use certain types of taxes on healthcare providers as a way to help pay for Medicaid expenses. These taxes are typically supported by providers because the taxes are used to improve provider payment rates and improve quality. This rule redefines what CMS would consider an ''allowable'' provider tax beyond what is in the law, replacing the current objective and quantitative test for determining whether a provider tax, or quality fee, is permissible with a new test that is completely subjective.
Graduate medical education 72 Fed. Reg. 28930.	Proposed rule issued May 23, 2007; current moratorium (sec. 7002 of P.L. 110–28) through May 25, 2008.	This rule would prohibit Federal Medicaid reimbursement payments for graduate medical education programs that train providers so they have the experience and skills necessary to meet the unique needs of Medicaid beneficiaries, particularly individuals with disabilities. Forty-seven States and the District of Columbia currently provide these payments under the Medicaid program.

During the comment periods for these regulations, CMS received virtually no comments in support of the seven regulations. CMS indicated that of approximately 1,000 comments on the public provider payment rule, one piece of correspondence contained a positive comment, the rest indicated opposition. Of the 333 comments received on the hospital outpatient rule, only 1 was positive. Of the 1,240 pieces of correspondence received on the school-based admin-

istration and transportation rule, 1,225 were in opposition. There were no positive comments among the 1,845 pieces of correspondence received on the rehabilitation rule.

In spite of the significant opposition expressed by the public comments on these seven regulations, CMS issued a number of the regulations in final form, even after Congress specifically directed the agency to cease such activities. The public provider payment rule was issued in final form after Congress enacted the moratorium on the rule, but before the President signed the legislation making that law effective. Likewise, the rule on school-based administration and transportation was issued in final form after Congress passed a bill placing a moratorium on it, but before the President signed the bill into law.

H.R. 5613 will allow for Congressional review of both the agency's apparent disregard for the public comments received and the agency's apparent disregard of Congressional intent. In fact, only minor provisions of two of the seven regulations were in response to statutory changes. The moratoria in H.R. 5613 would allow those two portions of the rules, which were specifically enacted by Congress, to proceed.

These regulations were not published as a result of Congressional action. Congress has not acted to change these sections of the statute for years. For example, Congress last took legislative action on the hospital outpatient department benefit in 1977, and there has been no change in the statute regarding school services since 1987. And in a number of instances, Congress specifically rejected the changes the Administration made through regulations. In 2006, a majority of the House of Representatives wrote to HHS Secretary Michael Leavitt expressing opposition to the regulatory proposals included in the President's Budget for fiscal year 2007, including changes to school-based administration and transportation services, public provider payments, provider taxes, and rehabilitation services. These views were conveyed in two separate letters: a letter dated July 26, 2006, signed by all 201 House Democratic Members, 1 Independent Member, and 4 Congressional Delegates; and a May 8, 2006, letter signed by 80 House Republican Members.

PAYMENTS TO PUBLIC PROVIDERS CMS 2258—FC

Federal Medicaid law has long allowed States to use funds transferred from other units of government, such as counties or localities, to meet Medicaid's State share requirement. These intergovernmental transfers (IGTs) are also allowed when the counties or localities operate hospitals or nursing facilities that participate in Medicaid. In 1991, Congress enacted legislation prohibiting the use of donations from non-governmental organizations but codifying the authority for States to use IGT funds transferred from units of government, including those that operate providers, to State Medicaid agencies for use as the non-Federal share.

In 1997, Congress enacted legislation giving States broad flexibility in setting payment rates for inpatient hospital and nursing facility services, whether furnished by public or by private providers. As a result, States have for more than a decade had broad flexibility in setting payment rates to reimburse hospitals and nursing homes for covered Medicaid services, whether those facili-

ties are public or private. This flexibility allows each State to decide whether its Medicaid program should contribute toward the cost of treating the uninsured.

The CMS proposed rule would restrict Federal Medicaid reimbursements for services offered in hospitals, nursing homes, and other providers operated by units of government to their "direct costs" of furnishing services to Medicaid patients. Under this regulation, Medicaid would no longer contribute toward the costs incurred by public providers in treating the uninsured and for specific things such as the losses that the hospital might incur for emergency room visits, burn units, or trauma care. In contrast, Medicare includes coverage for direct and indirect costs. Indirect costs include Medicare's fair share of the overall costs of running the hospital.

This rule was not published as a result of any recent Congressional action. Congress has not acted to change payments for public providers under Medicaid since 1997. The Government Accountability Office (GAO) testified at the April 3, 2008, hearing before the Subcommittee on Health of the Committee on Energy and Commerce on H.R. 5613 that additional transparency is necessary in public provider payments and transfers of funds from the local to the State levels. The Committee believes, however, that "transparency" can be accomplished without this regulation.

In a 1994 report GAO suggested that Congress consider enacting legislation to prohibit Medicaid payments that exceed costs to any government facility, to minimize the likelihood that States can develop illusory financing mechanisms whereby providers return Medicaid payments to the States, thus reducing the States' share of Medicaid funding. In several reports subsequent to 1994 reviewing various aspects of inappropriate payment arrangements, GAO has reiterated this matter for the Congress to consider. (See HEHS–94–133, GAO/T–HEHS–00–193, GAO–04–228, GAO–04–574T, See GAO–05–748, GAO–05–836T, and GAO–08–255T.) And, Congress passed legislation on this matter in 2000 (P.L. 106–554), and CMS rules implementing these changes became final in 2001.

In a 2007 GAO report that reviewed CMS oversight of State Medicaid arrangements, it noted that the CMS initiative undertaken within the agency's existing regulations had not been implemented in a transparent manner, contributing to concerns about the consistency of the agency's actions. GAO recommended that the Administrator of CMS issue guidance to clarify allowable arrangements for financing the non-Federal share of Medicaid payments. GAO noted that such guidance could include finalizing the January 18, 2007, draft regulation that limited payments to government providers to costs. (See GAO–07–214, GAO–08–255T.)

The Committee believes, however, that CMS, through its successful oversight initiative launched in 2003, has already largely addressed all of the issues cited in the GAO and OIG testimony, without the provisions in the public provider rule. According to a CMS chart dated November 2006, only 3 States remained that CMS had identified potentially questionable IGT practices, down from 15 in 2005. The most recent GAO report on the topic verified this and found that CMS had successfully terminated inappropriate financing arrangements in 29 States. The GAO testified at the April 3,

2008, hearing before the Subcommittee on Health that they have no recent reports demonstrating a continuing problem.

The National Association of Public Hospitals and Health Systems (NAPH), American Hospital Association (AHA), and the Association of American Medical Colleges (AAMC) have filed suit against in the United States District Court for the District of Columbia asking for a preliminary injunction prohibiting CMS from implementing these regulations restricting payments to public providers.

HOSPITAL OUTPATIENT RULE CMS 2213–P

In September of 2007, CMS issued a proposed rule making significant changes to the Medicaid hospital outpatient department benefit. This regulation was not published as a result of Congressional action. In addition, GAO testified at the hearing before the Subcommittee on Health of the Committee on Energy and Commerce on April 3, 2008, that it has not done any work in this area. At this same hearing, the Director of the CMS Center for Medicaid and State Operations noted that "CMS does not anticipate a major impact on providers or beneficiaries under this regulation as [they] do not believe attempts to inflate UPLs [upper payment limits] through this manner are widely used currently, but [they] do believe it is important to clarify this policy." The Committee requested the agency provide State-by-State information on the effect of this rule, but CMS has yet to respond.

The proposed rule would restrict the types of outpatient services that can be reimbursed by the Federal Government. The rule would, for example, limit coverage of dental services and screening services as an outpatient department service.

The Committee believes that such a restriction could have a negative effect on State efforts to reduce unnecessary emergency room use. Hospitals have used the outpatient clinics as a way to keep beneficiaries out of the emergency room. This is a more cost-effective alternative. And further, these clinics can provide a medical home for the patient.

In the proposed rule, CMS states the rule is necessary to prevent Medicaid from raising payment limits for Medicaid services. GAO and other entities have reported on Medicaid's historically low payment rates. In fact, one of the witnesses at the April 3, 2008, Subcommittee on Health hearing on H.R. 5613 noted that Medicaid's payment rates are low. Ms. Grace-MarieTurner, President of the Galen Institute, said that "[t]he great majority of providers serving Medicaid patients are working to provide the best care possible, often at considerable sacrifice, such as physicians who treat Medicaid patients even if the Medicaid payment means they are taking a financial loss." Since low payments can impair access to providers, the rule raises concerns regarding access for beneficiaries.

This proposed rule would eliminate the practice used by many States to control costs of paying "all-inclusive" for outpatient hospital services. These rates, like Medicare's rate, are paid to the hospital and include a professional component, for the services of the physician. Unlike Medicare, the physician cannot bill the Medicaid program separately. In order to receive Federal Medicaid reimbursements, the proposed rule would require States to break apart their payments, paying the facility and professional components

separately. This would require States to amend their long standing payment policies.

PROVIDER TAX RULE CMS 2275—P

Federal law allows States to generate the State's share of Medicaid funding from other governmental sources. Many States use provider taxes as a way to raise funds to support Medicaid. These taxes are allowed as long as they meet a multi-prong test to ensure the tax is "broad-based and uniform" and do not hold the provider harmless for the amount of the tax. One part of this multi-prong test determines whether the tax is 'positively correlated' with provider payments. This is to prevent States from simply using the tax to generate Federal Medicaid dollars, and holding the provider harmless for the amount of the tax.

Currently, States rely on a mathematical test to determine whether or not their provider tax was allowable. The State mathematical formula determines if the tax has a 'positive correlation' with provider payments. If so, the tax is not allowed. This test is simple and transparent.

CMS issued a final rule making significant changes to the Medicaid provider tax requirements in February 2008. States were given two months to comply with the significant changes made in the rule, which takes effect on April 22, 2008. The final rule eliminated the mathematical test as the standard. States will have no clear, transparent guidance to follow to determine whether their program was operating in accordance with the law.

Moreover, because many State provider tax programs are outlined in State statute, States would be unable to conform their programs to the new requirements in the two months provided by the rule. States would not only have to negotiate new allowable arrangements with CMS, but also have such arrangements approved by their State legislature. This cannot likely be accomplished in two months.

The rule was not published as a result of work carried out by the Government Accountability Office. GAO testified at the April 3, 2008, hearing before the Subcommittee on Health, that there was no basis in GAO work done for the provisions in the provider tax regulation, particularly those sections where there is no basis in law.

The Deficit Reduction Act of 2005 (P.L. 109–171) (DRA) directed CMS to ensure taxes on managed care organizations were within the scope of the provider tax requirements. The Tax Relief and Health Care Act of 2006 lowered the allowable tax rate from 6 percent to 5.5 percent from January of 2008 through September of 2011.

H.R. 5613 does not place a moratorium on these two Congressionally-mandated changes. It only places a moratorium on the parts of the rule that go beyond the two statutory changes.

GRADUATE MEDICAL EDUCATION CMS 2279—P

CMS published a proposed rule in May 2007 eliminating Medicaid payment for graduate medical education programs that train providers so they have the experience and skills necessary to meet the unique needs of Medicaid beneficiaries. Currently 47 States and the District of Columbia provide payment for graduate medical

education costs under Medicaid. Only Illinois, Texas, and North Dakota do not provide such payments.

In his testimony before the Committee, the Director of the CMS Center for Medicaid and State Operations noted that "GME is not included as a service, or a component of a service, that is eligible for FFP." CMS has, however, historically and consistently recognized, approved, and funded its share of Medicaid GME payments. According to the Congressional Research Service (CRS), "Historically, Medicare and Medicaid have recognized * * * graduate medical education (GME) costs. * * *" States have the authority to cover GME payments as a cost of delivering hospital services, which comes under the broad requirements of 1902(a)(13)(A) which informs States of the process by which to establish their rates.

In addition, GME is noted in both statute and regulation. Congress expressly identified GME as an allowable expense in the Deficit Reduction Act of 2005 (P.L. 109–171), in noting that default rates paid to certain Medicaid providers in Section 1932(b)(2) should be "less any payments for indirect costs of medical education and graduate medical education". In 2002, CMS modified Medicaid managed care regulations. In those regulations (42 CFR 438.60), CMS required States to adjust Medicaid managed care payments "to account for the aggregate amount of GME payments to be made directly to hospitals" to ensure that States were not paying twice for GME.

GAO testified at the April 3, 2008, hearing on H.R. 5613 that it had not worked to identify fraud and abuse in this area. CMS, however, believes that it does not have sufficient information on what Medicaid GME supports. Currently Medicaid State plans must include a description of how States will administer GME payments under Medicaid. CMS approves all these plans.

Teaching hospitals, which receive these payments, represent only 6 percent of all hospitals yet are the sites for approximately 25 percent of all Medicaid hospitalizations. They also supply nearly half of all pediatric intensive care beds and one-third of all intensive care beds for premature or seriously ill newborns. With the increase in the number of uninsured, and the increase in enrollment in Medicaid due to a decline in employer-coverage, Medicaid assistance to ensure physicians have training to deal with the unique needs of these beneficiaries is even more critical. Eliminating GME payments in Medicaid will harm physician-training programs at a time when the Nation faces a physician shortage and primary care physicians are becoming so important for this type of care.

On a bipartisan basis, Governors have indicated the negative effect this regulation would have on patient care. Governor Haley Barbour of Mississippi noted "If the GME program is eliminated, the University of Mississippi Medical Center's ability to provide care for our Medicaid beneficiaries will be threatened." Ohio Governor Ted Strickland noted, "Ohio's teaching hospitals will lose millions of dollars if these regulations and or proposals are allowed to proceed and it will undercut their ability to train the next generation of physicians."

SCHOOL ADMINISTRATION AND TRANSPORTATION SERVICES CMS 2287–F

CMS proposed a final rule restricting payments for school administrative and transportation services in December 2007, after Congress enacted a moratorium on implementation of the rule but before the President signed that bill into law. This rule eliminates Medicaid funding for any Medicaid administrative services conducted by schools, including outreach, enrollment, and care coordination. The rule also eliminates Medicaid payment for specialized medical transportation for children with disabilities to and from school on a day the child receives a Medicaid service in the school.

This rule was not published as a result of recent Congressional action or as a result of work done by the Government Accountability Office. GAO testified at the April 3, 2008, hearing before the Subcommittee on Health that it had not recommended changes, such as elimination of payments for administration and transportation services in any of its work.

According to a GAO 2005 report addressing the use of contingency fee contractors in Medicaid, GAO noted that the Department of Health and Human Services Office of the Inspector General had reviewed school-based claims in 18 States. These reviews largely cover claims made prior to issuance by CMS of the Medicaid Administrative Claiming guide (MAC), which provided schools and Medicaid agencies with clear guidance on billing for such services.

In a 2000 GAO report, it recognized the importance of school-based administrative activities for Medicaid. GAO wrote, "Close to one-third of Medicaid-eligible individuals are children, making schools an important arena for Medicaid services * * * Outreach and identification activities—in many varied settings—help ensure that the nation's most vulnerable children receive routine preventive health care or ongoing primary care and treatment."

Current law allows for schools to be reimbursed when they perform legitimate Medicaid activities. Federal Medicaid law calls for the provision of Federal funding for administrative activities that the Secretary finds "necessary * * * for the proper and efficient administration of the State [Medicaid] plan."

Until now, many States have entered into interagency agreements with schools whereby school nurses and other school staff identify children eligible for Medicaid and help their families through the enrollment process. School nurses also coordinate healthcare services for children with special needs, inform families of services that are available to the children, and help families access those services. States are required to provide these latter activities as part of the Federal Medicaid Early Periodic Screening Diagnostic and Treatment (EPSDT) benefit.

The regulation would eliminate Medicaid payment for all of these services. Many school-based outreach efforts that successfully enroll uninsured low-income children in Medicaid would end, resulting in an increase in the number of children who are eligible for the program, but who remain uninsured. The regulation would also make it much more difficult for States to carry out their EPSDT responsibilities, which include arranging for and helping children access needed health care.

The regulation would also eliminate all payments for Medicaid-covered transportation services to and from school. Under Medicaid, States must ensure children have transportation to and from providers. Many children who are in special education programs actually receive health services covered by Medicaid in schools.

The Medicare Catastrophic Coverage Act of 1988 required Medicaid payment for Medicaid-covered services provided to Medicaid-eligible children pursuant to an Individualized Education Program (IEP) under the Individuals with Disabilities Education Act (IDEA). Section 1903(c) of the Social Security Act states, "Nothing in this title shall be construed to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act [IDEA] * * *". Thus, because transportation is a Medicaid-covered service for children, when specialized medical transportation is listed in an IEP as a required service, it is supposed to be reimbursed by Medicaid.

As CMS has acknowledged in the preamble to its interim final rule, Medicaid coverage of school-based transportation services is already highly restricted. Under current law, Medicaid only pays for specialized medical transportation to and from school if the child is receiving special education and transportation is listed in the child's Individualized Education Plan (IEP). Even then, Medicaid payment is only available on days when a child receives a Medicaid-covered service in school. The rule on schools, however, would eliminate all payments for Medicaid-related transportation under the current construct.

"Regular" transportation to and from school is clearly not a covered Medicaid service. Since at least 1999, CMS has made clear that such transportation is not covered by Medicaid. A May 21, 1999, letter to State Medicaid directors stated, "HCFA would like to clarify that a child with special education needs under IDEA who rides the regular school bus to school with other non-disabled children in his/her neighborhood should not have transportation listed in his IEP and the cost of that bus ride should not be billed to Medicaid."

CASE MANAGEMENT RULE CMS 2237—IFC

CMS published an interim final rule restricting payments for Medicaid case management services in December 2007. This rule became effective on March 3, 2008. This rule restricts Medicaid funding for case management provided as an administrative activity. The rule also restricts Medicaid payment for targeted case management services needed for people with disabilities to remain in or transition to community living settings.

Forty-nine States and the District of Columbia provide targeted case management services to various groups of adults with disabilities. All States, in compliance with the EPDST benefit must provide medically-necessary case management services to children. Case management is a critical Medicaid benefit, helping millions of low-income children and adults with disabilities gain access to needed medical services. The term "targeted" case management is

used when the case management is provided to one specific group of beneficiaries.

A January 2005 report by the Department of Health and Human Services notes the importance of case management, "[b]ecause successfully supporting working age adults with serious mental illness in the community often involves not only addressing their treatment needs, but also assisting them in other areas * * * the coverage of targeted case management services is a means to support linkages to other services, as well as to monitor the well-being of individuals and assist them to address problems they might encounter in community living."

In spite of this relatively recent support for case management by the HHS, the recent rule proposes to restrict this important benefit. In addition, GAO testified at the April 3, 2008, hearing before the Subcommittee on Health that many of the components of the case management regulation, such as requiring States to submit payment in 15-minute increments or reducing the amount of time beneficiaries can receive case management services when they are trying to move from an institution to the community, were not recommended by GAO. In a 2005 report dealing with the use of contingency fee consultants in two States, however, GAO noted that some claims for case management services were inconsistent with current CMS policy and that, to ensure compliance with existing policies, CMS establish or clarify certain policies and then communicate them, including policies for targeted case management services. GAO reiterated these recommendations in Congressional testimony (GAO–08–255T and GAO–05–836T.)

In the Deficit Reduction Act of 2005, Congress directed CMS to issue a rule relating to certain aspects of case management clarifying that (1) case management can include contacts with individuals who are not eligible for Medicaid when necessary to manage the care of the Medicaid beneficiary, but does not include management of the ineligible individual's own needs; and (2) case management does not include direct delivery of services to which the individual has been referred. DRA also clarified which specific foster care services are not considered part of Medicaid's case management benefit. Congress did not direct CMS to change the Medicaid coverage of other case management services.

H.R. 5613 would not impose a moratorium on the components of the rule that were published in accordance with Congressional direction. The bill would impose a moratorium on the components of the rule that seem to go beyond the DRA provisions. For example, the bill would put a moratorium on the provisions of the rule that restrict the ability of States to get reimbursement for case management that are provided as an administrative activity. It would also put a moratorium on the portion of the regulation that requires States to bill for case management services in separate 15-minute increments, rather than paying all-inclusive rates.

It would also place a moratorium on the provision of the rule that shortens the time that people moving out of an institution into the community can receive case management services. The case management rule restricts the amount of time a case manager can spend helping a person with disabilities plan and execute a transition to the community. Some individuals would only have 14 days of case management to accomplish all these goals. Case manage-

ment services for others, who have been in an institution for more than 180 days, would be limited to 60 days.

The moratorium in the legislation also would apply to that the portion of the case management rule that prohibits payment for the case management services until the individual actually transitions to the community. Case managers would bear greater financial risk, and in some cases could receive no payment at all. For example, if a person with a mental illness suffered a complicating setback that postponed his or her ability to transition out of the nursing home, the case manager, who had arranged for the community services needed by the beneficiary, would receive no payment because the beneficiary was unable to transition at that particular time.

The moratorium would also apply to the portion of the case management rule that imposes a hard limit of one case manager per person. While in most cases this is appropriate, for a beneficiary with multiple conditions, such as HIV/AIDS, mental illness, or an intellectual disability, no single case manager may be able to coordinate housing, health care, and social needs across multiple systems. DRA did not place any such limits on case management services.

The rule would impose an integral component test to prohibit Medicaid coverage of services that CMS deems are integral to other Federal or State non-medical programs. This test has no basis in the Medicaid statute. Further, it mirrors a policy that CMS sought to include in the rehabilitation services option under DRA, but which was specifically rejected by the Congress. The moratorium would also apply to this portion of the rule.

The rule would require case management services for Medicaid-covered children in foster care by a Medicaid provider operating outside of the foster care system. Today States can reimburse providers in the foster care system when they provide Medicaid-covered services. States allocate payment to the foster care worker based on the time the foster care worker spends on Medicaid case management activities or having a qualified contractor of the foster care agency provide case management.

The States of Maine, Maryland, New Jersey, and Oklahoma have filed a suit against the U.S. Department of Health and Human Services in the District of Columbia U.S. District Court, seeking injunctive and declaratory relief against the case management rule, which they argue is an "arbitrary and capricious exercise, taken without regard to procedure required by law and in excess of Defendants' statutory jurisdiction, authority, or limitations, in violation of the Administrative Procedure Act * * *" New York also joined the suit in April 2008.

REHABILITATION RULE CMS–2261–P

CMS proposed a rule restricting payments for rehabilitation services in August 2007. This rule restricted Medicaid's rehabilitation benefit, including eliminating Medicaid payment for a number of services that have been covered for years.

The Social Security Act (Section 1905(a)(13)) defines rehabilitation as "diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, home, or other setting) recommended by a physician or other

practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."

Rehabilitation option services are broader than simple clinical treatment and assist individuals with disabilities in acquiring the skills essential for every day functioning. For example, one type of program offered through Medicaid's Rehabilitation Option is Mental Health Skills Training. Both adults and children with serious mental illnesses can benefit from this type of program, which allows for skills trainers to work with recipients on specific, individualized treatment goals that focus on their unique mental and behavioral needs. These services are typically offered at a location in the community or in the beneficiary's home. Examples of goals in the individualized treatment plan may include: promoting various anger management skills and coping skills, working with a beneficiary who is suicidal on ways to keep him/her safe, and assisting a child suffering from depression in working to overcome self esteem issues.

The rehabilitation option allows States to provide services in community settings, including a home or work environment, whereas other service categories specify the setting in which the services can be provided. The rehabilitation option also allows services to be provided by a broader range of professionals than other service categories. Community paraprofessionals and peer specialists can provide needed services, whereas they could not under other service categories. A 2006 report from the Department of Health and Human Services notes, "This flexibility is very useful to states because it allows them to cover a number of intensive home and community services that are particularly important for youth with SED [serious emotional disturbance] and their families."

But States cannot cover anything under the rehabilitation option. Current guidance specifies what services cannot be covered under this option, including vocational training, personal care services, case management services directed toward gaining access to and monitoring of non-Medicaid services. Furthermore, in order for States to provide rehabilitation services, their plan must clearly define the scope of the benefits the State is providing through the option and be approved by CMS.

This rule was not published as a result of work done by GAO. A 2005 GAO report dealing with the use of contingency fee contractors in Medicaid recommended that CMS establish or clarify certain policies, and then communicate them, including policies for rehabilitation services. (See GAO–05–748.) GAO reiterated these recommendations in two subsequent testimonies. (See GAO–05–836T and GAO–08–255T.) GAO, however, testified at the April 3, 2008, Subcommittee on Health hearing that it had not recommended the changes made by the rule such as eliminating coverage of certain rehabilitation services.

One issue in the rehabilitation rule is the imposition of an "intrinsic element" test to prohibit Medicaid coverage for services that are otherwise coverable under the rehabilitation services option, on the basis that these services are intrinsic to another Federal or State non-medical program. The Congress has established in the Medicaid statute a third party liability system to delineate when

Medicaid's payment obligations are superseded by another program. Under the proposed rule, CMS would deem a service ineligible for FFP, whether or not a third party was available to pay for a service. It should be noted that the concept of an intrinsic element test has no basis in the Medicaid statute and the Congress specifically rejected such a test in its deliberations leading up to the enactment of the Deficit Reduction Act of 2005.

Another issue is the elimination of coverage for day habilitation services for persons with mental retardation and related conditions. The proposed rule would eliminate coverage of day habilitation services under the rehab and clinic options for persons with developmental disabilities in contravention of Section 6411(g) of the Omnibus Budget and Reconciliation Act of 1989 (OBRA '89, P.L. 101–239). This provision of law states that the Secretary may not deny Medicaid funding for habilitation services unless the Secretary promulgates a final regulation that "specifies the types of day habilitation and related services that a State may cover * * * on behalf of persons with mental retardation or with related conditions." In contravention to the language of Section 6411(g) of OBRA '89, the proposed rule does not specify the types of day habilitation services that a State may cover. Instead, the proposed rule would prohibit the provisioning of habilitation services under the clinic and rehab options.

In enacting OBRA '89, the Congress clearly intended to protect access to day habilitation programs for people with mental retardation and related conditions. A Committee on the Budget House Report accompanying this legislation stated, "In the view of the Committee, HCFA should be encouraging states to offer community-based services to this vulnerable population, not restricting their efforts to do so."[1] The moratorium imposed by H.R. 5613 would allow these programs to continue.

Adult day health care programs provide a related set of services, similar in many respects to habilitation services for persons with developmental disabilities, but generally targeted to seniors, including persons with Alzheimer's disease and other forms of dementia and/or cognitive impairments. These programs provide a cost-effective alternative to institutional placement by providing States the opportunity to offer community-based treatment programs that support individuals in retaining their capability for independence and self-care. Currently, there are eight States that operate such adult day health care programs. By placing a one-year moratorium on the rehabilitation rule, Congress ensures that these habilitation programs and adult day health care services programs can continue to operate.

In addition to eliminating coverage of day habilitation programs, under the proposed rehabilitation rule those with mental retardation and related conditions (including epilepsy, autism, and cerebral palsy) will be ineligible for most rehabilitation option services, based on the presumption that, because these individuals have cognitive impairments, they have never achieved a level of functioning that could require rehabilitation services to restore or maintain. These illnesses can cause loss of function that needs to be restored,

[1] Report of the House Committee on the Budget, "Explanation of the Commerce and Ways and Means Committees Affecting Medicare-Medicaid Programs," September 20, 1989.

but they would no longer qualify for rehabilitation services to restore that functioning.

In the rehabilitation rule, services must be not only for the maximum reduction of disability but also must restore previous functioning or skills. For example, this is problematic for a child, born with a defect, who may walk with therapy, but wasn't born walking, or for a person with developmental disabilities who may not have had a particular skill but can learn it through therapy.

These two changes would make it likely that many people who are today living successfully in the community would no longer receive the services that enable them to do so. People with disabilities could need to go back into institutions to receive these necessary services. Institutional care is more expensive than community care and for some populations can cost upwards of $100,000 a year. In 2006, the national average for one-year of care in a large (16+ persons) private ICF–MR was nearly $70,000. Depending on the setting, these costs rise to more than $171,000 per year for care in a large, State-operated ICF–MR.

Finally, the rehabilitation rule would place constraints on State flexibility in billing. The rehabilitation rule would require States to bill for services individually in 15-minute increments, eliminating State the flexibility to select its own payment methodology such as case rate payments, daily payments, or various other forms of capitated or bundled payments. Moreover, billing in 15-minute increments, instead of on a case rate basis that is tied to the average time the provider spends working with a patient, would make it difficult to provide services that require a provider to be on call at all times.

Together, these seven rules would affect the ability of States to provide critical Medicaid services. A March 2008 House Committee on Oversight and Government Reform report on the Medicaid regulations provides additional insights as to the effect of these regulations on States. This report summarized the results of a 50 State survey of Medicaid directors. That Committee received responses from 43 States, representing nearly 95 percent of total Medicaid spending.

State responses to the Committee on Oversight and Government Reform indicated that the regulations will reduce spending by shifting costs, not through greater efficiencies. These regulations will impose administrative burdens and costs on State Medicaid programs.

The National Governors Association (NGA) sent a letter on February 26, 2008, urging Congress to block the implementation of these regulations. NGA sent a subsequent letter on April 2, 2008, indicating the Dingell-Murphy legislation is a high priority for the Nation's governors. In addition, the National Association of State Medicaid Directors (NASMD) and the American Public Human Services Administrators (APHSA) issued a joint letter urging Congress to stop the implementation of these regulations noting, "* * * these regulations will impose billions of dollars of cuts over the next five years, an amount that will be difficult for states to absorb and would restrict the reach and effectiveness of the Medicaid program in many States." More than 2,000 organizations have written in support of H.R. 5613. A complete list can be found

at http://energycommerce.house.gov/MedicaidProtection__110/index.shtml

In addition to the effect on State budgets and beneficiaries, many elements of these regulations are of questionable legality. A March 2008 report by Professor Sara Rosenbaum, Chair of the Department of Health Policy, the George Washington University School of Public Health and Health Care Services, entitled, "CMS' Medicaid Regulations: Implications for Children with Special Health Care Needs" on the effect these regulations have on children found that many provisions in the Medicaid regulations were in violation of the Medicaid statute, which guarantees health care for children with special needs. The rules would restrict or eliminate critical coverage for the Early Periodic Screening Detection and Treatment benefit that is essential for children to attain maximum growth and development. The EPSDT benefit was added by Congress at the request of President Johnson. It was done in response to extensive evidence showing a high level of preventable physical, dental, and mental health conditions among low income children and adolescents. This included both preschool children in early Head Start programs, young children served in the Nation's first community health centers, and young military draftees. The intent of the EPSDT amendments was to both assure access to health care and establish comprehensive coverage for all categorically needy children under age 21 (that is, children whose family incomes and assets make them eligible for Medicaid).

Three examples of where the regulations are inconsistent with Medicaid law, EPSDT benefits, for children with special needs are outlined below:

• With regard to targeted case management services, the report notes, "[t]he Deficit Reduction Act (DRA) made no changes whatsoever in states' administrative obligations to manage the care of children receiving care financed through EPSDT. Access to care is an administrative obligation of all Medicaid programs under the statutory EPSDT access requirements. Payment for EPSDT medical assistance and administrative services is required regardless of whether the child is also receiving child welfare or special education services." Yet the new targeted case management regulation would eliminate payment for important administrative activities needed to manage care for children with special needs and ensure access to that care.

• With respect to the hospital outpatient rule, the report notes, "[t]o the extent that states have defined outpatient hospital services to include the special services offered by hospital outpatient departments to children (such as developmental therapies and interventions for children with physical or mental health conditions), the regulation directly contravenes the EPSDT statute in excluding federal financial participation in hospital outpatient care programs that furnish EPSDT diagnostic and treatment services that may have no counterpart in federal Medicare law."

• With respect to the rule eliminating payment for school-based administrative and transportation services the report notes, "[t]o the extent that schools contract with health agencies, including agencies and programs receiving Title V funding, to provide administration services in schools, the regulation directly contravenes federal laws requiring the use of health agencies and title V agen-

cies and grantees as well as state agency payment for all services furnished by such agencies, whether medical assistance or administrative in nature." Title V of the Public Health Service Act is a block grant that provides funding for Maternal and Child Health Services.

HEARINGS

On Thursday April 3, 2008, the Subcommittee on Health of the Committee on Energy and Commerce held a hearing entitled "H.R. 5613, the Protecting the Medicaid Safety Net Act of 2008." The hearing examined the effect of the regulations on States, beneficiaries, and providers. The witnesses included: Barbara Coulter Edwards, Interim Director of the National Association of State Medicaid Directors (NASMD); Randy Mohundro, Superintendent of the DeLeon Independent School District and Executive Committee Member of American Association of School Administrators; James Cosgrove, Ph.D., Acting Director of Health Care Issues for the Government Accountability Office; James E. Buckner, Jr., CHE, Administrator of Uvalde Memorial Hospital; Joseph R. Antos, Ph.D., Wilson H. Taylor Scholar in Health Care and Retirement Policy of the American Enterprise Institute; Stuart H. Shapiro, M.D., President and Chief Executive Officer of the Pennsylvania Health Care Association, Marsha Raulerson, MD, FAAP of the American Academy of Pediatrics; Ms. Grace-Marie Turner, President of the Galen Institute; Dennis G. Smith, Director of the Center for Medicaid and State Operations of the Centers for Medicare and Medicaid Services; the Honorable Herb Conaway, Jr., M.D., State Assemblyman representing Legislative District 7 of the State of New Jersey; and John G. Folkemer, Deputy Secretary of Health Care Financing of the Department of Health and Mental Hygiene.

Prior to this legislative hearing, the Subcommittee on Health held four hearings during January-February of 2008, which focused, in part, on these regulations. At the January 16, 2008, hearing entitled, "Helping Families with Needed Care: Medicaid's Critical Role For Americans With Disabilities," witnesses described the difficulties posed for beneficiaries as a result of the targeted case management, rehabilitation, and school-based outreach and transportation regulations. At the January 29, 2008, hearing entitled, "Covering Uninsured Kids: Missed Opportunities for Moving Forward," the Committee heard testimony from Dennis Smith, Director of the Center for Medicaid and State Operations, Centers for Medicaid and Medicare Services; Tricia Brooks, President and CEO of New Hampshire's Healthy Kids Corporation, which administers the State's Medicaid and SCHIP program; and Ann Kohler, Deputy Secretary of the New Jersey Department of Health and Human Services regarding these regulations.

At the February 26, 2008, hearing entitled "Covering Uninsured Kids: Reversing Progress Already Made" the Subcommittee heard testimony from five Governors opposed to the implementation of the seven CMS regulations. Finally, at the February 28, 2008, "A Review of the Department of Health and Human Services Fiscal Year 2009 Budget" the Committee on Energy and Commerce had the opportunity to question HHS Secretary Michael Leavitt about the regulations.

COMMITTEE CONSIDERATION

On Wednesday, April 9, 2008, the Subcommittee on Health met in open markup session and favorably forwarded H.R. 5613, amended, to the full Committee for consideration, by a voice vote. On Wednesday, April 16, 2008, the full Committee met in open markup session and ordered H.R. 5613 favorably reported to the House, amended, by a record vote.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. A motion by Mr. Dingell to order H.R. 5613 favorably reported to the House, amended, was agreed to by a recorded vote of 46 yeas and 0 nays. The following are the recorded votes taken on the motion and amendments, including the names of those Members voting for and against.

COMMITTEE ON ENERGY AND COMMERCE -- 110TH CONGRESS
ROLL CALL VOTE # 55

BILL: H.R. 5613, the "Protecting the Medicaid Safety Net Act of 2008", as approved by the Subcommittee on Health on April 9, 2008.

MOTION: An Amendment by Mr. Deal, # 3, amending certain funding levels in section 6 and adding at the end Sec. 7 on Medicaid Minimum Dispensing Fee.

DISPOSITION: NOT AGREED TO, by a roll call vote of 15 yeas to 26 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Dingell		X		Mr. Barton	X		
Mr. Waxman		X		Mr. Hall			
Mr. Markey				Mr. Upton	X		
Mr. Boucher		X		Mr. Stearns			
Mr. Towns		X		Mr. Deal	X		
Mr. Pallone		X		Mr. Whitfield	X		
Mr. Gordon		X		Mrs. Cubin			
Mr. Rush				Mr. Shimkus	X		
Ms. Eshoo		X		Mrs. Wilson			
Mr. Stupak		X		Mr. Shadegg			
Mr. Engel		X		Mr. Pickering			
Mr. Green		X		Mr. Fossella	X		
Ms. DeGette		X		Mr. Blunt			
Ms. Capps		X		Mr. Buyer	X		
Mr. Doyle		X		Mr. Radanovich	X		
Ms. Harman				Mr. Pitts	X		
Mr. Allen		X		Ms. Bono Mack	X		
Ms. Schakowsky		X		Mr. Walden	X		
Ms. Solis		X		Mr. Terry	X		
Mr. Gonzalez		X		Mr. Ferguson			
Mr. Inslee		X		Mr. Rogers	X		
Ms. Baldwin		X		Mrs. Myrick	X		
Mr. Ross		X		Mr. Sullivan			
Ms. Hooley		X		Mr. Murphy			
Mr. Weiner				Mr. Burgess	X		
Mr. Matheson		X		Ms. Blackburn			
Mr. Butterfield		X					
Mr. Melancon		X					
Mr. Barrow		X					
Mr. Hill		X					
Vacancy							

04/16/2008

COMMITTEE ON ENERGY AND COMMERCE -- 110TH CONGRESS
ROLL CALL VOTE # 56

BILL: H.R. 5613, the "Protecting the Medicaid Safety Net Act of 2008", as approved by the Subcommittee on Health on April 9, 2008.

MOTION: A Motion by Mr. Dingell to order H.R. 5613 favorably reported to the House, amended.

DISPOSITION: AGREED TO, by a roll call vote of 46 yeas to 0 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Dingell	X			Mr. Barton	X		
Mr. Waxman	X			Mr. Hall			
Mr. Markey				Mr. Upton	X		
Mr. Boucher	X			Mr. Stearns	X		
Mr. Towns	X			Mr. Deal	X		
Mr. Pallone	X			Mr. Whitfield	X		
Mr. Gordon	X			Mrs. Cubin			
Mr. Rush				Mr. Shimkus			
Ms. Eshoo	X			Mrs. Wilson			
Mr. Stupak	X			Mr. Shadegg	X		
Mr. Engel	X			Mr. Pickering			
Mr. Green	X			Mr. Fossella	X		
Ms. DeGette	X			Mr. Blunt	X		
Ms. Capps	X			Mr. Buyer	X		
Mr. Doyle	X			Mr. Radanovich	X		
Ms. Harman				Mr. Pitts	X		
Mr. Allen	X			Ms. Bono Mack	X		
Ms. Schakowsky	X			Mr. Walden	X		
Ms. Solis	X			Mr. Terry	X		
Mr. Gonzalez	X			Mr. Ferguson			
Mr. Inslee	X			Mr. Rogers	X		
Ms. Baldwin	X			Mrs. Myrick	X		
Mr. Ross	X			Mr. Sullivan	X		
Ms. Hooley	X			Mr. Murphy	X		
Mr. Weiner				Mr. Burgess	X		
Mr. Matheson	X			Ms. Blackburn	X		
Mr. Butterfield	X						
Mr. Melancon	X						
Mr. Barrow	X						
Mr. Hill	X						
Vacancy							

04/16/2008

COMMITTEE OVERSIGHT FINDINGS

Regarding clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Subcommittee on Health held a legislative hearing, and the oversight findings of the Committee regarding H.R. 5613 are reflected in this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The purpose of H.R. 5613 is to impose a one year moratorium on seven rules issued by the Department of Health and Human Services which would restrict or eliminate Medicaid payment for certain health care services and safety net institutions. The purpose is to ensure that Congress is able to consider the effect of these rules on States, beneficiary groups, and providers to determine whether the changes made by the rules are appropriate and in the best interest of the Medicaid program or warrant any further action.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

Regarding compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee adopts as its own the estimate of budget authority, entitlement authority, tax expenditures, and revenues regarding H.R. 5613 prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

EARMARKS AND TAX AND TARIFF BENEFITS

Regarding compliance with clause 9 of rule XXI of the Rules of the House of Representatives, H.R. 5613 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9(d), 9(e), or 9(f) of rule XXI.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate on H.R. 5613 prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate on H.R. 5613 provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, April 22, 2008.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 5613, the Protecting the Medicaid Safety Net Act of 2008. The bill was ordered reported on April 16, 2008.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Jeanne De Sa.

Sincerely,

ROBERT A. SUNSHINE
(For Peter R. Orszag, Director).

Enclosure.

H.R. 5613—Protecting the Medicaid Safety Net Act of 2008

Summary: H.R. 5613 would extend existing moratoria on certain regulatory actions taken by the Centers for Medicare & Medicaid Services (CMS) with regard to the Medicaid program. Those actions are related to payments for services furnished by public providers, for graduate medical education, for school-based administration and transportation services, and for rehabilitation services. In addition, the bill would impose new moratoria on Medicaid regulations involving targeted case-management services and provider taxes and on a proposed regulation involving outpatient hospital services. The bill would appropriate $5 million to study the effects of these regulations on the Medicaid program.

The bill would make additional changes to Medicaid by requiring more stringent verification of assets in certain eligibility determinations. H.R. 5613 also would appropriate $25 million a year to the Secretary of Health and Human Services to address fraud and abuse in Medicaid and would reduce funding for the Medicare physician assistance and quality initiative (PAQI) fund in fiscal year 2013, and increase such funding in 2014.

Some of the bill's provisions would increase direct spending; others would reduce direct spending. CBO estimates that the increases would amount to $1.8 billion over the 2008–2013 period and $1.9 billion over the 2008–2018 period, largely due to the required delays in implementing regulations. Other provisions related to asset verification and adjustments to the PAQI fund would reduce direct spending by similar amounts. On net, H.R. 5613 would reduce direct spending by $3 million over the 2008–2013 and 2008–2018 periods.

H.R. 5613 would not affect federal revenues or discretionary spending. This bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 5613 is shown in the following table. The changes in direct spending fall within budget functions 550 (health) and 570 (Medicare).

	By fiscal year, in millions of dollars—												
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2008–2013	2008–2018
CHANGES IN DIRECT SPENDING													
Moratoria on Certain Medicaid Regulations:													
Estimated Budget Authority	445	1,205	0	0	0	0	0	0	0	0	0	1,650	1,650
Estimated Outlays	445	1,205	0	0	0	0	0	0	0	0	0	1,650	1,650
Funds to Reduce Fraud and Abuse:													
Estimated Budget Authority	0	25	25	25	25	25	25	25	25	25	25	125	250
Estimated Outlays	0	24	25	25	25	25	25	25	25	25	25	124	249
Study on Impact of Regulations:													
Estimated Budget Authority	5	0	0	0	0	0	0	0	0	0	0	5	5
Estimated Outlays	0	5	0	0	0	0	0	0	0	0	0	5	5
Medicaid Asset Verification:													
Estimated Budget Authority	0	−80	−130	−180	−230	−380	−490	−590	−690	−820	−950	−1,000	−4,540
Estimated Outlays	0	−80	−130	−180	−230	−380	−490	−590	−690	−820	−950	−1,000	−4,540
Medicare Physician Assistance and Quality Fund:													
Estimated Budget Authority	0	0	0	0	0	−1,203	3,777	58	0	0	0	−1,203	2,633
Estimated Outlays	0	0	0	0	0	−782	2,027	1,387	0	0	0	−782	2,633
Total Changes:													
Estimated Budget Authority	450	1,150	−105	−155	−205	−1,558	3,312	−507	−665	−795	−925	−423	−2
Estimated Outlays	445	1,154	−105	−155	−205	−1,137	1,562	822	−665	−795	−925	−3	−3

Note: Components may not sum to totals because of rounding.

Basis of estimate: The bill contains provisions that would both increase and decrease direct spending. CBO estimates that the net impact would be savings of $3 million over both the 2008–2013 period and over the 2008–2018 period. This estimate assumes that the bill will be enacted by late May 2008.

Moratoria on certain Medicaid regulations

CMS has taken regulatory action to limit payments under the Medicaid program for certain financing mechanisms and services. The Congress previously enacted moratoria on four of those regulations. H.R. 5613 would extend the existing moratoria through April 1, 2009, and would impose new moratoria through April 1, 2009, on certain provisions of regulations involving targeted case-management services, provider taxes, and covered outpatient services. In total, CBO estimates that the seven moratoria would increase Medicaid spending by $1.7 billion over the 2008–2009 period.

All of the regulations addressed by H.R. 5613 are incorporated either fully or partially in CBO's baseline projections of Medicaid spending. For final regulations, CBO fully incorporates the projected effects into the baseline (after any moratorium ends), reflecting implementation of current law. For proposed rules or other significant administrative actions, CBO generally assigns a weight of 50 percent in its baseline, reflecting the uncertainties of the administrative process.

Payment to Public Providers. CMS issued a final rule on May 29, 2007, to restrict the use of intergovernmental transfers and limit payment to public providers to cost (public providers are health care providers owned or operated by a unit of government). The final rule:

- Clarifies that the only providers that may participate in providing the nonfederal share of Medicaid funding are those that are part of a unit of government;
- Limits Medicaid payments to cost for providers operated by units of government; and
- Requires that providers retain the full amount of their Medicaid payments.

The Congress enacted a moratorium on implementation of that rule that will remain in effect until May 25, 2008, under current law. Using information from CMS on how states use intergovernmental transfers, estimates of hospital and nursing home spending based on administrative data, and analysis of the distribution of spending by facility ownership, CBO estimates the bill's extended moratorium on the public provider final rule would increase spending by a total of $0.8 billion in fiscal years 2008 and 2009.

Graduate Medical Education. On May 23, 2007, CMS issued a proposed rule to prohibit payment for Medicaid graduate medical education. The Congress enacted a moratorium on further regulatory action in this area, which remains in effect until May 25, 2008. The extension of that moratorium on the proposed rule for graduate medical education would increase spending by $0.1 billion over the 2008–2009 period, CBO estimates, based on information from CMS about which states use Medicaid funds for graduate medical education. Because the graduate medical education regulation is proposed and not final, CBO's estimate represents half of the potential costs of this moratorium.

School-based Administration and Transportation Services. On December 20, 2007, CMS issued a final rule prohibiting payments for administrative costs for any activities performed by employees or contractors of local school districts and for transportation of Medicaid recipients from their home to their school. The Congress enacted a moratorium on implementing that rule, which will remain in effect until May 25, 2008. Relying on spending information provided by CMS, CBO estimates that extending this moratorium would increase spending by a total of $0.5 billion in fiscal years 2008 and 2009.

Rehabilitation Services. On August 13, 2007, CMS issued a proposed rule to narrow the definition of rehabilitation services. The proposed rule would:

- Prohibit payments for services that are "intrinsic parts" of other programs such as foster care, child welfare, or juvenile justice;
- Ban states from using bundled rates to pay for therapeutic foster care (which is a type of rehabilitation service);
- Prohibit payments, unless otherwise permitted by a Secretarial waiver, for habilitation services (which help individuals to develop new skills instead of restoring previously existing skills); and
- Restrict payments for recreational or social services.

The Congress enacted a moratorium on further agency action in this area, which remains in effect until May 25, 2008. The bill's extended moratorium on implementing the rehabilitation rule would increase spending by $0.1 billion over the 2008–2009 period. Because the rehabilitative services regulation is proposed and not final, CBO's estimate represents half of the potential costs of this moratorium.

Targeted Case Management. The Deficit Reduction Act of 2005 clarified and narrowed payment policy for targeted case-management services, and required CMS to issue a final rule to implement the policy. On December 4, 2007, CMS issued a final rule, which went into effect on March 3, 2008. The rule defines case-management and targeted case-management services and clarifies that those services may not include the direct delivery of other social services, specifically foster care. It also limits transitional assistance services to individuals in institutions to 60 days (as opposed to 180 days), restricts services to only one case manager per person, requires that payments be based on 15-minute increments, and prohibits child welfare agencies and contractors from serving as case managers.

The bill would not prevent CMS from implementing the clarification of targeted case management outlined in the Deficit Reduction Act of 2005. However it would prohibit implementation of portions of the rule that are more stringent than the statute, particularly the restriction on days of service and the limit of one case manager per person. The moratorium on implementing the portion of the targeted case management final rule that is more stringent than the underlying statute would increase spending by a total of $0.1 billion in fiscal years 2008 and 2009, CBO estimates. CBO based its analysis of this rule on projections of expenditures for targeted case management by state, using administrative spending and en-

rollment data, and analysis of the regulation by the Kaiser Family Foundation.

Provider Taxes. On February 22, 2008, CMS issued a final rule that revises standards on permissible provider taxes through 2011, lowering allowable amounts from 6.0 percent to 5.5 percent of gross patient revenues. The final rule specifies methodologies for determining when states are using an impermissible tax. H.R. 5613 would allow the provider tax limits to go into effect, but would delay implementation of the clarifications outlined in the regulation. CBO estimates this delay would have no effect because the regulation codifies current practices, which would continue in the absence of that regulation.

Outpatient Clinic and Hospital Services. On September 28, 2007, CMS issued a proposed rule to clarify the definition of outpatient clinic and hospital services eligible for payment under the Medicaid program and to require states to use the definition of "outpatient hospital services" that is used by Medicare.

Based on Medicaid administrative spending data, information from CMS, and analysis of the regulation by the Kaiser Family Foundation, CBO expects that the moratorium on the proposed rule clarifying outpatient clinic and hospital services would allow certain services to be performed in higher-cost settings and estimates that a delay in implementation would increase spending by a total of $0.1 billion in fiscal years 2008 and 2009. Because the regulation is proposed and not final, CBO's estimate represents half of the potential costs.

Funds to reduce fraud and abuse

H.R. 5613 would appropriate $25 million a year for the Secretary of Health and Human Services to address fraud and abuse in the Medicaid program. CBO estimates that this provision would cost about $125 million and $250 million over the 2009–2013 and 2009–2018 periods, respectively.

Study on impact of Medicaid regulations

The bill would appropriate $5 million for the Secretary of Health and Human Services to contract with an independent organization to produce a report on the impact of the regulations subject to the moratoria and an analysis of the problems the regulations were designed to address. CBO anticipates those funds would be spent in fiscal year 2009.

Medicaid asset verification demonstration

Section 5 would require all states to incorporate into their Medicaid programs a demonstration program from the Supplemental Security Income (SSI) program. The program uses Web-based techniques to identify assets that might otherwise not be discovered through the eligibility-determination process and requires beneficiaries to allow access to their financial information. Under current law, New York and New Jersey, which both operate the SSI demonstration, are required to implement this program for Medicaid through 2013. The bill would allow a five-year phase-in period during which CMS would develop a staggered schedule for states to adopt the necessary administrative and systems requirements. California, which recently implemented the SSI demonstration,

would be required to implement the program for Medicaid by the end of fiscal year 2009. The bill would permit states to enroll people in the demonstration program even if they refuse to allow disclosure of their financial information.

Based on information from CMS, CBO expects that the new Medicaid procedures would result in denial of or delay in eligibility for some people and reduced enrollment in Medicaid, mainly for individuals seeking nursing home coverage or other high-cost long-term care services. CBO estimates that this provision would reduce federal outlays by $1.0 billion over the 2009–2013 period and $4.5 billion over the 2009–2018 period.

Medicare physician assistance and quality initiative fund

Under current law, the Secretary of Health and Human Services has $5.0 billion available in 2013 to use for initiatives related to physician payments and quality improvements in Medicare. Section 6 would reduce the funding available in 2013 by $1.2 billion and would increase the funding for 2014 by $3.8 billion. CBO estimates that those changes in funding would decrease outlays by $0.8 billion in 2013 and would increase outlays by $2.6 billion over the 2013–2015 period.

Intergovernmental and private-sector impact: H.R. 5613 contains no intergovernmental or private-sector mandates as defined in UMRA. The bill would impose a new requirement on states to electronically verify the assets of Medicaid enrollees. That requirement would increase administrative spending by states; however, the provision also would result in lower caseloads and an overall decline in state spending. Because Medicaid provides states with significant flexibility to make programmatic adjustments to accommodate changes, the requirement to verify assets would not be an intergovernmental mandate as defined by UMRA. State, local, and tribal governments would benefit from provisions in the bill that would delay the implementation of several Medicaid regulations.

Estimate prepared by: Federal Costs: Jeanne De Sa; Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Patrick Bernhardt.

Estimate approved by: Keith J. Fontenot, Deputy Assistant Director for Health and Human Resources, Budget Analysis Division.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates regarding H.R. 5613 prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act would be created by H.R. 5613.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for H.R. 5613 is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with for-

eign nations, among the several States, and with the Indian Tribes, and in the provisions of Article I, section 8, clause 1, that relate to expending funds to provide for the general welfare of the United States.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that H.R. 5613 does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act of 1995.

EXCHANGE OF COMMITTEE LETTERS

Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS
1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225-3625
Washington, DC 20515-6348
http://waysandmeans.house.gov

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BRETT LOPER,
MINORITY STAFF DIRECTOR

April 21, 2008

The Honorable John Dingell
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear John:

I am writing regarding H.R. 5613, the "Protecting the Medicaid Safety Net Act of 2008."

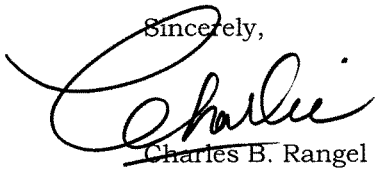
As you know, the Committee on Ways and Means maintains jurisdiction over bills that affect the Medicare program. Accordingly, Section 6, which addresses payment for physician services under Medicare, falls within the jurisdiction of the Committee on Ways and Means.

In order to expedite this legislation for Floor consideration, the Committee will forgo action on this bill, and will not oppose the inclusion of Section 6 within H.R. 5613. This is being done with the understanding that it does not in any way prejudice the Committee with respect to the appointment of conferees or its jurisdictional prerogatives on this bill or similar legislation in the future.

The Honorable John Dingell
April 21, 2008
Page 2

I would appreciate your response to this letter, confirming this understanding with respect to H.R. 5613, and would ask that a copy of our exchange of letters on this matter be included in the Committee Report of consideration of the legislation and anywhere else that is relevant in the record.

Sincerely,



Charles B. Rangel
Chairman

cc: The Honorable Nancy Pelosi
The Honorable Steny Hoyer
The Honorable James Clyburn
The Honorable John Boehner
The Honorable Roy Blunt
The Honorable Joe Barton
The Honorable Jim McCrery
Mr. John Sullivan, Parliamentarian

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GREGG A. ROTHSCHILD, CHIEF COUNSEL

ONE HUNDRED TENTH CONGRESS

U.S. House of Representatives
Committee on Energy and Commerce
Washington, DC 20515–6115

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TIM MURPHY, PENNSYLVANIA
MICHAEL C. BURGESS, TEXAS
MARSHA BLACKBURN, TENNESSEE

April 22, 2008

The Honorable Charles B. Rangel
Chairman
Committee on Ways and Means
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Charlie:

Thank you for your letter regarding H.R. 5613, the "Protecting the Medicaid Safety Net Act of 2008".

Your letter expressed the jurisdictional interest of the Committee on Ways and Means in section 6 of the bill, as reported. That section concerns the fund under section 1848(l) of the Social Security Act.

I recognize that the Committee on Energy and Commerce shares jurisdiction with the Committee on Ways and Means over that fund. I appreciate your agreement to forgo action on the bill, and I concur that the agreement does not in any way prejudice the Committee on Ways and Means with respect to the appointment of conferees or its jurisdictional prerogatives on this bill or similar legislation in the future.

Again, I appreciate your cooperation in expediting this important legislation. I will include our letters in the report filed by the Committee on Energy and Commerce on the bill.

Sincerely,

JOHN D. DINGELL
CHAIRMAN

cc: The Honorable Nancy Pelosi, Speaker
U.S. House of Representatives

The Honorable Steny Hoyer, Majority Leader
U.S. House of Representatives

The Honorable James Clyburn, Majority Whip
U.S. House of Representatives

The Honorable John Boehner, Republican Leader
U.S. House of Representatives

The Honorable Roy Blunt, Republican Whip
U.S. House of Representatives

The Honorable Joe Barton, Ranking Member
Committee on Energy and Commerce

The Honorable Jim McCrery, Ranking Member
Committee on Ways and Means

Mr. John Sullivan, Parliamentarian

BARNEY FRANK, MA, CHAIRMAN

United States House of Representatives
Committee on Financial Services
2129 Rayburn House Office Building
Washington, DC 20515

SPENCER BACHUS, AL, RANKING MEMBER

April 22, 2008

The Honorable John D. Dingell
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

I am writing regarding H.R. 5613, the "Protecting the Medicaid Safety net Act of 2008". This bill was introduced on March 13, 2008, and has been ordered reported by the Committee on Energy and Commerce. It is my understanding that the bill will be scheduled for floor consideration shortly.

The Committee on Financial Services has a jurisdictional interest in section 5 of the bill as reported. That section concerns a program through which the States will verify the financial resources of individuals applying for or receiving medical assistance under the Medicaid program. In so doing, the program modifies the Right to Financial Privacy Act within the jurisdiction of this Committee. However, I am willing to forego a referral of this bill. In return, I ask for a response from you confirming the jurisdictional interest of the Committee on Financial Services, as well as an agreement that this will not in any way prejudice the Committee on Financial Services on this or similar legislation in the future.

Finally, I request that this exchange of correspondence be included in the committee report filed by the Committee on Energy and Commerce on this bill. I am pleased to cooperate in this important matter.

BARNEY FRANK
Chairman

Cc: The Honorable Spencer Bachus

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ONE HUNDRED TENTH CONGRESS

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April 22, 2008

The Honorable Barney Frank
Chairman
Committee on Financial Services
2129 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Frank:

Thank you for your letter regarding H.R. 5613, the "Protecting the Medicaid Safety Net Act of 2008".

Your letter expressed the jurisdictional interest of the Committee on Financial Services in section 5 of the bill, as reported. That section concerns a program through which the States will verify the financial resources of individuals applying for or receiving medical assistance under the Medicaid program under title XIX of the Social Security Act.

I recognize that section 5 touches on the jurisdiction of the Committee on Financial Services because the section affects the Right to Financial Privacy Act. I appreciate your agreement to forgo action on the bill, and I concur that the agreement does not in any way prejudice the Committee on Financial Services with respect to any of its jurisdictional prerogatives on this bill or similar legislation in the future.

Again, I appreciate your cooperation in expediting this important legislation. I will include our letters in the report filed by the Committee on Energy and Commerce on the bill.

Sincerely,

JOHN D. DINGELL
CHAIRMAN

cc: The Honorable Nancy Pelosi, Speaker
U.S. House of Representatives

The Honorable Steny Hoyer, Majority Leader
U.S. House of Representatives

The Honorable James Clyburn, Majority Whip
U.S. House of Representatives

The Honorable John Boehner, Republican Leader
U.S. House of Representatives

The Honorable Roy Blunt, Republican Whip
U.S. House of Representatives

The Honorable Joe Barton, Ranking Member
Committee on Energy and Commerce

The Honorable Spencer Bachus, Ranking Member
Committee on Financial Services

Mr. John Sullivan, Parliamentarian

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

Section 1 establishes the short title of the Act as the "Protecting the Medicaid Safety Net Act of 2008".

Section 2. Moratoria on certain Medicaid regulations

(a) Extension of certain moratoria in Public Law 110–28

This subsection extends moratoria Congress previously placed on two Medicaid regulations issued by the Department of Health and Human Services having to do with restrictions on Medicaid payments to public providers and elimination of Medicaid payments for graduate medical education (GME). These moratoria were enacted through the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (P.L. 110–28) and will expire on May 25, 2008. This section extends the current moratoria through March of 2009.

(b) Extension of certain moratoria in Public Law 110–173

This subsection extends moratoria Congress previously placed on two Medicaid regulations dealing with restrictions on Medicaid payments for rehabilitation services and elimination of Medicaid payments for school-based transportation and administration services. These moratoria were enacted in the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110–173) and will expire on June 30, 2008. This subsection extends the current moratoria through March of 2009. This moratorium would insure that CMS cannot implement an intrinsic element test or eliminate State day habilitation programs for persons with mental retardation and related conditions, as well as coverage under approved State plans of adult day health care programs, which are covered by that regulation.

(c) Additional moratoria

This subsection would prohibit the Secretary from going beyond current law, through regulation, to put limits on what States can provide in terms of case management services in their Medicaid programs. Case management services are those that assist beneficiaries in gaining access to needed medical, social, educational, and other services and include assistance for transitioning out of a nursing home. This subsection would allow the Secretary to provide regulations to implement the current law provisions passed in the deficit reduction act (DRA) as long as they are not more restrictive than the policies set forth in previous guidance from the Centers for Medicare and Medicaid Services relating to State responsibilities under Medicaid for persons with disabilities. The Secretary may exercise such authority so long as restrictions are not imposed on case management services that are more restrictive than the policies set forth in the Dear State Medicaid Director letter issued on January 19, 2001 (SMDL #01–013), which clarified the interaction of Medicaid with the Title IV–E foster care program and included a listing of some of the allowable services under the Medicaid case management benefit for children receiving Title IV–E services, and so long as restrictions are not imposed on commu-

nity transition case management more restrictive than the policies set forth in the Dear State Medicaid Director letter issued on July 25, 2000 (Olmstead Update 3), including the standard that permits Medicaid coverage of transition case management for 180 days, and which does not include a prohibition on payment for transition case management until an individual has successfully completed a community transition.

This subsection also would place a moratorium on the proposed regulations that restrict Medicaid payment for preventative care, rehabilitation services, and dental care provided in outpatient hospital settings.

This subsection would prevent the Secretary from implementing the portions of the final regulation relating to Medicaid allowable provider taxes that does not directly implement the changes Congress made in the Tax Relief and Health Care Act of 2006 (P.L. 109–432). The Secretary went beyond the current law by redefining what is considered an "allowable" provider tax.

The bill as approved by the Committee modified the language of subsection (c) in section 2 of the introduced bill to address concerns that the scope of the moratoria was too broad. Language was substituted as used in P.L. 110–73, the Medicare, Medicaid, and SCHIP Extension Act.

Section 3. Funds to reduce Medicaid fraud and abuse

Section 3 of the bill included $25 million a year appropriation to the Secretary of Health and Human Services beginning with fiscal year 2009 for the purposes of reducing fraud and abuse in the Medicaid program. In addition, this section includes a requirement for the Secretary to report to the Committee on Energy and Commerce and the Committee on Finance on the activities funded and results of such activities.

Section 4. Study and reports to Congress

Section 4(a) requires the Secretary of Health and Human Services to submit a report to the Committee on Energy and Commerce and the Committee on Finance by July 1, 2008. This report would outline what specific problems the Medicaid regulations are intended to address, how the regulations address those problems and the legal authority for such regulations.

Section 4(b) directs the Secretary to enter into a contract with an independent organization for the purpose of producing a report on the prevalence of the problems identified in the regulations, identifying existing strategies to address such problems, and assessing the impact of each regulation on the States and the District of Columbia. The independent report produced under section 4(b) shall identify strategies in existence to address the problems outlined in the Secretary's report to Congress to indicate where current legal authority is sufficient to respond to any identified problems, and shall assess the impact of the regulations referred to in the report conducted under section 4(a) on each State and the District of Columbia. This shall include an examination of the effect that these regulations would have on State efforts to operate evidence-based programs consistent with the current standards of best professional practice in the various areas covered by the rules. Section 4 provides $5 million for the purposes of conducting this report.

Section 5. Asset verification through access to information held by financial institutions

Section 5 requires all States to phase in a program for electronic verification of the assets of aged, blind, and disabled individuals applying for Medicaid coverage. States would submit and implement an asset verification program so that such a program is applied to approximately, but not less than 12.5 percent of Medicaid enrollees by the end of fiscal year 2009; 25 percent by the end of fiscal year 2010; 50 percent by the end of fiscal year 2011; 75 percent by the end of fiscal year 2012; and 100 percent by the end of fiscal year 2013. Section 5(a) requires the Secretary to develop this schedule taking into account the feasibility of implementing asset verification programs in each individual State. States are permitted to voluntarily request approval to implement an 'asset verification program' in advance of being required by the Secretary.

Section 5(a) defines an "asset verification program," established under section 5 of this bill, as a program requiring that each applicant for, or recipient of, medical assistance under a Medicaid State plan, on the basis of being aged, blind, or disabled, authorize the State to obtain financial records held by any financial institution. States that do not apply an asset test in determining eligibility of categories of individuals who qualify for Medicaid on the basis of being aged, blind, or disabled obviously would not be required to apply the electronic asset verification system to such individuals. An asset verification program requires an individual to authorize the State to obtain financial records when the State determines it is needed in connection with determining eligibility for medical assistance under the Medicaid program. Under current law, States might need to verify assets of a spouse in determining eligibility of an individual, but the authority to require other individuals to provide authorization to obtain financial records is limited, and should not extend to parties whose assets are not relevant to the determination. The State shall use those financial records to verify the financial resources of individuals applying for, or receiving medical assistance. An asset verification program established under section 5 must verify individual assets in a manner consistent with procedures used by the Commissioner of Social Security.

Section 6. Adjustment to PAQI fund

Section 6 amends the Social Security Act, as amended by the Medicare, Medicaid, and SCHIP Extension Act of 2007, to reduce the amount of money available to the Physician Assistance and Quality Initiative Fund for expenditure during 2013 from $4,960,000,000 to $3,790,000,000. Section 6, however, makes $3,690,000,000 available to the fund for expenditures during 2014 under the same limitations provided for expenditures made with money available during 2013.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SECTION 7002 OF THE U.S. TROOP READINESS, VETERANS' CARE, KATRINA RECOVERY, AND IRAQ ACCOUNTABILITY APPROPRIATIONS ACT, 2007

SEC. 7002. (a) PROHIBITION.—

(1) LIMITATION ON SECRETARIAL AUTHORITY.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, [prior to the date that is 1 year after the date of enactment of this Act] *prior to April 1, 2009*, take any action (through promulgation of regulation, issuance of regulatory guidance, or other administrative action) to

(A) finalize or otherwise implement provisions contained in the proposed rule published on January 18, 2007, on pages 2236 through 2248 of volume 72, Federal Register (relating to parts 433, 447, and 457 of title 42, Code of Federal Regulations) *or in the final regulation, relating to such parts, published on May 29, 2007 (72 Federal Register 29748)*;

* * * * * * *

(C) promulgate or implement any rule or provisions restricting payments for graduate medical education under the Medicaid program*, including the proposed regulation published on May 23, 2007 (72 Federal Register 28930)*.

* * * * * * *

SECTION 206 OF THE MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT OF 2007

SEC. 206. MORATORIUM ON CERTAIN PAYMENT RESTRICTION.

Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, prior to [June 30, 2008] *April 1, 2009*, take any action (through promulgation of regulation, issuance of regulatory guidance, use of Federal payment audit procedures, or other administrative action, policy, or practice, including a Medical Assistance Manual transmittal or letter to State Medicaid directors) to impose any restrictions relating to coverage or payment under title XIX of the Social Security Act for rehabilitation services*, including the proposed regulation published on August 13, 2007 (72 Federal Register 45201),* or school-based administration and school-based transportation*, including the final regulation published on December 28, 2007 (72 Federal Register 73635),* if such restrictions are more restrictive in any aspect than those applied to such areas as of July 1, 2007.

SOCIAL SECURITY ACT

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

PAYMENT FOR PHYSICIANS' SERVICES

SEC. 1848. (a) * * *

* * * * * * *

(l) PHYSICIAN ASSISTANCE AND QUALITY INITIATIVE FUND.—

(1) * * *

(2) FUNDING.—

(A) AMOUNT AVAILABLE.—

(i) IN GENERAL.—Subject to clause (ii), there shall be available to the Fund the following amounts:

(I) * * *

* * * * * * *

(III) For expenditures during 2013, an amount equal to **[**$4,960,000,000**]** *$3,790,000,000*.

(IV) For expenditures during 2014, an amount equal to $3,690,000,000.

(ii) LIMITATIONS ON EXPENDITURES.—

(I) * * *

* * * * * * *

(IV) 2014.—The amount available for expenditures during 2014 shall only be available for an adjustment to the update of the conversion factor under subsection (d) for that year.

(B) TIMELY OBLIGATION OF ALL AVAILABLE FUNDS FOR SERVICES.—The Secretary shall provide for expenditures from the Fund in a manner designed to provide (to the maximum extent feasible) for the obligation of the entire amount available for expenditures, after application of subparagraph (A)(ii), during—

(i) * * *

(ii) 2009 for payment with respect to physicians' services furnished during 2009; **[**and**]**

(iii) 2013 for payment with respect to physicians' services furnished during 2013**[**.**]***; and*

(iv) 2014 for payment with respect to physicians' services furnished during 2014.

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

(69) provide that the State must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936; **[**and**]**

(70) at the option of the State and notwithstanding paragraphs (1), (10)(B), and (23), provide for the establishment of a non-emergency medical transportation brokerage program in order to more cost-effectively provide transportation for individuals eligible for medical assistance under the State plan who need access to medical care or services and have no other means of transportation which—

(A) * * *

* * * * * * *

(B) may be conducted under contract with a broker who—

(i) * * *

* * * * * * *

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on the prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate)**[**.**]***; and*

(71) provide that the State will implement an asset verification program as required under section 1940.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X (or title XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)). The provisions of paragraphs (9)(A), (31), and (33) and of section 1903(i)(4) shall not apply to a religious nonmedical health care institution (as defined in section 1861(ss)(1)).

* * * * * * *

PAYMENT TO STATES

SEC. 1903. (a) * * *

* * * * * * *

(i) Payment under the preceding provisions of this section shall not be made—

(1) * * *

* * * * * * *

(22) with respect to amounts expended for medical assistance for an individual who declares under section 1137(d)(1)(A) to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this title, unless the requirement of subsection (x) is met; **[**or**]**

(23) with respect to amounts expended for medical assistance for covered outpatient drugs (as defined in section 1927(k)(2)) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad**[**.**]***; or*

(24) if a State is required to implement an asset verification program under section 1940 and fails to implement such program in accordance with such section, with respect to amounts expended by such State for medical assistance for individuals subject to asset verification under such section, unless—

(A) the State demonstrates to the Secretary's satisfaction that the State made a good faith effort to comply;

(B) not later than 60 days after the date of a finding that the State is in noncompliance, the State submits to the Secretary (and the Secretary approves) a corrective action plan to remedy such noncompliance; and

(C) not later than 12 months after the date of such submission (and approval), the State fulfills the terms of such corrective action plan.

Nothing in paragraph (1) shall be construed as permitting a State to provide services under its plan under this title that are not reasonable in amount, duration, and scope to achieve their purpose. Paragraphs (1), (2), (16), (17), and (18) shall apply with respect to items or services furnished and amounts expended by or through a managed care entity (as defined in section 1932(a)(1)(B)) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.

* * * * * * *

ASSET VERIFICATION THROUGH ACCESS TO INFORMATION HELD BY FINANCIAL INSTITUTIONS

SEC. 1940. (a) IMPLEMENTATION.—

(1) IN GENERAL.—Subject to the provisions of this section, each State shall implement an asset verification program described in subsection (b), for purposes of determining or redetermining the eligibility of an individual for medical assistance under the State plan under this title.

(2) PLAN SUBMITTAL.—In order to meet the requirement of paragraph (1), each State shall—

(A) submit not later than a deadline specified by the Secretary consistent with paragraph (3), a State plan amend-

ment under this title that describes how the State intends to implement the asset verification program; and

(B) provide for implementation of such program for eligibility determinations and redeterminations made on or after 6 months after the deadline established for submittal of such plan amendment.

(3) PHASE-IN.—

(A) IN GENERAL.—

(i) IMPLEMENTATION IN CURRENT ASSET VERIFICATION DEMO STATES.—The Secretary shall require those States specified in subparagraph (C) (to which an asset verification program has been applied before the date of the enactment of this section) to implement an asset verification program under this subsection by the end of fiscal year 2009.

(ii) IMPLEMENTATION IN OTHER STATES.—The Secretary shall require other States to submit and implement an asset verification program under this subsection in such manner as is designed to result in the application of such programs, in the aggregate for all such other States, to enrollment of approximately, but not less than, the following percentage of enrollees, in the aggregate for all such other States, by the end of the fiscal year involved:

(I) 12.5 percent by the end of fiscal year 2009.

(II) 25 percent by the end of fiscal year 2010.

(III) 50 percent by the end of fiscal year 2011.

(IV) 75 percent by the end of fiscal year 2012.

(V) 100 percent by the end of fiscal year 2013.

(B) CONSIDERATION.—In selecting States under subparagraph (A)(ii), the Secretary shall consult with the States involved and take into account the feasibility of implementing asset verification programs in each such State.

(C) STATES SPECIFIED.—The States specified in this subparagraph are California, New York, and New Jersey.

(D) CONSTRUCTION.—Nothing in subparagraph (A)(ii) shall be construed as preventing a State from requesting, and the Secretary approving, the implementation of an asset verification program in advance of the deadline otherwise established under such subparagraph.

(4) EXEMPTION OF TERRITORIES.—This section shall only apply to the 50 States and the District of Columbia.

(b) ASSET VERIFICATION PROGRAM.—

(1) IN GENERAL.—For purposes of this section, an asset verification program means a program described in paragraph (2) under which a State—

(A) requires each applicant for, or recipient of, medical assistance under the State plan under this title on the basis of being aged, blind, or disabled to provide authorization by such applicant or recipient (and any other person whose resources are material to the determination of the eligibility of the applicant or recipient for such assistance) for the State to obtain (subject to the cost reimbursement requirements of section 1115(a) of the Right to Financial Privacy Act but at no cost to the applicant or recipient) from any

financial institution (within the meaning of section 1101(1) of such Act) any financial record (within the meaning of section 1101(2) of such Act) held by the institution with respect to the applicant or recipient (and such other person, as applicable), whenever the State determines the record is needed in connection with a determination with respect to such eligibility for (or the amount or extent of) such medical assistance; and

(B) uses the authorization provided under subparagraph (A) to verify the financial resources of such applicant or recipient (and such other person, as applicable), in order to determine or redetermine the eligibility of such applicant or recipient for medical assistance under the State plan.

(2) PROGRAM DESCRIBED.—A program described in this paragraph is a program for verifying individual assets in a manner consistent with the approach used by the Commissioner of Social Security under section 1631(e)(1)(B)(ii).

(c) DURATION OF AUTHORIZATION.—Notwithstanding section 1104(a)(1) of the Right to Financial Privacy Act, an authorization provided to a State under subsection (b)(1) shall remain effective until the earliest of—

(1) the rendering of a final adverse decision on the applicant's application for medical assistance under the State's plan under this title;

(2) the cessation of the recipient's eligibility for such medical assistance; or

(3) the express revocation by the applicant or recipient (or such other person described in subsection (b)(1), as applicable) of the authorization, in a written notification to the State.

(d) TREATMENT OF RIGHT TO FINANCIAL PRIVACY ACT REQUIREMENTS.—

(1) An authorization obtained by the State under subsection (b)(1) shall be considered to meet the requirements of the Right to Financial Privacy Act for purposes of section 1103(a) of such Act, and need not be furnished to the financial institution, notwithstanding section 1104(a) of such Act.

(2) The certification requirements of section 1103(b) of the Right to Financial Privacy Act shall not apply to requests by the State pursuant to an authorization provided under subsection (b)(1).

(3) A request by the State pursuant to an authorization provided under subsection (b)(1) is deemed to meet the requirements of section 1104(a)(3) of the Right to Financial Privacy Act and of section 1102 of such Act, relating to a reasonable description of financial records.

(e) REQUIRED DISCLOSURE.—The State shall inform any person who provides authorization pursuant to subsection (b)(1)(A) of the duration and scope of the authorization.

(f) REFUSAL OR REVOCATION OF AUTHORIZATION.—If an applicant for, or recipient of, medical assistance under the State plan under this title (or such other person described in subsection (b)(1), as applicable) refuses to provide, or revokes, any authorization made by the applicant or recipient (or such other person, as applicable) under subsection (b)(1)(A) for the State to obtain from any financial institution any financial record, the State may, on that basis, deter-

mine that the applicant or recipient is ineligible for medical assistance.

(g) USE OF CONTRACTOR.—For purposes of implementing an asset verification program under this section, a State may select and enter into a contract with a public or private entity meeting such criteria and qualifications as the State determines appropriate, consistent with requirements in regulations relating to general contracting provisions and with section 1903(i)(2). In carrying out activities under such contract, such an entity shall be subject to the same requirements and limitations on use and disclosure of information as would apply if the State were to carry out such activities directly.

(h) TECHNICAL ASSISTANCE.—The Secretary shall provide States with technical assistance to aid in implementation of an asset verification program under this section.

(i) REPORTS.—A State implementing an asset verification program under this section shall furnish to the Secretary such reports concerning the program, at such times, in such format, and containing such information as the Secretary determines appropriate.

(j) TREATMENT OF PROGRAM EXPENSES.—Notwithstanding any other provision of law, reasonable expenses of States in carrying out the program under this section shall be treated, for purposes of section 1903(a), in the same manner as State expenditures specified in paragraph (7) of such section.

* * * * * * *

SECTION 4 OF THE TMA, ABSTINENCE EDUCATION, AND QI PROGRAMS EXTENSION ACT OF 2007

(Public Law 110–90)

AN ACT To provide for the extension of transitional medical assistance (TMA), the abstinence education program, and the qualifying individuals (QI) program, and for other purposes.

* * * * * * *

[SEC. 4. EXTENSION OF SSI WEB-BASED ASSET DEMONSTRATION PROJECT TO THE MEDICAID PROGRAM.

[(a) IN GENERAL.—Beginning on October 1, 2007, and ending on September 30, 2012, the Secretary of Health and Human Services shall provide for the application to asset eligibility determinations under the Medicaid program under title XIX of the Social Security Act of the automated, secure, web-based asset verification request and response process being applied for determining eligibility for benefits under the Supplemental Security Income (SSI) program under title XVI of such Act under a demonstration project conducted under the authority of section 1631(e)(1)(B)(ii) of such Act (42 U.S.C. 1383(e)(1)(B)(ii)).

[(b) LIMITATION.—Such application shall only extend to those States in which such demonstration project is operating and only for the period in which such project is otherwise provided.

[(c) RULES OF APPLICATION.—For purposes of carrying out subsection (a), notwithstanding any other provision of law, information

obtained from a financial institution that is used for purposes of eligibility determinations under such demonstration project with respect to the Secretary of Health and Human Services under the SSI program may also be shared and used by States for purposes of eligibility determinations under the Medicaid program. In applying section 1631(e)(1)(B)(ii) of the Social Security Act under this subsection, references to the Commissioner of Social Security and benefits under title XVI of such Act shall be treated as including a reference to a State described in subsection (b) and medical assistance under title XIX of such Act provided by such a State.]

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